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Psychiatric Considerations in Cancer Care

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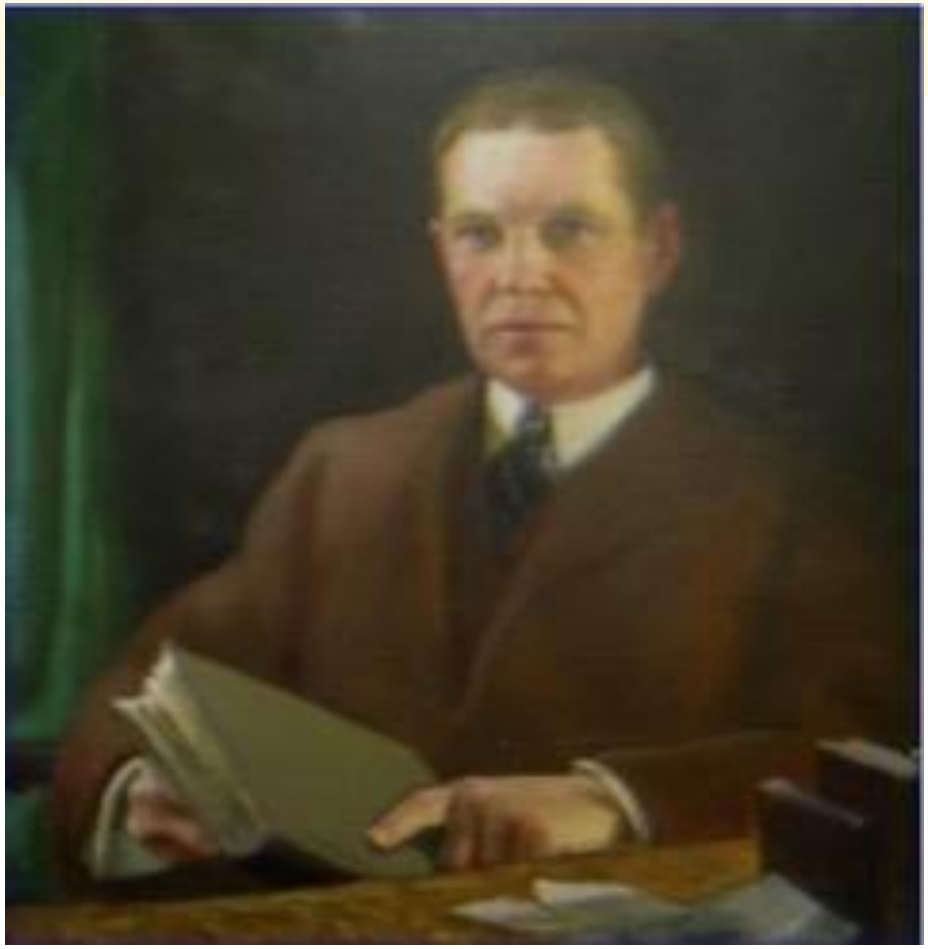
Disclosure

This presenter has no financial interest or other relationships with manufacturers of commercial products, suppliers of commercial services, or commercial supporters.

Today's Plan

- Intro/background
- History of Psycho-oncology
- The Psychological Impact of Cancer
- Distress Screening and Psychiatric Diagnoses
- Treatment
  - Psychotherapeutic Interventions
  - Management of distress
  - Adjustment Disorders
  - Anxiety Disorders
  - Depressive Disorders
  - Delirium
  - Pain



“For the secret of the care of the patient…..

