Understanding Depression in the Elderly Cancer Patient

Nearly 60% of cancer diagnoses are in persons 65 years of age and older—a group that is now the fastest growing segment of the US population. Cancer patients in this age group suffer significant psychological distress that should be recognized and effectively treated, said Andrew J. Roth, MD, Associate Attending Psychiatrist, Memorial Sloan-Kettering Cancer Center (MSKCC), New York.

Most of this "distress" among elderly patients does not rise to the level of major depressive disorder, although the incidence of major depression in older persons (17%–25%) is higher than that of the general community (3%). Rates among older cancer patients, in particular, are not known. More common is minor depression, which includes dysthymia and subthreshold depression and has a significant impact on function. In the MSKCC Geriatric Psychiatry Clinic experience, 27% of patients have depression or mood disorders significant enough to warrant psychiatric intervention, he said.

Table 1

Losses of Older Age That May Lead to Loneliness and Isolation

Losses
Physical losses
Sight
Hearing
Mobility
Stamina
Energy
Mental acuity
Sex versus intimacy
Multiple medical problems
Anticipated losses
Increased dependence
Questions about dying (eg, how, when, and how painful)
Personal losses
Loss of spouse/confidant, family, peers, pets, job, support systems
Factors may be different for men and women

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Risk factors for depression, in general, include loss of a spouse, functional disability, inadequate emotional support, other life stresses or losses, uncontrolled pain and advanced illness, poor physical condition, history of depression, family history of depression or suicide, and use of medications known to cause depression.

In particular, psychological distress in cancer patients may be precipitated by physical symptoms (eg, pain, fatigue), psychological symptoms (eg, fear, sadness), social concerns (for family and their future), spiritual concerns (eg, need for comforting philosophical, religious, or spiritual beliefs), and existential concerns (seeking meaning in life while confronting possible death and its meaning).

Erikson offered some insights on aging, concluding that there were several "psychological tasks" of older age. They included making peace with the life one lived, staying as active and involved in life as possible while facing the fact of a shortened future and death, and serving as a link between the past and the future—mentoring, teaching, and passing on values, information, and "wisdom" to the next generation.

"We are trying to develop a geriatric-specific form of psychotherapy using these concepts in a cognitive model of treatment," Dr. Roth said.

Overall, elderly people appear to cope with cancer better than do younger patients, but their psychiatric distress is more difficult to assess, he added. "Many elderly patients, especially men who have never had psychiatric treatment, are less willing to accept psychiatric help in the cancer setting."

Coping with cancer at older ages is particularly difficult because of other life-cycle events and losses (Table 1), such as retirement; widowhood; death of peers; and loss of hearing, sight, and mobility. A major challenge for older cancer patients is deciding whether or not to undergo treatment for their cancer, Dr. Roth commented.

Recognizing Distress

The causes of distress may be voiced by patients; hopefully, they will be heard with sensitivity by clinicians (Table 2), he noted. "When we hear certain words, we get a sense of whether to intervene more."

Older cancer patients, however, often do not express their loneliness or depression. They tend to stigmatize "mental" issues, to minimize depressive symptoms, and to blame their illness. "The bottom line is that about 25% of older patients do not report psychiatric symptoms and,

Table 2

Causes of Distress: Patients' Thoughts

Should I have treatment for the cancer or not?
Which treatment is best for me… …in terms of cure? …in terms of quality of life and complications?
I don't have the energy to do what I used to do, so I don't do anything.
I've been more irritable lately.
Since I am on hormones, I have no interest in sex … why is my wife complaining about wanting more intimacy?
Since I found Viagra and the penile injections, I'm interested in having sex…why is my wife complaining?
I've lived my whole life without medications for depression, and I have been through hell. Why do I need any (medications) now? I'm already on too many medications.
I don't want to be a burden on anyone; let me die.

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therefore, go untreated," Dr. Roth noted. "The trick is figuring out where the patient lands on the continuum that extends from 'normal' sadness to minor depressive symptoms to major depression. Further complicating things, depression is often combined with anxiety."

Depressed elderly patients are more likely to have somatic complaints than do younger patients; however, issues with sleep, appetite, and energy may be less reliable signs in the elderly than in younger patients. Cognitive symptoms of depression (eg, hopelessness, worthlessness, guilt, suicidal thoughts) may be significant.

Evaluating Patients

When patients disavow feeling depressed, they may be asked a few questions." To identify anhedonia, ask, "Are there things you still enjoy doing?" To detect hopelessness, ask, "How does the future look?" To evaluate feelings of helplessness, ask, "Do things feel out of control?" Finally, Dr. Roth advised, to identify feelings of worthlessness and guilt, ask, "Do you worry about being a burden?"

Physical symptoms of cancer must be distinguished from the neurovegetative symptoms of depression. They may be sifted out by asking about pain control, fatigue, insomnia, appetite, libido, and psychomotor activity.

