Depression in Patients With Advanced Cancer

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Depression is one of the most prevalent syndromes worldwide, affecting as many as 340 million people and resulting in significant disability (Greden, 2001). People with cancer are three times more likely than the general public to experience a depressive disorder. An estimated 20%–25% of patients with cancer experience depression at some point during their illness (Bottomley, 1998; van’t Spijker, Trijsburg, & Duivenvoorden, 1997). In the advanced stages of cancer, the incidence of major depressive syndromes increases to 58% (Breitbart, Bruera, Chochinov, & Lynch, 1995). Greater incidence of depression is correlated with site of malignancy (e.g., pancreatic, lung, or gynecologic cancer), stage of disease (e.g., late versus early), symptom distress (e.g., polysymptomatic versus controlled symptoms), social support (e.g., isolated versus integrated), functional level (e.g., bedbound versus ambulatory), and history of prior psychiatric morbidity (Roth & Holland, 1994). Many of the symptoms experienced in the advanced stages of cancer mimic, mask, or compound depression. Therefore, oncology nurses must be educated in assessment criteria that will aid the differential diagnosis and management of clinical depression during the final phase of life.

Each year, more than half a million people die of cancer (Jemal et al., 2003). Many are burdened by considerable physical and psychological symptom distress prior to death. Depression consistently is ranked as one of the top 10 most troublesome symptoms for people living with an advanced stage of illness (Hotopf, Chidgey, Addington-Hall, & Ly, 2002). Evidence exists that depression can impair quality of life, reduce capacity for pleasure, decrease survival time, exacerbate pain and other symptoms, increase length of hospitalization, elevate healthcare costs, enhance desire for hastened death, and heighten risk for suicide during the advanced stages of cancer (Block, 2000; Breitbart et al., 1995, 2000; Lovejoy & Matteis, 1997). Despite the high incidence and devastating consequences of depression among patients with cancer, under-recognition and inadequate treatment prevail.

Sadness is a normal reaction to the fears, anxieties, and uncertainties during any stage of cancer but is especially problematic during the advanced stage. Depressive symptoms and syndromes frequently coexist during this time and affect quality of life. Depression is an overlooked and undertreated symptom during late-stage cancer. This article provides an overview of the epidemiology, neurophysiology, diagnostic and screening approaches, risk factors, and treatment modalities for depression in patients with advanced cancer.

Key Words: depression, antidepressive agents, cognitive therapy

Neurophysiology of Depression

Psychological distress in patients with cancer evolves from complex interactions of social, psychological, and biologic factors. Depression results when an interruption of homeostasis within the central nervous system causes neurochemical, neuroendocrine, neuroimmune, and neuroanatomical alterations (McDaniel, Musselman, Porter, Reed, & Nemeroff, 1995). The psychobiologic alterations leading to depression emanate from deficiencies of several key chemical messengers called neurotransmitters in the mood-sensitive regions of the brain (Kline, Folks, Palmer, & Powers, 1998). The biologic basis of depression is best described by the monoamine hypothesis, which theorizes that behavioral depression is caused by insufficient activity of the neurotransmitters, namely dopamine and norepinephrine, and serotonin (5-HT); deficits of these neurotransmitters may cause a chemical imbalance at certain sites within the brain, which may lead to depression (Stahl, 1998a).

The malignant disease process may play a causal role in the evolution of depression. Immune activation secondary to tissue destruction and associated inflammation may prompt the activation of pro-inflammatory...
cytokines that contribute to depression through two distinct yet interrelated pathways (Musselman et al., 2001). First, pro-inflammatory cytokines directly reduce 5-HT levels through the suppression of tryptophan, a precursor of 5-HT (Musselman et al.). This, in turn, reduces neurotransmission, a hallmark of the depressive response. Second, pro-inflammatory cytokines activate the hypothalamic-pituitary-adrenal axis, which results in adrenal glucocorticoid hypersecretion. The hypersecretion of glucocorticoids deleteriously affects mood and further suppresses tryptophan (Menkes & MacDonald, 2000). Additionally, cytokine production promotes alterations in the noradrenergic system, which regulates mood states emanating from the central nervous system (Leonard, 2001).