……is in caring for the patient”

Francis Weld Peabody, 1926

Background and Epidemiology

- Most common cancers
  - Men: prostate, lung, colorectal
  - Women: breast, lung, colorectal
- Cancer mortality decreasing since 1990's
- 13 million cancer survivors in the US
  - ~1.7MM new cases per year
  - ~35,000 new cases in Maryland

Psycho-Oncology

- 1970's: Jimmie Holland, MD
  - Started the first psycho-oncology service at Sloan-Kettering (1970's).
  - Luminary in the field.
- 1980's: Cancer care moves to clinics
- 2007: Institute of Medicine mandates integration of psychosocial care

Attitudes in First Half of Twentieth Century

- Belief was that cancer equals death
- Diagnosis was not revealed to the patient; it was considered cruel and inhumane: "They will give up hope"
- Century old fears, negative attitudes and stigma toward mental illness

Attitudinal Barriers Reduced: 1970's

- New optimism about curative treatments but concerns about long-term side effects
- Debates about telling diagnosis
- More cancer survivors who revealed their diagnosis
- Cancer revealed by Betty Ford, Happy Rockefeller (1975)
- Women's and patients' rights movements
- Cancer was finally "out of the closet"

Psycho-Oncology Defined

- Multi-disciplinary subspecialty of oncology concerned with the emotional responses of patients at all stages of disease, their families and staff (PSYCHOSOCIAL)

- The psychological, social, and behavioral variables that influence cancer prevention, risk, and survival (CANCER CONTROL)

Early Research Issues

- Self-report was not accepted as a valid measure of subjective symptoms, both clinically and in research
- Only objective ratings by the physician were considered valid
- No rating scales were available
- First major effort was to develop reliable and valid quantitative scales to measure subjective symptoms

1970's -1980's

- Validated, quantitative tools were developed for:
  - Health-related Quality of Life (QOL)
  - Pain
  - Fatigue
  - Anxiety
  - Depression
  - Delirium
- These tools produced data in clinical trials which showed the effect of an intervention on a specific symptom

1990's – Managed Care

Most cancer care in the US is delivered in overly busy offices and clinics.

RESULT: psychosocial problems received limited attention.

Yet studies showed that 35% or more of patients have significant distress.

National Comprehensive Cancer Network (NCCN) 1997

Appointed a multidisciplinary panel with wide representation to evaluate and improve psychosocial care in cancer:

- Oncologist
- Nurse
- Social Work
- Psychologist
- Psychiatrist
- Clergy
- Patient

Panel Task

First:

- The label of “Psychiatric,” “Psychological,” or “Emotional” are embarrassing and stigmatizing

- Find a more acceptable term

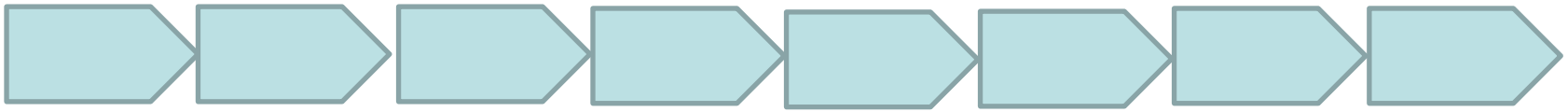
- Find a word that covers psychological, social, and spiritual concerns

CHOSEN WORD: DISTRESS

Distress Continuum

Normal Distress

Severe Distress



Fears
Worries
Sadness

Depression
Anxiety

Distress Is Caused by:

- Physical symptoms (pain, fatigue)
- Psychological symptoms (fears, sadness)
- Psychiatric complications (depression, anxiety, delirium)
- Spiritual concerns – seeking comforting philosophical, religious or spiritual beliefs
- Existential concerns – seeking meaning in life while confronting possible death

Standard of Care: NCCN

- Distress should be recognized, monitored, documented, and treated promptly beginning at initial visit
- Screening should identify the level and nature of the distress and it should be managed by Clinical Practice Guidelines
- An interdisciplinary committee should implement and monitor standard of care

…..Next Step

- How do we measure distress?
- Proposal to use what had been the successful approach to pain measurement:

