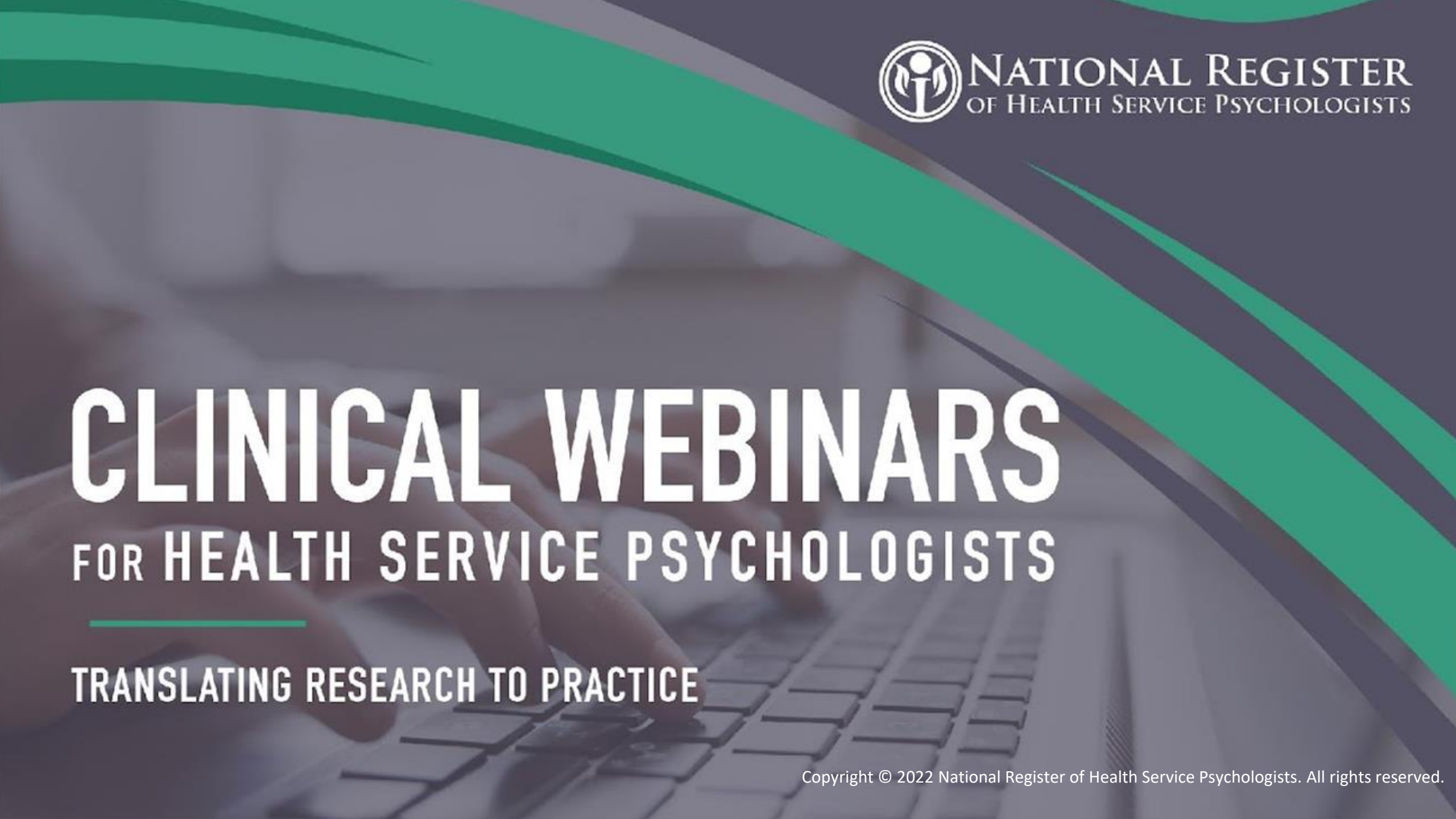

Clinical Practice of Psychosocial Oncology

Jonathan Kaplan, M.D. & Lauren Rynar, Ph.D.
Rush University Medical Center
Chicago, IL

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Jonathan Kaplan, M.D.