Exogenous and endogenous factors regulate adaptive responses that are directed at maintaining a homeostatic internal environment.

**Diagnosing Depression**

Depression is a complex, affective, neurologic-cognitive response to loss or deprivation, resulting in physical and psychological features (Lovejoy, Tabor, Matteis, & Lillis, 2000). It can be manifested as an adjustment disorder with depressed mood, a mood disorder caused by medical conditions or substances, a major depressive disorder, or dysthymia (a disorder with a chronic depressed mood, a mild form of depression with prolonged duration). Depression is distinguished by its intensity, duration, and the extent to which an individual’s functioning is compromised. Numerous physiologic, treatment-related, and psychological factors have been identified as risk factors for the occurrence of depression in patients with cancer (see Figure 1). Uncontrolled pain has been cited as the most prominent and reversible cause of depressed mood in patients with advanced cancer (Spiegel, Sands, & Koopman, 1994). Patients with advanced cancer commonly receive multiple pharmacologic agents to abate cancer-related symptoms and manage other chronic health conditions. Medication interactions and side effects may contribute deleteriously to depressed mood states, particularly in advanced illness. Multiple barriers obscure the detection of depression coexisting with cancer. These barriers may have patient, family, and clinician etiologies.

Psychological distress frequently is normalized as an expected consequence of advanced disease (Lloyd-Williams, 2001). Patients often underestimate their own distress, believing it is an extended extension of the disease trajectory. Additionally, they may lack the ability to describe their psychological distress (Beliles & Stoudemire, 1998). Family members and friends of seriously ill patients generally are not helpful in determining depression in advanced disease. Their reports of psychological distress have been found to reflect their own distress rather than the patients’ (Fuller, Lang, & Schilling, 1995). Barriers regarding healthcare providers relate primarily to the perception and recognition of depression. For example, somatic symptoms of advanced cancer (e.g., lethargy, lack of appetite), coupled with the perception that depression is an expected outcome of advanced disease, often preclude nurses’ recognition of clinical depression.

McDaniel (2000) noted that healthcare professionals often have a mistaken notion that reactive depressions are not pathologic; therefore, they do not intervene. Additionally, they feel ill-equipped to differentiate appropriate sadness from clinical depression (Block, 2000). Physical manifestations of advanced illness may mirror some of the diagnostic criteria for major depression. For example, anorexia, weight loss, sleep disturbance, and fatigue are common features of advanced cancer. These symptoms must be examined carefully because they may represent the coexistence of depression. Several studies of oncology professionals’ accuracy in recognizing moderate to severe depressive symptoms indicated that more than half of the time, depressive symptoms were markedly underestimated (McDonald et al., 1999; Passik et al., 1998). In general, failure to recognize and treat psychological morbidity occurs as much as 80% of the time in patients with cancer; depression is the most under-recognized symptom in advanced cancer (Lloyd-Williams, 2000). Professionals may believe that they do not have the necessary time to identify sources of emotional distress. They often mistakenly believe that exploration of psychological issues will precipitate distress (Block). In addition, some healthcare professionals fear that if expressions of depression are relayed, they might feel inadequately prepared to intervene or refer appropriately. Finally, healthcare providers often are reluctant to prescribe and administer psychotropic medications for various reasons, such as concern about adverse effects (Macleod, 1998).

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) (American Psychiatric Association, 2000) is the gold standard for diagnosing psychopathology. The diagnostic criteria for major depression include the presence of depressed mood and/or loss of pleasure for more than two weeks in addition to at least three physical (weight gain or loss, sleep disturbance, loss of energy, psychomotor retardation) or psychological (difficulty concentrating, guilt or low self-esteem, thoughts of suicide or death) manifestations of depression. However, in the medically ill, the DSM-IV-TR criteria for diagnosing major depression are not to be used. In cancer care, major obstacles include distinguishing physical manifestations of depressive psychopathology from disease- or treatment-related symptoms and the differentiation of psychological responses commonly experienced by patients with cancer (Lovejoy & Matteis, 1997). Figure 2 illustrates the interacting variables in advanced cancer that contribute to the somatic manifestations of depressive illness.