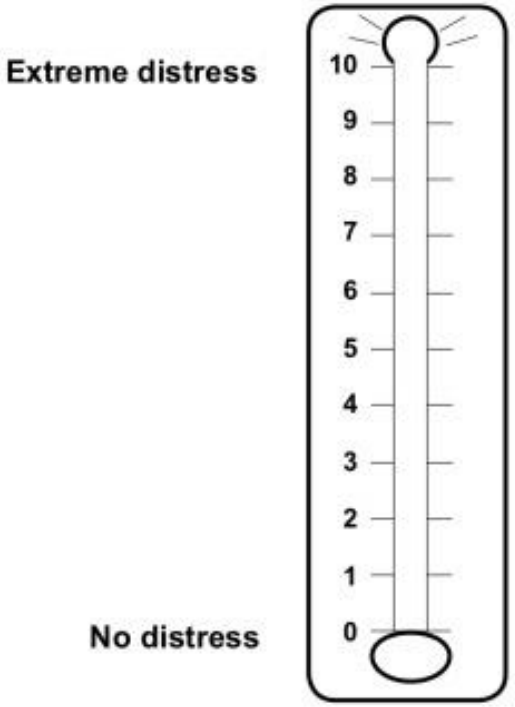
How is your pain on a 1 to 10 scale?

National Comprehensive Cancer Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

		Spiritual/religious concerns
❑	❑	

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

_____

…….Next Step

- Developed the NCCN Distress Management Standard of Care and Clinical Guidelines
- Updated annually, evidence-based when possible, otherwise based on clinical consensus

IOM Report - 2008

- The psychosocial domain must be integrated into routine cancer care

Role of the Psycho-oncologist

- Address the emotional reaction to cancer for the patient, caregivers, and staff
- Address the psychological issues that affect cancer incidence and survival
- Behavioral health team leader/liaison
- Psychotherapy
- Psychopharmacology

Some Problems

- The majority of psychological issues in cancer care <u>appear insidiously</u>

- Frequently, they are NORMALIZED, even by healthcare professionals:

  "Of course he's depressed……

  …….he has cancer"

- This hampers timely and effective psychosocial treatment early in the cancer trajectory.

Comorbid Depression in Cancer

- Worse quality of life
- Increased sensitivity to pain
- Difficulties with treatment
- Caregiver burnout
- Increased risk of suicide
- Longer periods of hospitalization
- Reduced expectation of survival

Normal or Abnormal?

- Sadness and Worry – can be normal distress responses that drive adaptive behaviors (information seeking, developing supports to reduce anxiety)

- Validated screening instruments can help, but often a careful clinical interview is necessary to adequately assess

Psychological Impact of Cancer

- Response is highly variable, individualized
  - Successful establishment of a “new normal” by those adaptable with good coping skills and adjustment (~50%)
  - Less adaptable may experience:
    - Dysphoric mood
    - Anxiety
    - Appetite change
    - Insomnia
    - Irritability

Coping Strategies

- Realistic optimism
- Identifying what can be controlled and what cannot
- Focus on solutions or redefine problem into solvable form
- Acknowledge and put into perspective
- Psycho-education
  - Thoughts, Emotions, Behaviors

Variation in Vulnerability

- Vulnerability to psychiatric disorders varies with phase of treatment
- Peaks:
    1) diagnosis
    2) recurrence
- Often decreases with active treatment
- Spike in symptoms with transition to survivorship
- Being in “limbo”

Relevant Medical Issues

- Illness specific
  - CNS
- Treatment side effects
  - Surgery
  - Chemotherapy
  - Radiation
  - BMT
- Cure can be worse than the disease

Common Psychiatric Syndromes

- Adjustment disorders
- Depression
- Anxiety
- PTSD
- Organic mental syndromes
  - Cognitive impairment
  - Delirium
  - “Chemo-brain”

Adjustment Disorder

- Emotional reaction to a stressor creates symptoms (excessive worry, depression, hopelessness etc.)
- Out of proportion to expected reaction
- Produces some level of functional impairment
- Most common diagnosis in cancer setting
- Fine line between “abnormal” and ”normal”

Treatment for Adjustment Disorder

- Focus on restoring patients ability to cope with stressors
- Clarifying what is a realistic understanding of the seriousness of the diagnosis and prognosis
- Focus on adapting to and accepting the diagnosis
- Education, control of physical symptoms, and maintaining communication
- Pharmacotherapy, if indicated
- CBT with a focus on overly negative or irrational beliefs.

