



Research paper

The suitability of the Hospital Anxiety and Depression Scale, Distress Thermometer and other instruments to screen for psychiatric disorders in both lung cancer patients and their partners



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ABSTRACT

Background: Lung cancer patients and their partners report high rates of distress. Although distress is of importance, psychiatric disorders might be more important in terms of prognostic value and additional psychological treatment. This study examined the suitability of the Hospital Anxiety and Depression Scale (HADS), Distress Thermometer (DT), Beck Depression Inventory (BDI-II) and State subscale of State Trait Anxiety Inventory (STAI-S) to screen for psychiatric disorders in lung cancer patients and partners. **Methods:** A consecutive sample of lung cancer patients and partners completed the screening instruments. The Structured Clinical Interview DSM-IV (SCID-I) was used to diagnose psychiatric axis I disorders.

Results: In 144 patients, overall ability of HADS total score (HADS-T) screening for patients with psychiatric disorders was good, whereas DT appeared less suitable. In 98 partners, the performance of HADS-T was good. Although no instrument was successful in identifying psychiatric disorders, HADS-T came closest with a fair performance in patients and partners.

Limitations: Several patients and partners declined participation because they perceived participation as too distressing. As decliners possibly have the highest rates of disorders, our findings might underestimate the prevalence of psychiatric disorders. A low prevalence negatively affects the positive predictive value and complicates efficient screening for psychiatric disorders.

Conclusion: The HADS-T appears to be a suitable screening instrument for ruling out those lung cancer patients and partners without a psychiatric disorder. Regarding identifying those with a psychiatric disorder, HADS-T should be used to refer both patients and partners for further diagnostics and treatment to a psychiatrist/psychologist.

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1. Introduction

Lung cancer is the leading cause of death by cancer worldwide. As patients often develop severe physical symptoms, undergo intrusive treatment and face a poor prognosis, lung cancer has a major impact on psychological wellbeing. Patients report among the highest rates of psychological distress (43–45%) (Carlson et al., 2004; Linden et al., 2012) and depressive disorders (11%) (Walker et al., 2014) of all cancer patients. Generally, 15–19% of lung cancer patients meet the criteria of a psychiatric disorder (Akechi et al.,

2001). Psychiatric disorders in cancer patients have been associated with decreased quality of life, decreased compliance with medical care, prolonged hospital stay and even decreased overall survival (Colleoni et al., 2000; Lloyd-Williams et al., 2009; Okamura et al., 2005; Prieto et al., 2002).

Not only patients, but also their partners can be profoundly affected by the lung cancer diagnosis. Factors contributing to heightened distress include dealing with practical tasks, such as coordinating the patient's medical care, managing the patient's emotional reactions to the illness, facing the possible prospect of losing their beloved one and coping with an uncertain future (Mosher et al., 2013b). Up to 50% of partners of lung cancer patients report heightened levels of distress (Mosher et al., 2013a). In partners of cancer patients the prevalence of psychiatric disorder lays around 13–38% and has been associated with decreased

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quality of life and increased likelihood of a psychiatric disorder in patients (Bambauer et al., 2006; Drabe et al., 2008).

Although psychological distress is of significance, psychiatric disorders might be more important in terms of both prognostic value and need for additional psychiatric or psychological treatment. For that reason it is important to know which screening instruments could help us to identify those with a high likelihood of having a psychiatric disorder in both lung cancer patients and their partners, so these people can be referred for further diagnostics and treatment. Although lung cancer patients report the highest rates of depressive disorders, a recent prevalence study in 21,151 cancer patients (including 4361 lung cancer patients) revealed that they are the least likely to receive treatment for it (Walker et al., 2014).

The Hospital Anxiety and Depression Scale (HADS) has been the most thoroughly evaluated screening instrument in cancer patients (Wakefield et al., 2015; Zigmond and Snaith, 1983). The HADS combines the assessment of anxiety (HADS-A) and depressive (HADS-D) symptoms in one total scale (HADS-T) and has often been validated against standardized psychiatric interviews. A meta-analysis ($n_{\text{studies}}=24$) examined the suitability of the HADS as a screening instrument for psychiatric disorders established by a structured clinical interview (Mitchell et al., 2010). The weighted sensitivity and specificity of the HADS-T for any psychiatric disorder over 16 studies was fair to good with values of .73 and .81, respectively, of the HADS-D .76 and .66 ($n=4$) and of the HADS-A .66 and .71 ($n=4$) (Mitchell et al., 2010). However, the reported cut-offs of the HADS-T (from ≥ 10 to ≥ 16), HADS-A (from ≥ 7 to ≥ 9) and HADS-D (from ≥ 5 to ≥ 8) varied greatly between studies. Possibly, due to differences in cancer types and stages. Moreover, as far as we know, only two studies examined the suitability of the HADS-D as a screening instrument in lung cancer patients, using the Montgomery Ashberg Depression Rating Scale (MADRS), which is an observer-rated scale rather than a structured diagnostic interview (Castelli et al., 2009; Montgomery and Asberg, 1979; Néron et al., 2007). These studies used small sample sizes (49 and 53 patients, respectively) and resulted in optimal sensitivities and specificities of .63 and 1.00, and .73 and .75 respectively (Castelli et al., 2009; Néron et al., 2007). In partners, up till now no screening studies for psychiatric disorders have been conducted, despite their heightened psychological distress.