Making a diagnosis of depression in patients with advanced cancer is challenging. No reliable biologic markers for depression exist, physical symptoms of depression often are attributed to advanced disease, and...
no effective diagnostic tests have been developed (Lloyd-Williams, 2001). Two sets of diagnostic criteria have been proposed to aid in the accuracy of diagnosing depression among the medically ill: the Endicott Substitution Criteria (see Table 1) and the Cavanaugh Exclusive Criteria. The Endicott Substitution Criteria propose replacing the physical symptoms of depression with cognitive and affective features of depression that may be more sensitive indicators of depression in patients with medical illnesses (Endicott, 1984). The Cavanaugh Exclusive Criteria exclude the somatic symptoms (weight loss or gain, sleep disturbance, loss of energy, psychomotor retardation) of depression proposed in the DSM-IV-TR diagnostic criteria for depression and rely solely on psychological symptoms (difficultly concentrating, guilt or low self-esteem, thoughts of suicide or death) for diagnosing depression in the medically ill (Cavanaugh, 1984).

Koenig, George, Peterson, and Pieper (1997) substantiated that the substitution and exclusive diagnostic approaches were sensitive and reliable in detecting depression in medically ill adults. The undertreatment of depression in palliative care is pervasive and closely related to the absence of standardized diagnostic criteria for depressed patients with medical illnesses (Stiefel, Die Trill, Berney, Olarte, & Razavi, 2001).

**Figure 2. Multiple Etiologies of Common Symptoms During Advanced Disease**

Depression is largely underidentified when patients are left to volunteer their distress. However, when patients are questioned routinely about depression, both the incidence and intensity of depression are found to be significant (Hotopf et al., 2002). Moreover, when screening tools are integrated routinely into clinical practice, the detection of depression increases significantly (McDonald et al., 1999; Passik et al., 1998).

Screening tools do not predicate a depressive syndrome diagnosis; however, they do improve recognition of the symptoms predictive of depression. Four screening approaches have been proposed for integration into cancer care (see Table 2). The application of a validated assessment tool, consideration of the intensity and duration of psychological distress, and diagnostic studies aid healthcare professionals in the differential diagnosis of depression in patients with advanced cancer.

### Management of Depression in Advanced Cancer

Depression is a treatable condition, even in people in the advanced stage of disease with limited life expectancy. However, evidence suggests that fewer than 10% of patients with depression receive adequate treatment (Hirschfeld et al., 1997). For patients exhibiting depressive symptoms, clinicians should promptly initiate pharmacologic and nonpharmacologic measures to ameliorate depressive symptomatology (Bruera & Neumann, 1998). According to Valente and Saunders (1997), as many as 80%–90% of depressed patients with cancer may be effectively treated with combinations of pharmacologic, psychotherapeutic, and cognitive-behavioral interventions.

The National Comprehensive Cancer Network Practice Guidelines recommend a tiered approach to the management of depression, including evaluating for suicide risk, undertaking diagnostic testing, modifying risk factors for depression, and assessing safety. After safety is ensured, pharmacologic therapy can be initiated alongside psychotherapy, with ongoing evaluation of effectiveness and appropriate modifications in the management regimen (Holland & Murillo, 2002). Assessment of potentially reversible etiologies causing or exacerbating depressive symptoms is the first step in managing depression. Improving management of pain or other distressing symptoms, correcting metabolic abnormalities, and evaluating current pharmacotherapies should be part of the initial intervention. Additionally, healthcare professionals must differentiate between depression, delirium (acute onset, transient, waxing and waning attention span, hallucinations) and dementia (chronic, insidious, progressive, permanent, cognitive impairment) to achieve an accurate diagnosis and initiate appropriate interventions (Boyle, Abernathy, Baker, & Wall, 1998). Selection of an antidepressant is influenced by the nature of the medical condition, associated symptoms, prognosis, and dosing options. Depending on institutional practice, collaboration with a psychiatrist may be mandated, recommended, or available if needed for the selection, dosing, and monitoring related to depression management.