Anxiety Disorder

- Typically predates cancer diagnosis
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Phobias (e.g., needle phobia, claustrophobia)
  - Anxiety disorder due to another medical condition

Require careful medical and psychiatric workup to identify etiologic stressors, agents, or medical conditions.

Fear/Anxiety

- Fears experienced by individuals with a cancer diagnosis or their family members
  - Fear of mortality
  - Fear of recurrence/progression
  - Fear of short term and long term effects of treatment
  - Fear of changes in appearance/body image
  - Fear of being a burden/dependent on others
  - Fear of financial implication

Triggers of Anxiety

- Anxiety usually comes in waves
  - Medical events: diagnosis; recurrence; a new treatment
  - Scans/medical appointments
  - Waiting for results
  - Anniversary events (date of surgery; birthday)
  - Illness or death of others

Treatment for Anxiety Disorders

- Usually a reactivation of a previously diagnosed disorder
- Treatment should be directed toward the specifically diagnosed subtype of anxiety
- Generally involves pharmacologic, psychotherapeutic and psychoeducation

Depressive Disorders

- Typically cause most functional impairment
  - Major Depression
  - Adjustment Disorder with depressive features

More common in patients with pancreatic (33-50%), oropharyngeal (22-57%), breast (4.5-46%) and lung (11-44%)

A recent meta-analysis reported a 16.3% prevalence of all types of depression, and a 25-29% rate in palliative care.

The prevalence of major depression is cancer care is 5-10% which is about twice as high as the general population.

Treatment for Depressive Disorders

- Pharmacologic, psychosocial, and psychoeducational
- Combination of pharmacotherapy and psychotherapy shows more robust efficacy in clinical studies
- Cognitive behavioral therapy focuses on restructuring thinking patterns and behaviors
- Supportive expressive therapy allows patients to process their cancer-related experiences
- Pharmacologic therapy is generally indicated in the treatment of sustained depression

Psychological Themes

- Autonomy vs Dependence
- Denial and hope
- Disfigurement and body image
- Guilt
- Family adjustment
- Financial stress

More psychological issues

- Existential/spiritual
- Survivorship
- “Why me?”
- Grief and loss
  - Expected and imagined life
  - Assumed safety
- Death and dying

Parenting with Cancer

- Preserve structure, stability
  - Discipline & Warmth
- Be honest with children
- Actions, explanations should match care goals
- Welcome questions and discussion
  - Mad-Sad-Happy-Glad game
- Parents: give yourself a break

Therapeutic Approaches

- Individual psychotherapy
- Support groups
- Problem-specific support
- Psychopharmacology
- Creating a “team”

Psychotherapies

- Supportive therapy
- Insight oriented therapy
- Behavioral/CBT
- Meaning-based therapy
- Dignity therapy/life review

SSRI Antidepressants

	Dosing (mg/day)	Unique Benefits	Possible Side Effects
SSRI Antidepressants[a]			
Fluoxetine	10-80	Minimal risk of discontinuation syndrome owing to long half-life	Nausea, nervousness, weight gain, insomnia, inhibition of tamoxifen metabolism and other CYP2D6 substrates
Sertraline	25-200	Few DDIs	Headache, diarrhea, constipation, sexual dysfunction, restlessness
Paroxetine	5-60	Useful to treat comorbid anxiety	Inhibits conversion of tamoxifen to endoxifen; high potential for DDI via CYP450 enzymes; high discontinuation syndrome owing to short half-life; weight gain, sedation, dry mouth
Citalopram	10-40	Few DDIs	Headache, diarrhea, constipation, sexual dysfunction, restlessness
Escitalopram	10-20	Few DDIs; S-enantiomer of citalopram	Headache, diarrhea, constipation, sexual dysfunction, restlessness
Trazodone	25-400	Sleep aid	Significant sedation; orthostasis, priapism, sexual dysfunction

McFarland DC, Holland JC. The management of psychological issues in oncology. *Clin Adv Hematol Oncol*. 2016 Dec; 14 (12).