Dr. Jonathan Kaplan is an Assistant Professor in the Departments of Psychiatry and Behavioral Sciences and Internal Medicine at Rush University Medical Center. He is the psychiatrist for the Rush University Cancer Center and a consultation-liaison psychiatrist at Rush University Medical Center. He specializes in the psychiatric treatment of medically complex patients including patients with cancer. His research interests include psycho-oncology, collaborative care psychiatry, and supportive treatment models for patients with cancer.

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Lauren Rynar, Ph.D.

Lauren Z. Rynar, PhD, is an assistant professor in the Departments of Psychiatry and Behavioral Sciences and Internal Medicine at Rush University Medical Center, and a clinician in the Supportive Oncology Program at the Rush University Cancer Center. She specializes in the psychological care of cancer patients, survivors, and caregivers. Her research interests include quality of life, coping styles, cancer-related distress, and models of supportive care delivery across the cancer care continuum.

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Disclosures/Conflicts of Interest

In this presentation we will refer to our book, *Psychological Approaches to Cancer Care.* We receive income from sales of this book. We have no other conflicts of interest to disclose.

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Learning Objectives

1. Identify common psychiatric/psychological issues among individuals with cancer across the cancer continuum.
2. Explain treatments for common psychiatric/psychological issues among individuals with cancer, including medication management, direct psychological interventions, and models of care.
3. Identify special populations and considerations in Psychosocial Oncology.

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Defining Key Terms

- Supportive Oncology
- Psychosocial Oncology
- Cancer Survivorship
- Cancer Continuum

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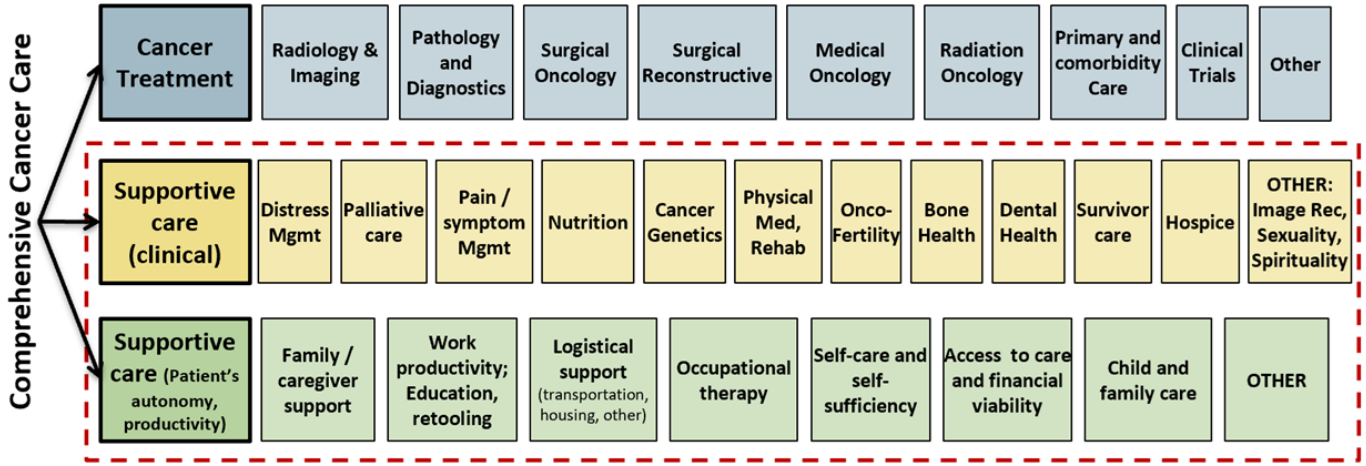
Defining Key Terms: Supportive Oncology

1. The Multinational Association of Supportive Care in Cancer (MASCC) defined supportive care in cancer as 'the prevention and management of the adverse effects of cancer and its treatment'. Enhancing rehabilitation, secondary cancer prevention, survivorship, and end-of-life care are integral to supportive care
2. National Cancer Institute (NCI) dictionary defined supportive care as 'care given to improve the quality of life of patients who have a serious or life-threatening disease. The goal of supportive care is to prevent or treat as early as possible the symptoms of a disease, side effects caused by treatment of a disease, and psychological, social, and spiritual problems related to a disease or its treatment. Also called comfort care, palliative care, and symptom management.