Although antidepressant therapy is significantly underutilized in clinical care, pharmacologic interventions are the mainstay of depression management. A paucity of clinical trials have evaluated antidepressant therapy in patients with cancer. The existing evidence base is translated from the wider population of patients who are medically ill (Berard, 2001). Presently, eight classes of antidepressants are used clinically. Table 3 summarizes these medications by mechanism of action and details their indications for use, dosing regimens, and potential side effects.

These psychopharmacologic agents exert their clinical effects primarily through the increased availability or reduced degradation of neurotransmitters integral to the regulation of mood states. The clinical efficacy of antidepressants in abating depressive symptoms is attributed primarily to their effects on the 5-HT neurotransmission system with secondary effects on the norepinephrine and dopamine neurotransmitter systems that influence mood states. The selection of an appropriate antidepressant...
class is based on established efficacy in ameliorating the confounding symptoms that coexist with depressed mood. For example, patients with advanced cancer, neuropathic pain, and insomnia may benefit from a tricyclic antidepressant with efficacy in amending depression, pain, and insomnia (Richeimer, Bajwa, Kahraman, Ransil, & Warfield, 1997). Patients with medication-induced fatigue or those in the final phases of life would benefit from the initiation of a psychostimulant because elevations in mood and energy level may be appreciated within 24 hours (Pereira & Bruera, 2001). Patients with depression coexisting with low appetite and insomnia may benefit from a noradrenergic-specific, serotonin-antidepressant such as mirtazapine. Mirtazapine has been found to enhance appetite, alleviate insomnia, and abate depression (Theobald, Kirsh, Holtsclaw, Donaghy, & Passik, 2002).

Psychotherapeutic interventions should be employed concurrently to address the interpersonal issues associated with depression. The interventions encompass a wide range of cognitive-behavioral therapy and psychosocial support. Cognitive-behavioral interventions address the role of unresolved stressors and defeatist attitudes that prompt depressive pathology (Lovejoy & Matteis, 1997). Negative attitudes stemming from feelings of isolation, rejection, and perceived lack of love frequently require attention. During cognitive-behavioral therapy, therapists take an active role in modeling and mentoring depressed individuals to reshape perceptions and empower new behaviors. For oncology nurses, cognitive-behavioral interventions can be integrated into practice through reframing, clarifying meaning, role playing, relaxation, distraction, and imagery in individual and group settings (Lovejoy et al., 2000). The interdisciplinary healthcare team, including social workers, psychotherapists, psychologists, psychiatrists, and spiritual care providers, plays an integral role in cognitive-behavioral interventions and provides supportive psychosocial care.

In addition to cognitive-behavioral interventions, psychosocial support has a well-recognized role in ameliorating depression. Chochinov (2001) noted that patients often perceive pharmacologic intervention in the absence of psychological support as abandonment. This issue is particularly relevant to coping at the end of life. Benefits of psychological support are difficult to quantify because of the subjective nature of coping (Ross, Boesen, Dalton, & Johansen, 2002). Family members and healthcare providers also can benefit from patient-focused psychosocial support. When family members are the recipients of psychosocial support, the culture of social support often functions more effectively. A study by Hann et al. (2002) revealed that greater perceived adequacy of social support and satisfaction with family functioning were correlated with reduced severity of depression. Therefore, interventions directed toward improving family affect and functioning can reduce depressive mood states in patients.

Several other modalities are postulated to have a role in the management of depression in advanced cancer. Electroconvulsive therapy and repetitive transcranial magnetic stimulation are recognized treatment modalities for individuals suffering from severe or refractory depression (Janicak et al., 2002). Patients self-managing depression commonly employ a number of nonprescription therapies. Hypericum perforatum (St. John’s wort) and S-adenosyl-L-methionine (SAMe) are over-the-counter preparations popular with the general public. However, St. John’s wort was found in multicenter, randomized, controlled trials to be ineffective in treating major depression (Shelton et al., 2001). Particular concerns exist about potential drug interactions with St. John’s wort. SAMe is a popular over-the-counter preparation to relieve or reduce the symptoms of depression. A meta-analysis conducted by the Agency for Healthcare Research and Quality (2002) indicated that SAMe, in most studies, was more effective than placebo in reducing depressive symptoms. Guided imagery, structured breathing, massage, acupuncture, and nutrition (i.e., increasing dietary omega-3 fatty acids, vitamin B, and protein intake) potentially aid in treatment of depression (Manber, Allen, & Morris, 2002; Rogers, 2001). The use of a multimodal approach may improve outcomes. However, studies of the efficacy and safety of multimodal approaches in patients with advanced cancer are lacking.