1.1. Aim

The aim of the current study is to examine the suitability of the HADS to screen for psychiatric disorders in a larger sample of both lung cancer patients and their partners using the Structural Clinical Interview for Diagnostic Statistical Manual (DSM) version IV (SCID) as the gold standard (First et al., 1997). Moreover, since it is widely used in routine clinical care of cancer patients, we were also interested in the possible suitability of the Distress Thermometer (DT) to screen for psychiatric disorder (Roth et al., 1998; Tuinman et al., 2008). As policy in several countries, including the Netherlands, dictates that adjustment disorders in cancer patients are excluded from reimbursement of the national health insurance, we screened for psychiatric disorders including and excluding adjustment disorders. In addition, we examined the possible suitability of the HADS-D and Beck Depression Inventory (BDI-II) to screen for depressive disorders and the HADS-A and the state subscale of the State Trait Anxiety Inventory (STAI-S) to screen for anxiety disorders in both populations (Beck et al., 1996; Spielberger et al., 1983). The BDI-II and STAI-S are often employed by psychiatrists to help diagnose depressive and anxiety disorders, respectively. While the HADS-D and HADS-A might be more appropriate for cancer patients because it was designed to use in

populations with physical illnesses, the BDI-II and STAI-S might be more suitable for partners.

2. Material and methods

2.1. Study population

The study population consisted of a consecutive sample of lung cancer patients and partners attending the outpatient clinic of the Department of Pulmonary Diseases of the Radboud University Medical Centre (Radboudumc). As an academic tertiary care clinic, the Radboudumc receives a large number of referrals for surgery and other specialized treatment, as well as second opinions. Inclusion criteria for patients were: (a) cytologically or histologically proven non-small cell lung cancer or small cell lung cancer; and (b) having completed or still receiving treatment. Exclusion criteria for both patients and partners were: (a) younger than 18 years old; (b) not able to understand or use the Dutch language; and (c) suffering from physical and/or cognitive impairments which would limit participation.

2.2. Procedure

Between March 2013 and December 2014, all patients attending the clinic with the diagnosis of lung cancer were invited to participate in the study. Based on a review of their charts a nurse practitioner contacted eligible patients and their partners to explain the study procedure at least one month after their diagnosis. Patients and partners who were willing to participate were sent an information leaflet, consent form and set of screening questionnaires. An appointment for a face-to-face or telephone interview was made for the SCID in the same week. Three psychologists (MS and two others) were trained in conducting the SCID by a psychiatrist (AS). The interviewers were blind to results of the questionnaires. The study was approved by our ethical review board (CMO Arnhem-Nijmegen) and registered under number 2011–519.

2.3. Measures

2.3.1. Structural Clinical Interview for Diagnostic Statistical Manual (DSM) IV (SCID)

The SCID-I was used for the diagnosis of psychiatric disorders according to the criteria outlined in the DSM-IV (First et al., 1997; van Groenestijn et al., 1998). To check for the possible presence of a psychiatric disorder, the interview started with 12 screening questions. If necessary, the interviewer asked additional questions on the frequency and severity of symptoms and the extent of suffering caused by the symptoms. The following parts were used: A. Mood episodes; D. Mood disorders; E. Substance abuse; F. Anxiety disorders; G. Somatoform disorders; I. Adjustment disorder. When it was unclear whether a participant fulfilled the criteria of a psychiatric disorder, the interviewer discussed the case with a psychiatrist (AS). Based on a subsample of 28 interviews, the interrater reliability of two independent assessors (MS and one other psychologist) was high ($Kappa=0.91$) for both the face-to-face as well as the telephone interviews.

2.3.2. Hospital Anxiety and Depression Scale (HADS)

The HADS, including the 7-item HADS-A and 7-item HADS-D, has been validated in several populations, including cancer patients and their caregivers (Bjelland et al., 2002; Lambert et al., 2011; Spinhoven et al., 1997; Zigmond and Snaith, 1983). For each item, participants are asked to choose one of four options that best

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