Easing Depression in People With Advanced Cancer

The CALM program “intervenes proactively rather than just waiting for people to get distressed, anxious, depressed, and overwhelmed.”

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People diagnosed with advanced cancer can face a host of challenges and stresses, from navigating the health care system to dealing with relationship disruptions and figuring out how to spend the time they have left, that can leave them vulnerable to depression. Yet cancer centers and clinics don’t routinely provide psychological support to all advanced cancer patients to help them cope.

In a new clinical trial, just three to six sessions of a tailored psychotherapy approach known as Managing Cancer and Living Meaningfully, or CALM, helped to lessen symptoms of depression in people recently diagnosed with advanced cancer. Results from the trial also showed that the approach may help prevent the onset of depression in those with advanced disease.

“We know there’s a lot of distress [among people with advanced cancer], and we’ve shown previously that, without treatment, the symptoms of depression get worse,” said study leader Gary Rodin, MD, head of the Department of Supportive Care at Princess Margaret Cancer Centre in Toronto, Canada.

“The idea of CALM is to intervene proactively rather than just waiting for people to get distressed, anxious, depressed, and overwhelmed,” he said.

The sustained improvement among patients after as few as three CALM sessions was impressive, said Ann O’Mara, PhD, RN, MPH, head of palliative research in NCI’s Division of Cancer Prevention, who was not involved in the study.

CALM therapy “addresses many issues that are above and beyond what palliative care services may [currently] provide,” O’Mara said. “If incorporated into a palliative care setting, this intervention could really help our patients with advanced cancer.”

Results of the randomized clinical trial were published June 29 in the Journal of Clinical Oncology.

Providing a Roadmap to Reduce Stress and Live Meaningfully

Rodin and colleagues Sarah Hales, MD, PhD, and Chris Lo, PhD, developed CALM to help patients in four key areas: symptom management and communication with health care providers; changes in self and close personal relationships; spiritual well-being and a sense of meaning and purpose in life; and concerns about mortality and the future.

“We try to help people understand that there are many ways to think about their situation and many ways to live meaningfully,” Rodin said.

CALM therapy consists of three to six 45- to 60-minute sessions over 3–6 months. The patient’s primary informal caregiver is invited to one or more sessions when acceptable to both patient and therapist.

The approach provides a general framework or “roadmap” that therapists can modify based on their own personal style and culture and on a patient’s individual needs and concerns, Rodin explained.

A wide range of cancer care and palliative care providers, including nurses, physicians, psychologists, and social workers, can provide CALM therapy after receiving the necessary training, which consists of an intensive 2-day workshop and ongoing supervision on at least three cases. These clinicians have typically had experience engaging in conversations with people with advanced cancer but may not have prior formal training in psychotherapy.

“CALM is meant to be initiated as soon as possible after diagnosis of an advanced cancer, to help people live their lives as well as they can,” Rodin said. “Sometimes people get so swallowed up by the cancer care system, or they feel so hopeless, that they give up on life while they’re still relatively well physically. That’s what we’re trying to prevent.”

Reducing and Preventing Symptoms of Depression

To measure the effects of CALM on symptoms of depression, Rodin’s team enrolled 305 patients recently diagnosed with advanced or metastatic cancer and an expected survival of 12–18 months. Participants were randomly assigned to receive either usual care (154 patients) or usual care plus CALM (151 patients). Usual care may include specialized psychosocial oncology services, but a previous study by Rodin’s team showed that less than 10% of patients with advanced cancer received any form of structured psychotherapy at the cancer center where the trial took place.

Participants in CALM were still being actively treated for their cancer, and most therapy sessions took place in outpatient clinics.

The team used a standard nine-item questionnaire, known as PHQ-9, to measure symptoms of depression when patients first entered the study (baseline) and at 3 and 6 months. A PHQ-9 score of 5–9 points out of a 27-point maximum is considered mild depression and a score of 10–14 is considered moderate depression.

The researchers also assessed other outcomes not central to the trial, including distress about

death, via standard questionnaires that participants completed at the time they entered the study, and again at 3 and 6 months after study entry.

At both 3 and 6 months, CALM participants reported less-severe symptoms of depression, on average, than those reported by participants in the usual care group. The benefits of CALM therapy appeared greater at 6 months than at 3 months, with a mean reduction in PHQ-9 scores of 1.29 and 1.09, respectively.

Although the overall difference in depressive symptoms between the two groups at 3 and 6 months was small, the ability to provide measurable improvement with the CALM approach is still notable, O'Mara said, because not all people with advanced cancer, like those in the study, are likely to experience depression.

To clarify the clinical meaning of their findings, the team performed additional analyses of the data in specific subgroups of patients. They found that CALM was more likely than usual care to provide a "clinically important" PHQ-9 reduction in depression of at least 5 points for participants who entered the study with a PHQ-9 score of at least 8 points at baseline.

These analyses also suggested "that not only does CALM reduce depression in some patients, it may also prevent the onset of depression" in participants who were not depressed at baseline, Rodin said.

Furthermore, the authors wrote, "The study findings suggest that participants with moderate levels of distress about dying and death benefited most from CALM therapy."

Assessing the Universality of CALM

The optimal timing of CALM and the most appropriate and meaningful ways to assess its outcomes require further research, the study authors said.

In an earlier pilot study, people with advanced cancer described multiple benefits of CALM therapy. For instance, Rodin said, patients reported that CALM provided a safe place to talk about their feelings, allowed them to face their fears, and helped them face the end of life and live their lives meaningfully.

And, he continued, his team believes that the qualitative data from patient interviews is also very important when judging the potential benefits of a program such as CALM. Such data provide valuable information about the experience of CALM therapy and about the mechanisms by which it may exert its effect.

One key limitation of the new trial, the authors noted, is that it was conducted at a single, urban cancer center with primarily English-speaking, white, well-educated participants.

Rodin's team has launched a global initiative to disseminate CALM in 20 countries to find out whether it can be generalized to people of diverse ethnicities and cultures.

Rodin’s team also is working with colleagues in Germany to develop an online version of CALM, which he said could make it available to people with more limited access to oncology and palliative care services, such as those living in rural areas.

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