OPEN ACCESS

Saudi Journal of Medical and Pharmaceutical Sciences
Abbreviated Key Title: Saudi J Med Pharm Sci
ISSN 2413-4929 (Print) | ISSN 2413-4910 (Online)
Scholars Middle East Publishers, Dubai, United Arab Emirates
Journal homepage: https://saudijournals.com

Original Research Article **Psychiatry**

The Importance of Early Screening for Depression in Elderly Patients with Prostate Cancer Undergoing Hormone Therapy

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DOI: https://doi.org/10.36348/sjmps.2025.v11i12.008 | **Received:** 16.10.2025 | **Accepted:** 08.12.2025 | **Published:** 11.12.2025

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Abstract

Introduction : Prostate cancer is the most common cancer in men over 65. Depression is frequent in this population but remains underdiagnosed, particularly due to atypical clinical presentations, confusion with treatment side effects, and sociocultural perceptions that trivialize the psychological distress of older adults. The objective of this study was to describe the obstacles to screening for depression in older patients treated for prostate cancer, analyze professional perceptions, and identify potential improvements to the care pathway. ***Methods :*** A qualitative study incorporating a clinical case of severe depression in a 76-year-old man treated with hormone therapy for prostate cancer, and semi-structured interviews conducted with a university hospital geriatrician and a geriatric psychiatrist. ***Results:*** Psychological vulnerability is increased by the cancer diagnosis, the loss of virility associated with treatment, geriatric frailty, and social isolation. Screening practices remain inconsistent: geriatricians used standardized tools, while psychiatrists intervened after the disorder had already developed. Identified obstacles included confusion between depressive symptoms and side effects, persistent taboos surrounding psychiatry, a lack of interdisciplinary coordination, and the absence of institutional protocols. Professionals agreed on the need for a structured screening protocol, targeted training, and interdisciplinary collaboration. Analysis of the literature and professional guidelines reinforced the need to implement a proactive screening approach, particularly at the initiation of hormone therapy. ***Conclusion :*** This study highlighted the need for a preventive and integrative approach to identify depression early in this high-risk population. Systematizing screening, adapting tools to the cultural context, and fostering collaboration among professionals working with older adults are essential to improving their quality of life and preventing suicidal complications.

Keywords: Depression, Cancer, Prostate, Elderly, Screening.

INTRODUCTION

Population aging is accompanied by a significant increase in age-related cancers. Among these, prostate cancer is the most common cancer in men in France and one of the most prevalent in men over 65. Therapeutic advances, particularly hormone therapy, have led to a considerable increase in life expectancy. However, this prolonged survival does not always guarantee a good quality of mental life [1].

In older adults, depression is a frequent complication but often goes unnoticed, exacerbated by physical frailty, loss of independence, geriatric syndromes, and the impact of the illness on one's identity (confrontation with the end). Hormone therapy increases this risk by disrupting sexual function and self-esteem. Furthermore, the side effects of treatment, such as fatigue, hot flashes, or sleep disturbances, can mask or mimic depressive symptoms [2].

Studies show that the risk of suicide increases significantly in this population, particularly in the first year following diagnosis [3].

In this context, early detection of depression is a major public health challenge. However, it remains inconsistent, often delayed, and dependent on the individual vigilance of the clinician. The lack of a systematic screening process contributes to delaying diagnosis and the initiation of treatment.

This work aims to analyze the obstacles to depression screening in this vulnerable population, based on a clinical case and professional interviews. Drawing on their practical experiences and perceptions, the goal is to identify potential levers for improvement and to consider avenues for improvement in preventive care based on the literature.

MATERIALS AND METHODS

This is a descriptive qualitative study combining:

- An in-depth analysis of a case report.
- Two semi-structured interviews with a university hospital geriatrician (at the Fann University Hospital Center, Dakar, Senegal) and a geriatric psychiatrist (at the Marne Public Mental Health Institution, France). The two practitioners were selected for their complementary expertise, aiming to obtain a cross-disciplinary perspective on screening practices and professional perceptions.