### Nursing Model of Care for Depression

Oncology nurses frequently have privileged and enduring relationships with patients and their families. They often spend the most time and have closer interactions with patients than other members of the
## Table 3. Antidepressant Pharmacotherapies

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug Name</th>
<th>Dosing Information</th>
<th>Indication for Use (Includes Off-Label Use)</th>
<th>Side-Effect Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serotonin selective reuptake inhibitors (SSRIs)</td>
<td>Fluoxetine (Prozac®, Eli Lilly, Indianapolis, IN)</td>
<td>20–80 mg by mouth daily</td>
<td>First-line agent in depression alone or in combination with anxiety</td>
<td>Agitation, sleep disturbance, sexual dysfunction, and gastrointestinal disturbance. Patients may become refractory to clinical benefit.</td>
</tr>
<tr>
<td></td>
<td>Sertraline (Zoloft®, Pfizer, Inc., New York, NY)</td>
<td>50–200 mg by mouth daily</td>
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<tr>
<td></td>
<td>Paroxetine (Paxil®, GlaxoSmithKline, Philadelphia, PA)</td>
<td>20–50 mg by mouth daily</td>
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<tr>
<td></td>
<td>Fluvoxamine (Luvox®, Solvay, Marietta, GA)</td>
<td>50–150 mg by mouth twice a day</td>
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<tr>
<td></td>
<td>Citalopram (Celexa™, Forest, St. Louis, MO)</td>
<td>20–60 mg by mouth daily</td>
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<tr>
<td></td>
<td>Amitriptyline (Elavil®, Astrazeneca, Wilmington, DE)</td>
<td>50–150 mg by mouth at bedtime</td>
<td>First-line agent in patients with depression, neuropathic pain syndrome, or insomnia</td>
<td>Dry mouth, blurred vision, constipation, drowsiness, hypotension, dizziness, and risk of cardiac arrhythmias</td>
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<tr>
<td></td>
<td>Nortriptyline (Pamelor®, Novartis, East Hanover, NJ)</td>
<td>50–150 mg by mouth at bedtime</td>
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<tr>
<td></td>
<td>Desipramine (Norpramin®, Aventis, Bridgewater, NJ)</td>
<td>100–300 mg by mouth in the morning</td>
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<tr>
<td></td>
<td>Clomipramine (Anafranil®, Novartis)</td>
<td>150–250 mg by mouth at bedtime</td>
<td></td>
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<tr>
<td></td>
<td>Imipramine (Tofranil®, Novartis)</td>
<td>150–300 mg by mouth at bedtime</td>
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<tr>
<td>Serotonin and norepinephrine reuptake inhibitor</td>
<td>Venlafaxine (Effexor®, Wyeth-Ayerst, Philadelphia, PA)</td>
<td>37.5–75 mg by mouth three times a day</td>
<td>Enhanced therapeutic effect on dual neurotransmitters with dose escalation; fewer drug interactions than SSRIs</td>
<td>Agitation, insomnia, weight loss, sexual dysfunction, and hypertension</td>
</tr>
<tr>
<td>Serotonin antagonist reuptake inhibitors</td>
<td>Nefazodone (Serzone®, Bristol-Myers Squibb, Princeton, NJ)</td>
<td>100–300 mg by mouth twice a day</td>
<td>Indicated in SSRI nonresponders and those unable to tolerate SSRIs; effective for treatment of depression in association with agitation, anxiety, sleep disturbance</td>
<td>Hypersomnia; difficult to manage in patients who have difficulty with medication adherence</td>
</tr>
<tr>
<td></td>
<td>Trazadone (Desyrel®, Apothecon, Princeton, NJ)</td>
<td>50–100 mg by mouth two or three times a day</td>
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<tr>
<td>Norepinephrine dopamine reuptake inhibitor</td>
<td>Bupropion (Wellbutrin®, GlaxoSmithKline)</td>
<td>100 mg by mouth three times a day</td>
<td>Treatment of SSRI nonresponders; preferred in patients with hypersomnia or cognitive slowing; good for patients concerned about sexual dysfunction</td>
<td>Overstimulation, agitation, insomnia, nausea, and seizures</td>
</tr>
<tr>
<td>Noradrenergic-specific serotonergic antidepressant (NaSSA)</td>
<td>Mirtazapine (Remeron®, Organon, West Orange, NJ)</td>
<td>15–45 mg by mouth at bedtime</td>
<td>Severe depression, SSRI side-effect burden, or nonresponders; good for use with anxiety and insomnia disturbances</td>
<td>Weight gain, sedation, cognitive slowing, and motor disturbance</td>
</tr>
<tr>
<td>Monoamine oxidase inhibitors</td>
<td>Phenelzine (Nardil®, Parke-Davis, Morris Plains, NJ)</td>
<td>15–30 mg by mouth three times a day</td>
<td>Second-line therapy for patients with atypical or refractory depression</td>
<td>Must strictly follow dietary restrictions (avoid tyramine-rich foods); high incidence of drug-drug interactions</td>
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<td></td>
<td>Tranylcypromine (Parnate®, GlaxoSmithKline)</td>
<td>15–30 mg by mouth twice a day</td>
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<tr>
<td>Psychostimulants</td>
<td>Methylphenidate (Ritalin®, Novartis)</td>
<td>2.5–30 mg by mouth every morning and at noon</td>
<td>First-line therapy alone or in combination with alternate agent for severe depression or in patients with limited life expectancy. Onset of action is 24–48 hours.</td>
<td>Hypertension, anxiety, agitation, confusion, and risk of arrhythmias and hepatic dysfunction; potential for tolerance or addiction</td>
</tr>
<tr>
<td></td>
<td>Dextroamphetamine (Dexedrine®, GlaxoSmithKline)</td>
<td>2.5–30 mg by mouth every morning and at noon</td>
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</tr>
<tr>
<td></td>
<td>pemoline (Cylert®, Abbott, North Chicago, IL)</td>
<td>37.5–75 mg by mouth every morning and at noon</td>
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</table>