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Defining Key Terms: Psychosocial Oncology

A subspecialty of oncology focused on the psychosocial impact of cancer on patients at all stages of the disease, on their families, and on individuals determined to be at increased risk for cancer.

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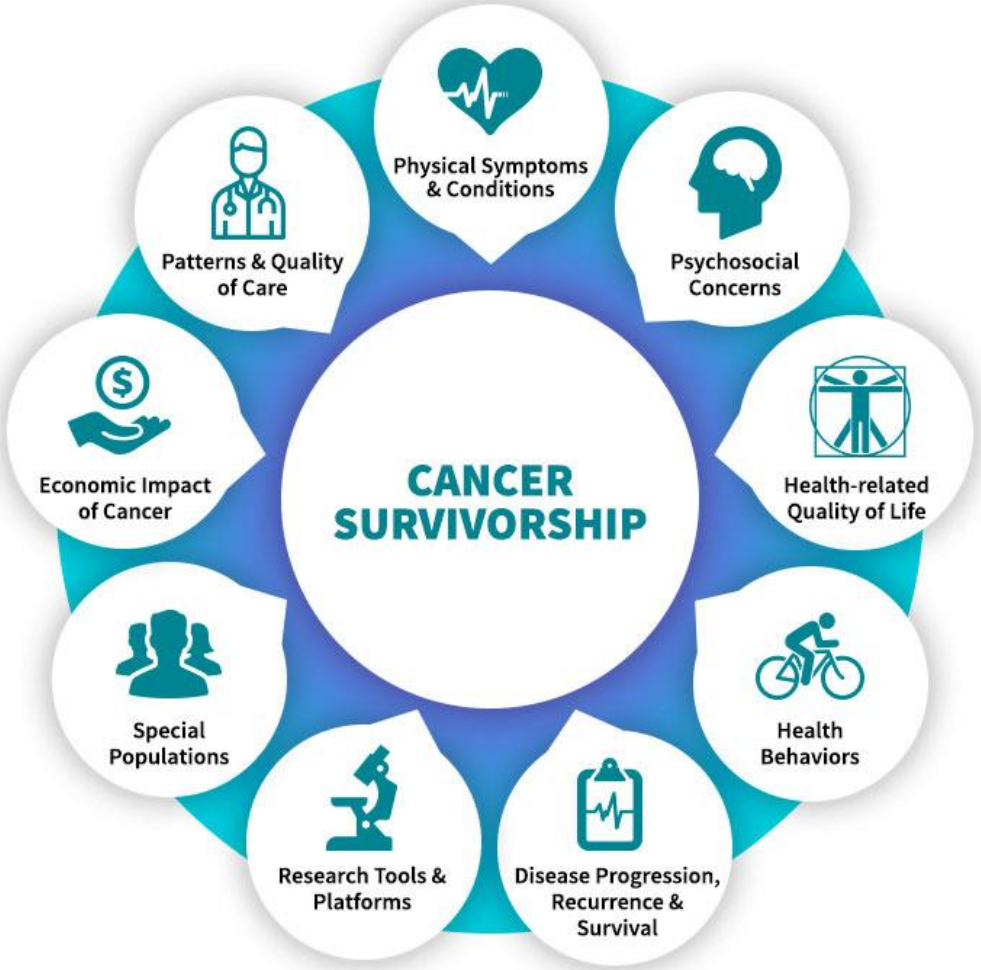

Defining Key Terms: Cancer Survivorship

An individual is considered a cancer survivor from the time of diagnosis, through the balance of his or her life. Family, friends, and caregivers are also impacted. There are many types of survivors, including those living with cancer and those free of cancer.

Periodic assessment is recommended for all survivors to determine any needs and necessary interventions. Care providers are also encouraged to assess the following at regular intervals to determine whether reversible or contributing causes for symptoms exist:

Current disease status
Functional/performance status
Medication
Comorbidities
Prior cancer treatment history and modalities used