For data collection, a novel semi-structured questionnaire was administered to the two practitioners. It consisted of 17 questions divided into 6 sections (Professional background and clinical context, Perception of the risk of depression, Screening practices, Coordination and care pathway, Perceptions and obstacles, and finally, Perceptions and perspectives).

The interviews were conducted individually, each lasting approximately 45 minutes.

- Literature review: this was conducted using PubMed and Google Scholar databases.
  The keywords was: *prostate cancer, elderly patients, depression, anti-androgen hormone therapy*.
  The recommendations of the French National Authority for Health (HAS) and the French-speaking Association for Oncology Supportive Care (AFSOS) were also analyzed.
- For the data processing: the verbatim transcripts underwent thematic analysis using an inductive approach. Emerging themes were then contextualized by triangulation with the clinical case and data from the literature.

RESULTS

❖ Case report

Mr. X, aged 76, was hospitalized in an acute psychiatric ward following a suicide attempt. He attempted to cut his throat and wrists in the context of depression (mood collapse, self-deprecation with feelings of having lost his dignity and masculinity). Those close to him reported a progressive loss of vitality, marked social withdrawal, and pessimistic speech for several weeks prior to his hospitalization.

Admission was prompted by the severity of the suicide risk. Mr. X had no known personal psychiatric history. He had never previously been treated for mood disorders nor hospitalized in a psychiatric ward. However, his family history revealed that his older brother, also suffering from prostate cancer, had been treated for a severe depressive episode that occurred during hormone therapy, requiring prolonged psychiatric care. This family history, while insufficient to establish a clear hereditary predisposition, highlighted a potential familial sensitivity to the mood-related impact of anticancer hormone treatments.

From a somatic perspective, Mr. X had prostate cancer diagnosed two years prior, treated with hormonal therapy. He was also taking anticoagulants for thromboembolic prevention. Paraclinical examinations performed upon admission, including brain imaging (CT scan then MRI), revealed no significant abnormalities.

The initial clinical course showed a marked improvement in mood during attempts to discontinue treatment, undertaken in consultation with the oncologists. This temporal link between the withdrawal of treatment and the alleviation of depressive symptoms reinforced the hypothesis of an iatrogenic depressive syndrome, possibly induced or exacerbated by the anticancer treatment. However, the mood relapse occurred rapidly after resuming treatment, this time accompanied by psychotic features: auditory hallucinations, delusional beliefs of persecution, and a feeling of being watched and threatened. This delusional onset prompted a reassessment of the clinical picture as a potentially secondary psychotic depressive episode due to medication.

Therapeutically, management required several medication adjustments, with successive switches between antidepressants and mood stabilizers. These attempts included duloxetine, followed by the introduction of lamotrigine, in transient combination with quetiapine to target the psychotic elements and the mixed mood component. Despite these adjustments, the patient's condition remained fluctuating, depending in particular on the modulation of the cancer treatment.

❖ **Interview reports with healthcare professionals (geriatrician and psychiatrist)**

Analyzing the practices and perceptions surrounding depression screening in elderly individuals treated for prostate cancer, we observed significant convergences but also some points of divergence.

✓ **A Consensus on Psychological Vulnerability**

Both professionals maintained that this population is particularly exposed to the risk of depression. They mentioned factors related to the cancer itself (a serious and chronic condition), the patient's underlying health (multiple pathologies, geriatric syndromes, isolation, bereavement), and the treatments (impact of hormone therapy, effects on virility).

"*Hormonal treatments increase the risk of depression in an already fragile context induced by the diagnosis and the urological dysfunctions (incontinence and erectile dysfunction) that result from this disease and its treatments.*" stated the psychiatrist.

The geriatrician added: "*Cancer, in general, is a risk factor for major depression. If it occurs in the context of aging, the risk increases. The diagnosis alone is a shock for the elderly person. This is especially true since it is a disease that progresses over a long period; by the time of discovery, the patient's health is already fragile. Furthermore, hormone therapy itself can lead to a decrease in libido, which in turn can be a contributing factor to depression*".