Note. Based on information from Breitbart et al., 1988; Physicians’ Desk Reference, 2002; Stahl, 1998b.
Healthcare team. The provision of mental health interventions is a natural extension of such close interactions. Equipped with the knowledge that depression is the most under-recognized symptom in advanced disease, oncology nurses are afforded a unique opportunity to reduce depressive symptom distress by integrating effective assessment and management strategies into clinical practice.

Caring for patients with cancer who may be experiencing depression is best addressed with an integrative approach encompassing assessment, advocacy, education, symptom management, and evaluation of response to interventions. The systematic assessment of risk factors for depression and routine integration of screening tools into clinical care aid in the early recognition of depression. Additionally, nurses have an important role in advocating for the intensive and aggressive management of depressive symptoms when they arise. Teaching patients and families to monitor for depression and accept pharmacologic and nonpharmacologic interventions to alleviate it are critical nursing interventions. Patients and family members often believe that admission of depression is a sign of personal weakness or inability to cope; anticipatory guidance and education reframe these common myths. Oncology nurses can reduce symptom distress by identifying risk factors and early signs of depression. Additionally, familiarity with medications, particularly those that can cause depression, is another strategy for minimizing the prominence of clinical depression. Ongoing assessment followed by treatment modification when necessary also is essential.

A special nursing consideration related to depression is concern about suicide. Patients with cancer, particularly those in the advanced stages of disease, are at a heightened risk for suicide; depression is a factor in 75% of such cases (Moscicki, 1997). In a study of patients with advanced lung cancer, Akechi, Okamura, Nishiwaki, and Uchitomi (2002) identified the experience of pain after disclosure of a cancer diagnosis, declining physical function, and the presence of pain after disclosure of a cancer diagnosis as significant predictors of suicidal ideation. Patients with advanced cancer often have a fluctuating will to live; the highest risk for suicide occurs in patients with unmanaged symptoms (including depression), hopelessness, preexisting psychopathology, suicide history, and inadequate social support (Breitbart, 1994; Tataryn & Chochinov, 2002). For patients displaying suicidal intent, ensuring safety by bolstering social supports, being hypervigilant in symptom management, and maintaining a therapeutic dialogue are paramount (Chochinov, 2001). Early recognition of suicide risk factors and rigorous lobbying for urgent multimodal interventions to reduce depression when suicide risk factors are identified are integral to a depression-sensitive nursing delivery of care model.