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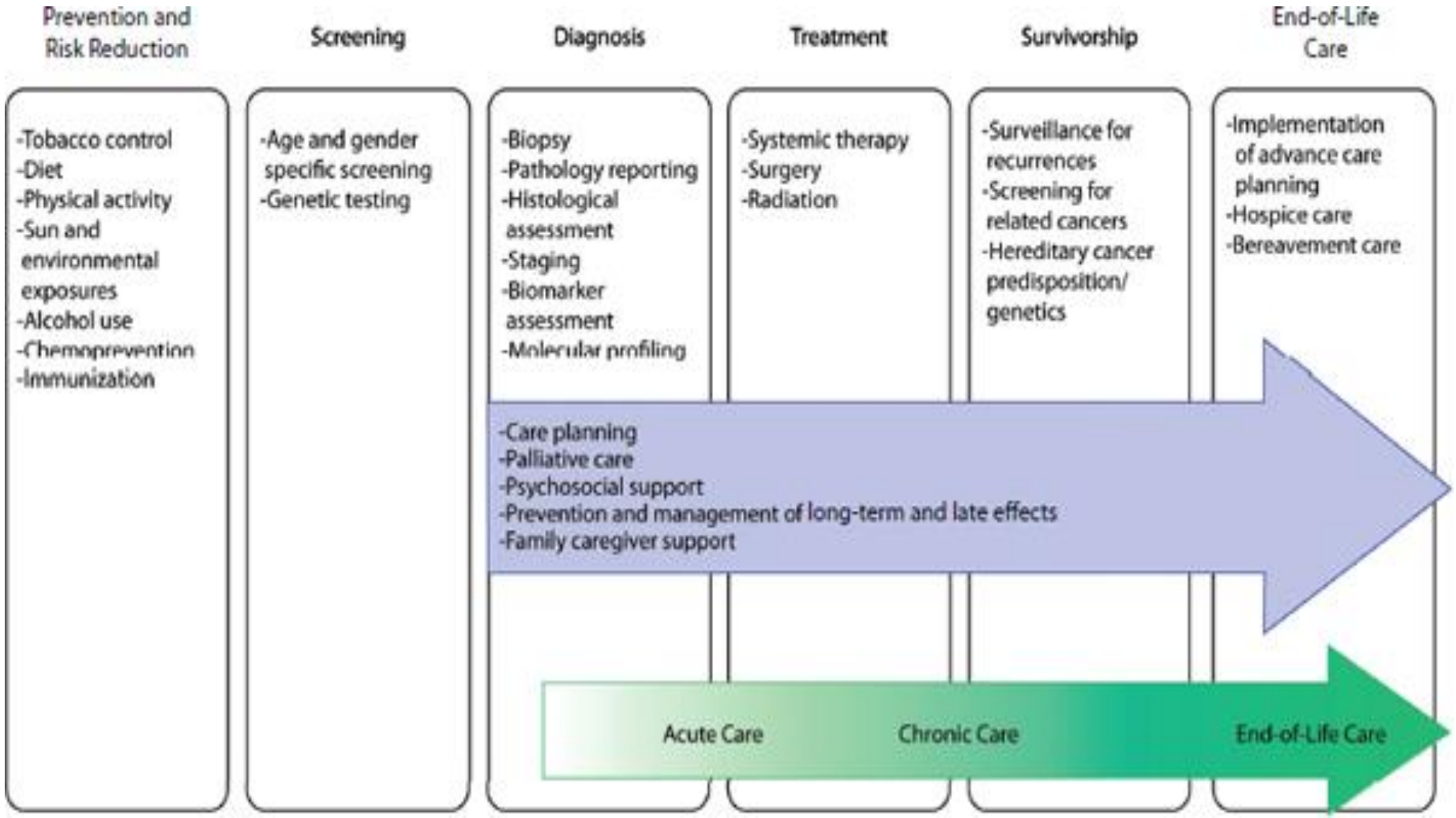
Defining Key Terms: Cancer Continuum