✓ **Unstructured Screening**

The importance of early detection is universally acknowledged; however, practices remain inconsistent. The psychiatrist reported not using any screening tools because she did not perform screening. Patients were referred to her after a depressive episode had already developed. She intervened to offer antidepressant treatment and, if necessary, psychotherapy. This reactive approach perpetuated a risk of underdiagnosis of depression in this population and, consequently, poor adherence to treatment and a decline in quality of life.

The geriatrician reported that all cancer patients seen in his department were systematically screened. He used the mini-Geriatric Depression Scale (GDS), and as soon as a score of 1 was obtained, he used more comprehensive scales such as the GDS and the G8 oncology coding system. The latter allowed for the rapid detection of frailty in older adults. The geriatrician also emphasized the importance of taking the time to thoroughly explore the difficulties faced by older adults: "*Our consultations are very time-consuming. It's not like in other specialties; a patient can easily take us an hour for an assessment*".

The professionals mentioned no formal organization for communication, and the connection between the various stakeholders (psychiatrists, geriatricians, urologists, and oncologists) was weak.

According to the geriatrician, collaboration with the psychiatrists was fairly smooth because they worked in the same university hospital, but there was no institutionalized protocol.

✓ **Barriers to Screening**

The obstacles were numerous, stemming from both patients and healthcare professionals.

The psychiatrist reported that patients commonly expressed feelings of shame due to the persistent taboos surrounding mental illness. According to her, elderly patients often feel apprehensive during their first meeting with a psychiatrist, given the many stereotypes circulating. She also highlighted a kind of trivialization of psychiatric symptoms in the context of oncological pathology and a confusion between the physical side effects of treatment and depressive signs. "*There seems to persist a lack of knowledge, both among physicians and psychiatrists, regarding the direct side effects of certain androgen suppression therapies*," she added.

The cultural context played a significant role, according to the geriatrician. He maintained that the GDS itself was poorly adapted to the senegalese context, thus leading to biases in the assessment of psychological distress. However, he clarified that "*You can't treat prostate cancer without addressing the underlying factors, such as mood, nutritional status, etc. (...) We geriatricians are interested in everything*".

Both professionals also emphasized the "social belief" that depression is "normal" in old age and that it is a consequence of aging.

✓ **Shared Perspectives for Improvement**

Despite their different approaches, both professionals agreed on the need to consider establishing a partnership system among the various healthcare providers. They suggested implementing awareness programs for patients and their families about the risks of developing depression, using brochures and promoting mental health in medical discourse and overall care.

According to them, screening should be systematic for all elderly patients undergoing hormone therapy for prostate cancer. It should be conducted at certain key points in the care pathway (diagnosis announcement, start of treatment, physical monitoring phases), perhaps through advanced practice nurses, combined with standardized screening tools (Mini GDS, GDS, G8-Oncodage).

Failing to organize targeted training for oncologists and urologists on the specific characteristics

of depression in this population, particularly somatic depression, they emphasized the possibility of including mental health professionals in multidisciplinary teams. Given the therapeutic potential and the resistance encountered, the psychiatrist felt it would be worthwhile to conduct studies on the benefits of early neuromodulation, such as repetitive transcranial magnetic stimulation (rTMS), in this type of patient, in combination with antidepressants and psychotherapy. Assessing practitioners' level of knowledge regarding depression and its management in older men with prostate cancer would open avenues for reflection on prevention and improve partnerships between different specialists, according to the geriatrician.

DISCUSSION

This study has limitations. First, it is a case report, which restricts the generalizability of the results. Interviews with Mr. X's spouse could provide a better understanding of his quality of life. This would also allow for an assessment of the psychological experience of the couple and their social circle.

Furthermore, the two professionals interviewed worked in a hospital setting, which may introduce a bias in terms of access to specialists. It would therefore be relevant, in a follow-up study, to extend this research to professionals in the community (general practitioners, private nurses, community psychologists) who care for elderly patients on androgen suppressants.

Another research avenue would be to propose a screening protocol to departments (urology and oncology) in order to assess its impact on the early diagnosis of depression in older adults.

❖ Psychopathological approach to the case report

This clinical case reminds us that the absence of a psychiatric history does not protect against the onset of a depressive disorder in old age. Although he had no known psychiatric history, our patient's depressive state developed gradually and silently, until it manifested abruptly in the form of a suicidal crisis. It is not uncommon to encounter cases of a "first episode" of depression, the vulnerability factors of which are linked to the experience of aging and somatic illnesses [4].

