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Assessment and Pharmacotherapy of Depression

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Depressive disorders are experienced by a significant number of patients with cancer, with reported rates of 0%–58% (Massie, 2004). Numerous studies have demonstrated that depression in patients with cancer is underdiagnosed and inadequately treated as a result of a number of factors (Schwartz, Lander, & Chochinov, 2002). Although more severe or complex situations involving depression or other mental illness necessitate specialist referral, sometimes professionals treating patients with cancer may find the need to initiate treatment. Thus, clinicians need to be aware of basic principles related to the assessment and treatment of depression.

Controversy exists regarding the diagnosis of depression in patients with cancer because of the overlap between somatic signs of depression (e.g., appetite or weight changes, fatigue) and symptoms associated with cancer and treatment side effects. Diagnostic systems vary with respect to the inclusion, exclusion, or substitution of somatic symptoms (Trask, 2004), but these have not demonstrated improved results (Valentine, 1999) over the most widely held standard, the *Diagnostic and Statistical Manual of Mental Disorders,* text revision (*DSM-IV-TR*) (American Psychiatric Association, 2000). Also, no singular approach exists regarding the threshold at which a diagnosis is made. Some clinicians adhere to strict diagnostic criteria, whereas others may prefer to not risk the possibility of an untreated illness.

Diagnostic Criteria

According to the *DSM-IV-TR*, at least five of nine specific symptoms must be present to meet the criteria for a major depressive episode (American Psychiatric Association, 2000). The core symptom, depressed mood or loss of interest or pleasure, is required. At least four of the other symptoms also must be present: insomnia or hypersomnia, recurrent thoughts of death or recurrent suicidal ideation (or an attempt or plan), loss of energy or feelings of fatigue, changes in appetite or weight, loss of concentration or difficulties in decision making, psychomotor retardation (i.e., significantly slowed thinking and movement) or psychomotor agitation (i.e., significantly accelerated thinking and movement), or feelings of worthlessness or excessive guilt. To diagnose depression, symptoms must have been present for at least two weeks and also must occur on most days of the week, except for thoughts of death or suicide. Symptoms must not be related directly to the physical effects of a medical condition or a substance (e.g., medication or drug of abuse). Significant distress or impaired social or occupational functioning also is necessary to meet diagnostic criteria. Furthermore, the symptomatology should not be related to bereavement (i.e., symptoms should persist longer than two months after bereavement begins) or be associated with significant functional impairment, suicidal ideation, preoccupation with worthlessness, psychomotor retardation, or psychotic symptoms, such as delusions or hallucinations, representing loss of contact with reality.

Assessment

Clinicians may observe evidence of possible depression, such as sad or anxious affect, reduced spontaneity, slowness in speech and behavior, negative statements, stooped posture, or reduced eye contact. Less commonly, irritability and restlessness may be seen. In many situations, however, depression is not evident on initial presentation, and patients may deny having depressed mood. Several screening tools used in the oncology setting may facilitate assessment when time is limited (Pirl & Roth, 1999); however, the use of a diagnostic interview based on the *DSM-IV-TR* criteria remains the standard (Pirl, 2004). Ideally, clinicians should not proceed routinely through a symptom checklist but rather engage patients in guided conversation about

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