IOM, 2013

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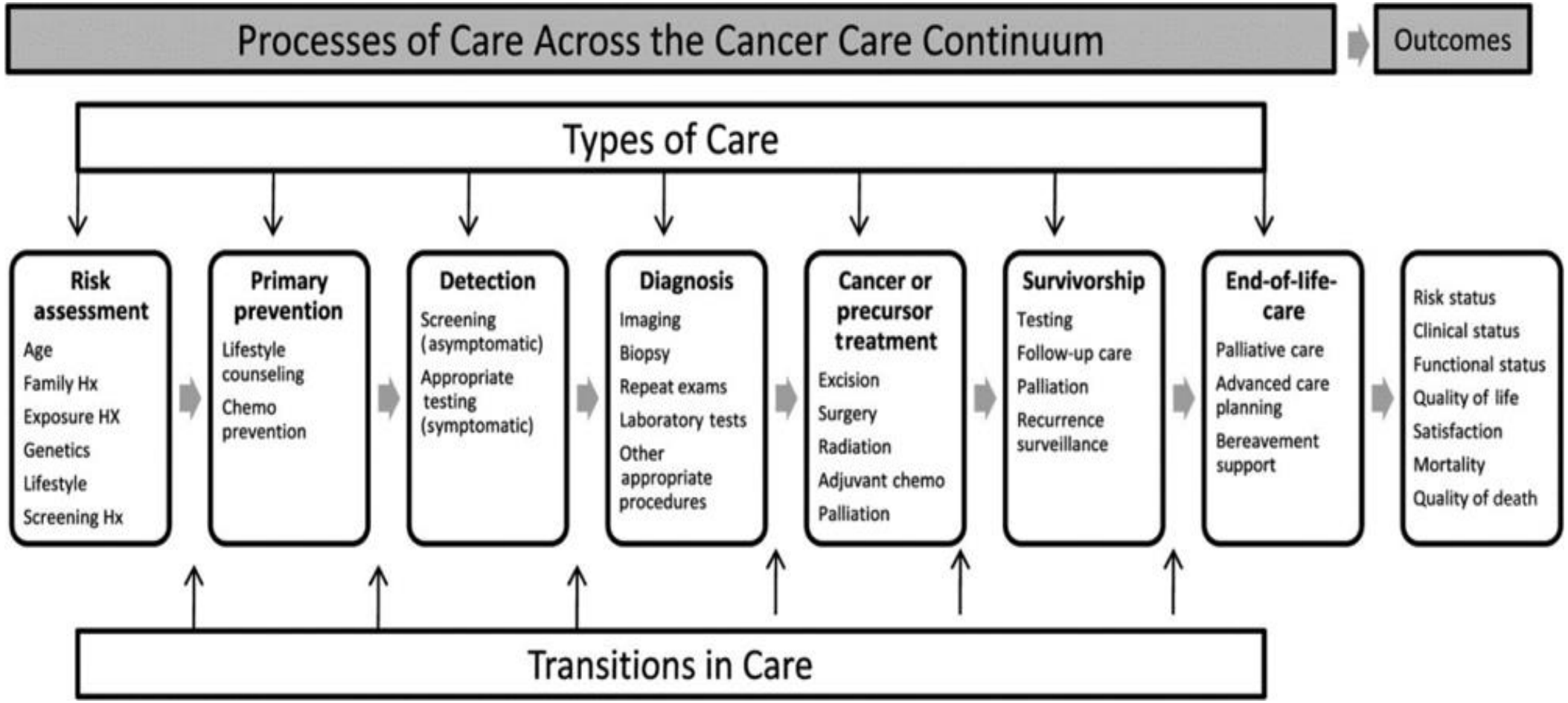
Defining Key Terms: Cancer Continuum



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General Responses to Cancer

Healthy Emotional Response

Most patients cope well with chronic stress & uncertainty with disease

Initial reaction = shock/disbelief, anger, denial, sadness, acceptance

Distress = anxiety/anger/low mood

Adjustment

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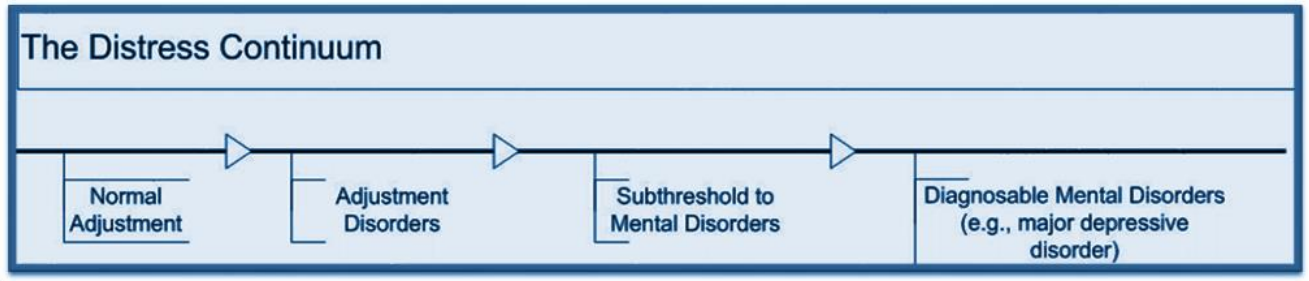
Cancer-Related Distress

A **multifactorial unpleasant emotional experience** of a psychological (cognitive, behavioural, emotional), social, and/or spiritual nature that may **interfere** with the ability to cope effectively with cancer, its physical symptoms and its treatment.