Indeed, a narcissistic restructuring and psychic processing of losses (social, physical, professional) occur upon entering old age, thus leading to a redefinition of identity. In this context, the diagnosis of prostate cancer would constitute a traumatic event, fraught with anxiety. The comorbidity of aging and chronic illness further weakens the subject's narcissistic foundations [5].

In our patient, cancer and its treatment constitute a major factor of psychological disorganization, adding to the identity shifts already present with advancing age. Confrontation with bodily and sexual limitations could impair self-esteem and secondarily precipitate a depressive episode. Our patient's complaint –"loss of virility"– reflects the psychological impact affecting the phallus. He would have experienced it as a symbolic castration. Here, understanding the psychodynamic and identity mechanisms sheds light on the subjective dimension of depression and avoids a purely symptomatic interpretation.

Furthermore, contrary to the common perception of a classic symptomatology centered on sadness and anhedonia, depression in the elderly often manifests atypically. We observe diffuse somatic complaints, irritability, social withdrawal, and memory problems that can mimic a neurocognitive disorder. These clinical manifestations make screening and management more complex, especially since cancer treatments themselves induce disturbances in older adults. These disturbances can manifest as fatigue, sleep disorders, hot flashes, or pain, which can mask or mimic certain depressive symptoms [4].

In the months preceding the suicidal crisis, our patient already presented with subtle symptoms: persistent fatigue, sleep disturbances, loss of appetite, and social withdrawal. These signs, easily attributed to treatment side effects or aging, were not identified as warning signs of a depressive state. The systematic use of appropriate screening tools would likely have identified depression earlier, allowing for preventive intervention.

In addition, it is important to remember that screening remains a relational process, not a technical procedure. Hence the importance of establishing a strong therapeutic alliance with elderly patients weakened by cancer. This requires emotional availability, active listening, and vigilance for signs of disengagement from life.

In our case, better coordination among the various professionals would have allowed us to anticipate the risk of depression associated with hormone therapy and prevent the progression to a suicidal crisis.

❖ Vulnerability Confirmed by the Literature

Our results are consistent with the data described by Anguiano *et al.*, who demonstrated a significant increase in suicide risk among cancer patients. The patient population consisted of individuals over 65 years of age, and prostate cancer was the most frequent of the tumors studied. Suicide most often occurred during the first year after diagnosis. There appears to be a correlation between the impact of depression in these individuals and the decline in their quality of life [3].

Prostate cancer impacts not only the individual but also the couple and the family system. The couple's

role is an aspect often overlooked in patient care. Some authors have begun to focus on this aspect. The prevalence of psychological distress among patients' partners and the decline in the couple's quality of life have been reported by Couper [6].

The partners' quality of life appears to deteriorate proportionally to that of the patients. Indeed, as with all chronic diseases, prostate cancer has an impact that extends beyond the patient themselves [7, 8]. It is important to raise clinicians' awareness of this so that they do not hesitate to address this issue.

❖ **Screening Still Too Infrequently Implemented**

The HAS and AFSOS guidelines emphasize screening throughout the entire patient journey [2, 16].

Tools exist, however, their use is inconsistent, as observed in the interviews.

In reflecting on how to improve practice, Frémont *et al.*, demonstrated that anything that can improve the quality of life of the patient and their family should be included in the treatment objectives. Given the significance of depression and its impact, it is therefore legitimate to offer systematic screening for it in order to provide appropriate treatment. According to them, it seems important to have a rapid, validated, and easy-to-use screening tool. For this population of affected individuals, the mini-GDS has proven to be a useful and specific tool. However, this screening should be complemented by a diagnosis made by a physician, referring to the International Classification of Diseases [9].

❖ **Impact of Hormone Therapy**

In the case presented, the temporal link between hormonal administration and mood fluctuations reinforces the iatrogenic hypothesis.

Regarding the treatment of advanced prostate cancer, the European Association of Urology (EAU) recommends the use of hormone therapy as the standard. This involves androgen suppression with a luteinizing hormone-stimulating hormone (LH-RH) agonist [10].