The National Comprehensive Cancer Network (NCCN) recommends that physicians use the NCCN Distress Thermometer and Problem List for triaging patients. Other screening tools are the Geriatric Depression Scale, the Center for Epidemiologic Studies-Depression Scale, the Hospital Anxiety and Depression Scale, and the Beck Depression Scale.

For some patients, brief screening approaches may work. One is a single-item interview that assesses depressed mood by asking, "Have you been depressed most of the time for the past 2 weeks?" Another is a two-item interview that assesses depressed mood and loss of interest in activities. According to Dr. Roth, a visual analog scale for depressed mood, such as the 13-item Beck Depression Inventory, also may be helpful. Finally, the risk of suicide increases with advancing age; the clinician also should assess the patient for this risk by asking about suicidal ideation, family history or prior attempts of suicide, and alcohol and drug use.

Depression Treatment

Psychotherapy and psychiatric medications may be effective, but they may need modification to accommodate elderly patients and end-of-life issues. Family and social resources must be taken into account to optimize treatment in this age group, Dr. Roth added.

Psychotherapeutic techniques include supportive therapy, treatment that is oriented toward cognitive behavior, group therapy, meaning-centered therapy, and dignity-conserving therapy. There is no one best approach specific to the needs of the elderly.

Therapy sessions usually are of shorter duration (20–30 minutes) for the elderly than for younger patients; they tend to assume a flexible style. "I may even use support, education, cognitive-behaviorally oriented therapy, and insight-oriented approaches all in one session," he said.

To be most effective, the therapist

Table 3

Some Commonly Used Antidepressants

DRUG CLASS	STARTING DOSE	COMMENTS
Selective serotonin-reuptake inhibitors		
Escitalopram	5–10 mg	Few side effects
Citalopram	10–20 mg	Less expensive
Paroxetine	10–20 mg (Paxil)/ 6.25 mg (Paxil CR)	Less expensive
Sertraline	25–50 mg	Less expensive
Newer		
Bupropion (extended- and sustained-release)	75–300 mg	No sexual dysfunction
Duloxetine	20–40 mg	Serotonin-norepinephrine reuptake inhibitor
Mirtazapine	15–30 mg	Take at bedtime/ weight gain
Trazodone	50–100 mg	Sedating; take at bedtime
Venlafaxine	25–37.5 mg	Serotonin-norepinephrine reuptake inhibitor
Stimulants		
Dextroamphetamine	5–10 mg	Less expensive
Modafinil	50–200 mg	Immediate effect
Methylphenidate	5–10 mg	Less expensive

If anxiety is present, use a low dose of alprazolam (0.125–0.5 mg) twice or three times daily or of clonazepam (0.25–0.5 mg).
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Table 4

Choosing an Antidepressant Based on Patient's Review of Symptoms

SYMPTOM	CONSIDERATION
Fatigue/sedation	Stimulant/SSRI/ bupropion
Anxiety/insomnia	Mirtazapine; SSRI
GI upset	Mirtazapine; tricyclic antidepressant
Constipation	SSRI; bupropion
Loss of appetite	Mirtazapine; tricyclic antidepressant; stimulant
Dry mouth	SSRI; stimulant
Pain	Stimulant; SNRI; tricyclic antidepressant

Abbreviations: SSRI = selective serotonin-reuptake inhibitor; SNRI = serotonin-norepinephrine reuptake inhibitor

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should understand the following truths about older people facing cancer: they may benefit from reviewing their lives and dealing with practical matters of passing on belongings eventually, they have an urgency to complete their work and may want to know "how much time is left," and they may be more resilient and better able to control their emotions than are younger patients, which some may call "wisdom."

It is often useful to explore the "why me?' question to understand how patients view their situation. "And when you ask about their concerns regarding treatment, you need to explore their history to identify points that can be used to guide your dialogue," he added.

In terms of psychopharmacology, the selective serotonin-reuptake inhibitors (SSRIs) are used as first-line (Table 3) therapy. Stimulants work faster; however, methylphenidate poses a risk for hypertension and tachycardia. Other psychotropic medication issues to be considered are the patient's liver and renal functions, cognitive function (eg, avoid tricyclic antidepressants due to anticholinergic effects), possible drug interactions, and use of alcohol. It is wise to start with low doses, to titrate slowly, and to schedule the first return visit within 2 weeks. Between visits, patients should be called by telephone to monitor their progress and, if they do not improve, to be referred to a psychiatrist.

The choice of medication is often based on the drug's additional actions to maximize benefits (Table 4).

Finally, Dr. Roth noted benefits observed when distressed patients receive appropriate help. In a study of depressed and anxious older patients on chemotherapy who were treated in oncology clinics, a telephone program was effective in significantly reducing anxiety, depressive symptoms, and total distress scores. When patients were asked, "What was important about the calls?" the most common answer was, "Somebody cared."