Extends along *a* **continuum**, ranging from common and normal feelings of vulnerability, sadness, and fears to problems that can become **disabling** , such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.



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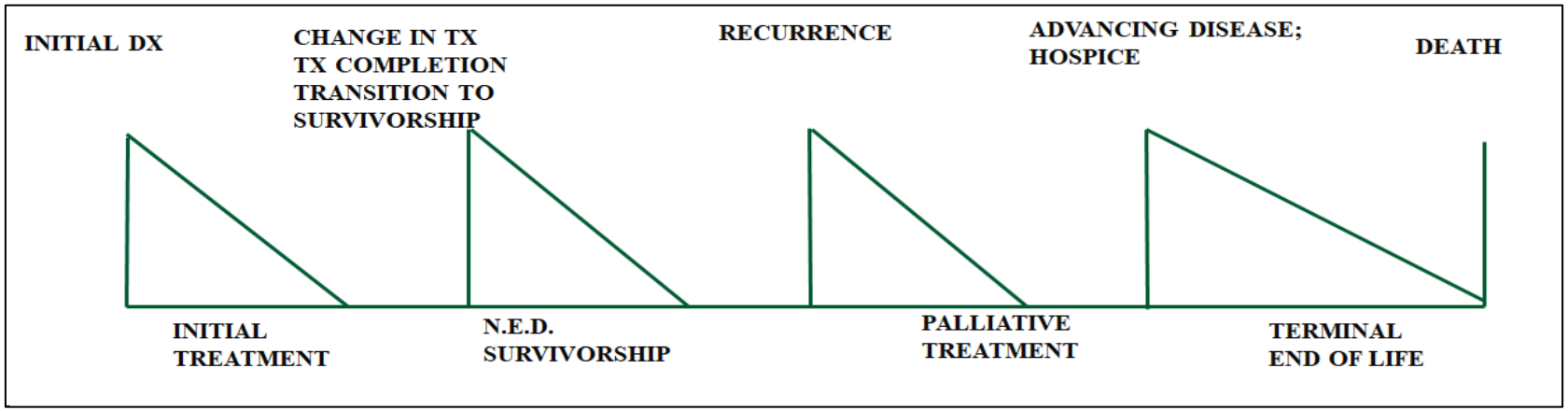
Cancer-Related Distress

There are proposed periods of increased vulnerability to cancer-related distress:

- At the time of initial dx distress tends to be high and diminishes over the course of initial treatment.
- Distress can be exacerbated again at the end of treatment when patients transition to survivorship. There is a sense of “what now?”, perhaps more time and resources to process the significance of the diagnosis, and many patients are challenged by the process of reintegrating into their usual roles.
- Distress is also heightened at the time of cancer recurrence, and certainly if recurrence is indicative of advancing disease that may be terminal and patients are coping with the anticipated end of their lives.
- For a subset of patients, distress may also peak very close to the time of death.