Several other studies have shown the occurrence of anxiety and depression in patients undergoing hormone therapy with this treatment [11, 12].

For example, Saini *et al.*, reported that anti-androgen treatment impairs quality of life by causing depression. Cherrier's work, evaluating the impact of nine months of anti-androgen treatment on a case-control study, also showed an improvement in mood after treatment discontinuation. Indeed, Schulman reported that a longer interval between injections was proportional to the improvement in quality of life in elderly subjects being treated for prostate cancer. It should be noted that studies examining the role of hormones in the development of depression in these subjects are still few in number. The populations studied are also small, making definitive conclusions difficult. However, the findings are similar, demonstrating greater psychological distress in these groups [13-15].

❖ **Towards an Interdisciplinary Organization**

The results demonstrate the need for:

- ✓ integrating a liaison psychiatrist into oncology care pathways.
- ✓ harmonizing communication.
- ✓ adapting tools to the cultural context.
- ✓ training oncologists and urologists on mood disorders related to anti-androgen hormone therapies.

According to the recommendations of the French National Authority for Health (HAS) and the guidelines of the French Association of Oncology Care (AFSO), screening is essential throughout the course of the disease. All patients should be screened at a minimum during each significant phase of their illness [2, 16].

Numerous diagnostic tools are recommended for older adults, but none are specific to prostate cancer. Some example are :

- ✓ Mini Geriatric Depression Scale (GDS), with a sensitivity of 81.3 % and a specificity of 78.4 %. It is significantly more accurate than the GDS-30.
- ✓ Cornell Scale for Depression in Dementia (CSDD) in older adults with cognitive impairment.
- ✓ Beck Depression Inventory (BDI).
- ✓ Hamilton Depression Rating Scale (HDRS).
- ✓ Neuropsychiatric Inventory (NPI).

The HAS concludes that, once the question of depression is raised, the physician must clinically assess the signs using the aforementioned assessment scales [2].

It seems important to reiterate that the diagnosis of a depressive episode is primarily clinical, in accordance with the diagnostic criteria of international classifications. Standardized assessment tools are diagnostic aids that must be subject to the clinician's judgment. The clinical interview therefore remains the essential tool.

In the absence of guidelines for the early screening of depression in older men undergoing hormone therapy for prostate cancer, we propose the following protocol :

✓ **Identification of the at-risk population**

- Target populations : men ≥ 75 years of age with prostate cancer, particularly those undergoing

hormone therapy, with or without comorbidities.
- Specific risk factors : social isolation, recent bereavement, impaired sexual performance and low self-esteem, personal or family history of depression.

✓ **Systematization of screening**
- When to screen ? : upon diagnosis and at the start of hormone therapy, after each change in treatment, in the presence of any unexplained somatic complaint, withdrawal, or loss of vitality.
- How to screen ? : clinical interview, suicidal risk, use of validated tools for older adults (see HAS recommendations on the previous page).

✓ **Facilitate specialized psychiatric evaluation**
- Integrate a liaison psychiatrist or clinical psychologist into the care pathway.
- Offer a psychiatric consultation as soon as any doubt arises.
- Promote the exchange of information between departments: oncology, psychiatry, geriatrics, urology.
- Reassess the benefit/risk balance of hormone therapy with the oncologist.

✓ **Involve the patient's support network by clearly informing them about :**
- Psychological risks related to the illness and hormone therapies.
- The availability of psychological or psychiatric support.

CONCLUSION

Depression in elderly patients with prostate cancer undergoing hormone therapy remains underdiagnosed.

Our patient's case is not merely a clinical vignette; it exemplifies the dramatic consequences of late diagnosis and argues for a proactive, integrative approach involving the patient, their family, and the multidisciplinary team. The question that current studies have not yet answered is whether the observed symptoms might occur in individuals who already had a pre-existing, undiagnosed neurodegenerative condition prior to hormone therapy. From a therapeutic standpoint, future research could explore the effects of new therapeutic approaches, such as rTMS, in this population, which remains sensitive to psychotropic medications.

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