SNRI/Miscellaneous Antidepressants

	Dosing (mg/day)	Unique Benefits	Possible Side Effects
SNRI Antidepressants			
Venlafaxine	37.5-300	Least likely to interact with tamoxifen; useful for hot flashes, neuropathic pain; few CYP450 interactions	Exacerbates hypertension; significant discontinuation syndrome
Desvenlafaxine	50	Metabolite of venlafaxine	
Duloxetine	20-60	Useful for hot flashes, neuropathic pain	Exacerbation of narrow angle glaucoma; hepatic insufficiency; sedation; urinary retention
Miscellaneous Antidepressants			
Mirtazapine	7.5-45	Stimulates appetite, weight gain; treats nausea; acts as sleep aid at lowest dose (7.5 mg) and as anxiolytic, antidepressant at higher doses	Somnolence, myalgias, weight gain, hyperlipidemia; rare but serious agranulocytosis; CYP1A2, CYP34 substrate
Bupropion	300-400	Noradrenergic and dopaminergic; may treat nicotine dependence	Lowers seizure threshold at high doses; strong CYP2D6 inhibitor

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Anxiolytics

	Dosing (mg/day)	Unique Benefits	Possible Side Effects
Benzodiazepines			
Alprazolam	0.125-2 orally; t½, 6-20 h	No cross-tolerance with other benzodiazepines	Significant rebound anxiety; multiple CYP3A4 drug interactions
Clonazepam	0.25-4 orally; t½, 20-50 h	Helpful in management of anxiety, seizure disorders, nocturnal sleep disorders, neuralgia, mania; may have less abuse liability than shorter-acting agents	Psychomotor impairment; respiratory depression
Diazepam	1-20 orally, IV, or IM; t½, 30-60 h	Helpful in management of anxiety, alcohol withdrawal, muscle spasm, seizure disorders	Psychomotor impairment; respiratory depression; bradycardia
Lorazepam	0.5-2 orally, IV, or IM; t½, 10-18 h	Antiemetic; alcohol withdrawal; preferable in those with liver disease because not subject to phase 1 metabolism	Psychomotor impairment; respiratory depression; bradycardia
Miscellaneous Anxiolytics			
Gabapentin	900-3600 in daily divided doses, 3× per day	Also treats neuropathic pain; sleep aid; may decrease alcohol cravings	Sedation; renal dosing; myoclonus
Buspirone	20-30 2-3× per day	Nonbenzodiazepine	Avoid use in renal or hepatic impairment; monitor for serotonin syndrome, extra-pyramidal symptoms
Hydroxyzine	200-400 daily divided dose, every 6 h	Nonbenzodiazepine; treats anxiety, nausea, insomnia	Monitor for anticholinergic side effects; renal dosing

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Stimulants and Antipsychotics

	Dosing (mg/day)	Unique Benefits	Possible Side Effects
Psychostimulants			
Methylphenidate	2.5-40	Quick relief from depressive symptoms, fatigue; effective in medically ill populations and does not usually cause weight loss, unlike in medically healthy populations; available in many dose and duration formulations	Agitation, restlessness, irritability, anorexia; hypertension
Dextroamphetamine	5-60	More potent than methylphenidate; dosed daily	Agitation, restlessness, irritability, anorexia; hypertension
Modafinil	100-200	Nonstimulant; long-lasting	Agitation, irritability; Stevens-Johnson syndrome; CYP3A4 substrate; CYP2C19 inhibitor; major CYP3A4 inducer; cost
Antipsychotics			
Olanzapine	2.5-20	Used as adjunct in treatment-refractory depression; can be used to treat chemotherapy-induced nausea; used to treat mania and as a mood stabilizer in bipolar disorder; used to treat psychotic disorders	QTc prolongation; somnolence; weight gain, metabolic syndrome
Haloperidol	0.5-5	Used to treat agitation/delirium; can be used to treat chemotherapy-induced nausea	QTc prolongation; somnolence; weight gain, metabolic syndrome

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Conclusions

- There have been notable and far-reaching advances in the realm of psych-oncology over the past 20 years.
- Distress screening and increased attention to the psychological realm of cancer are imperatives
- The patient experience of cancer induces a wide range of psychological adaptations that warrant informed assessment and treatment