Henselmans et al., 2010

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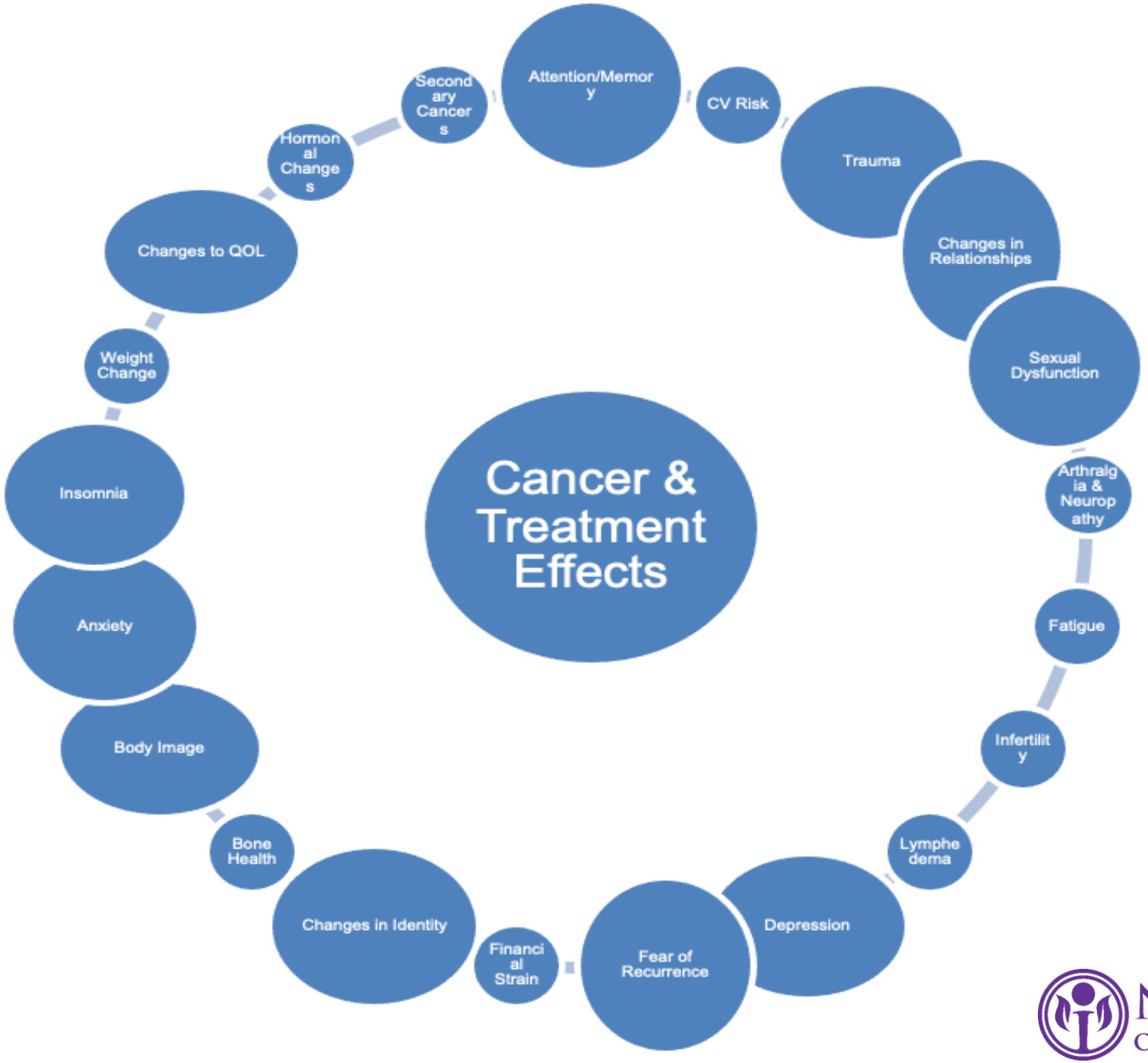
Cancer & Treatment Effects



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Protective Factors

- Acceptance of illness
- Perceived benefits of illness
- Disengagement of unattainable goals
- Re-engagement of new goals
- Positive redefinition
- Partner/caregiver support
- Active engagement
- Protective buffering
- “A fighting spirit”

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Risk Factors for Psychiatric Disorders

- Premorbid psychiatric disorder or substance use disorder
- Advanced Stage of Disease
- Burden of disease related symptoms
  - Pain, nausea, weight loss, fatigue, loss of function
- Disease Site Specific Factors
  - CNS Metastases, Anatomical changes due to cancer and surgery
- Treatment Specific Factors
  - Localized or whole brain irradiation, corticosteroids, hormonal therapy, chemotherapy, immunotherapy
- Social Factors
  - Perceived support
  - Housing/Finances/Insurance
  - Transportation/Geographic Limitations

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Contributors to Psychiatric Presentations