Future Research Agenda

Psychological, social, and existential sources of suffering in patients with advanced cancer represent an under-researched area of nursing inquiry. Exemplary nursing care during the advanced stages of cancer has the potential to decrease suffering and promote quality living. A critical component of the research agenda includes the development of diagnostic criteria that are applicable to clinical practice and accurately diagnose depression in patients with cancer. Additionally, symptom clusters that coexist and cause or exacerbate depression must be defined. Existing screening tools should be evaluated for reliability and validity for use with patients with advanced cancer. Controlled clinical trials with cancer populations will determine the efficacy and safety of the wide ranges of antidepressant agents currently available and their potential use in combination therapy regimens (Ballenger et al., 2001). Antidepressant pharmacotherapies should be evaluated in patients with cancer and coexisting metabolic abnormalities. Polypharmacy must be considered as dose, tolerance, and adverse effects are investigated. The role of psychosocial and integrative therapies in palliating depression in patients with advanced cancer has not been studied adequately. Some nursing research in palliative care has drawn negative comments regarding methodologic design and theoretical and conceptual framework (Bailey, Foggatt, Field, & Krishnasamy, 2002). To improve care in the advanced stages of cancer, researchers and clinicians must rigorously query and contribute to the limited evidence base on psychosocial symptom management.

Summary

Depression is a frequent comorbid condition that complicates living with advanced cancer. Like many other symptoms, depression is responsive to targeted therapeutic interventions. Oncology nurses have a responsibility to recognize and manage depression. This includes advocating for the alleviation of its devastating psychological consequences by increasing awareness of depression’s prominence during advanced cancer. Additionally, nurses play a crucial role in educating and supporting patients and families in managing depression through pharmacologic and nonpharmacologic methods.

Multiple patient, professional, and disease-related barriers interfere with the management of depression in patients with cancer. Patients may hesitate to admit that they have feelings of profound sadness. The commonly used DSM-IV-TR criteria for diagnosing depression lack sensitivity and specificity for assessing and confirming depression during the cancer experience. The multisymptom nature of late-stage cancer complicates the recognition of depression. Pharmacologic therapy of depression is hampered by lack of knowledge of current therapeutic options and concerns about addiction. A concerted effort must be made to address these numerous barriers and foster improved management of depression. Pharmacologic, psychotherapeutic, and cognitive-behavioral approaches can result in significantly reduced symptom distress from unmanaged depression and correlate with improved quality of life. Oncology nurses can reduce psychological suffering when they advocate, screen, educate, treat, and support patients and their families when depression predominates during advanced cancer.

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References


**Rapid Recap**

**Depression in Patients With Advanced Cancer**

- Greater incidence of depression is correlated with cancers that do not respond well to treatment, end-stage disease, presence of distressing symptoms, limited social support, and decreased functional levels.

- The consequences of untreated depression have far-reaching implications correlated with diminished quality of life and heightened symptom distress.

- The standard criteria for diagnosing depression have questionable applicability in patients with advanced cancer; the Endicott Substitution Criteria and other validated screening tools can assist clinicians in recognizing depression.

- Multimodal interventions involving the correction of reversible etiologies of depression, psychopharmacologic agents, cognitive-behavioral therapy, and psychosocial support may improve outcomes in managing depression in advanced cancer.

- Oncology professionals play a key role in identifying depression, educating patients and families, advocating for and providing management interventions, and evaluating clinical responses to interventions.

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For more information on this topic, visit the following Web sites.

Cancer Symptoms: Depression
www.cancersymptoms.org/symptoms/depression

End of Life/Palliative Education Resource
www.eperc.mcw.edu

Talaria: Depression and Cancer Pain
www.stat.washington.edu/TALARIA/LS7.3.1.html

Links can be found using ONS Online at www.ons.org.