Distress	Contributing Factors	
Anxiety	• Younger age • Living alone • Diagnosis of lung cancer or melanoma • Avoidance	• Previous mental health tx • Female • Advanced disease • Physical symptoms • Comorbidities • Social isolation
Fear of Recurrence	• Later stage at diagnosis • Younger age • Prior diagnosis of recurrence • Being less educated • Lower level of social support	• Higher number of clinician visits • Self-identification as a cancer patient • Having children • Female • Prior mental health issue
Post-Traumatic Stress	• Less education • Single status • Low SES/lower economic resources • Unemployment • Intensity of cancer treatments	• Nonwhite race • A more recent diagnosis • More perceived negative impact of cancer • Younger age at diagnosis

Distress	Contributing Factors	
Cancer Related Distress	• Persistent physical health problems • Lingering physical signs and changes in body image • Self-criticism • Nonwhite race	• Lower access to support • Financial concerns • Unmarried survivors and married survivors with low social support • Multiple primary cancers
Depression	• Earlier time from a cancer diagnosis • Prior history of depression • Sedentary lifestyle • Active smoking history • Cognitive avoidance • Less education • Poor body image • Greater perceived financial stress • Unemployment • Difficulty in ADLs (>65) • Racial minority (>65)	• 2+ comorbidities (>65) • History of multiple primary cancer • Higher number of physical symptoms or lower perceived health status • Lower income • Lack of receipt of survivorship care plan • Rumination and fear of recurrence • Female, single

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Rates of Psychiatric Disorders

- Adjustment Disorder: 19%
- Major Depressive Disorder: 8-24%
- Generalized Anxiety Disorder: 5-17%
- Panic Disorder: 9-20%
- Acute Stress Disorder - 33%
- Post-Traumatic Stress Disorder: 7-14%

- Often disorders precede cancer diagnosis and are exacerbated by the onset of cancer, cancer treatments, or transitions in the cancer continuum
- Avoid normalizing patient's symptoms: If the patient meets criteria for the disorder, treat them for the disorder
- Cancer is becoming a chronic disease, patients frequently re-exposed to cancer-related stressors
- The type of cancer and nature of progression can impact psychiatric presentation

Disease Trajectories and Distress

Pathway	**Description**	**Challenges**
Gradual slant	Long, slow decline, years	Progressive loss of functions, drain on pt/fm resources
Downward slant	Rapid decline, chronic phase is short or absent	Little time to prepare self / others for death
Peak & Valleys	Alternating remissions & relapses	Repeated adjustment to changes in function
Descending plateaus	Long, slow periods of decline followed by restabilization	Repeat adjustment over longer time, progressive loss of functionality

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Depression

- Grief
  - Waves of emotions
  - Maintain or quickly regain normal functioning
- Adjustment Disorder with Depressed Mood
  - Focus on presence of depressive symptoms that are excessive for the situation AND impairs functioning, but does not meet criteria for another diagnosis
- Major Depressive Disorder
  - Some symptoms overlap with symptoms due to cancer or side effects from cancer treatment
    - Sleep
    - Appetite
    - Energy
    - Concentration
  - Symptoms less likely to be caused by effects of cancer and associated treatments
    - Depressed mood/sadness
    - Anhedonia/ Low motivation
    - Poor self care
    - Hopelessness
    - Guilt
    - Suicidal Ideation

Table 2. Under-Recognition of Depression in Cancer Setting

Reasons
1. Normalization of symptoms
2. Patients may not disclose their symptoms (they may not think it's important for the oncologist to know about)
3. Stigma of mental illness
4. Clinician's lack of confidence in treating these symptoms
5. Paucity of adequate psychosocial resources
Differential Diagnosis
1. Cognitive impairment (eg, delirium or dementia)
2. Manic episode of bipolar illness with irritable mood or mixed state
3. Attention-deficit/hyperactivity disorder (ie, distractibility and low frustration tolerance)
4. Substance use or substance-induced mood disorder
5. Another mood disorder (eg, not meeting depressive episode criteria; see Table 1)
6. Endocrine disorders (eg, hypo/hyperthyroidism, parathyroid disorders, Cushing syndrome, hyperprolactinemia)
7. Neurologic disorders (eg, cerebrovascular attack, CNS lesions, CNS vasculitis, Parkinson's disease)
8. Other disorders (eg, vitamin deficiencies, anemia, hypoxia, renal disease/uremia, lupus and connective tissue diseases)
9. Medications (eg, interferon-alpha, corticosteroids, antihypertensives, anticonvulsants)

McFarland et al., 2016

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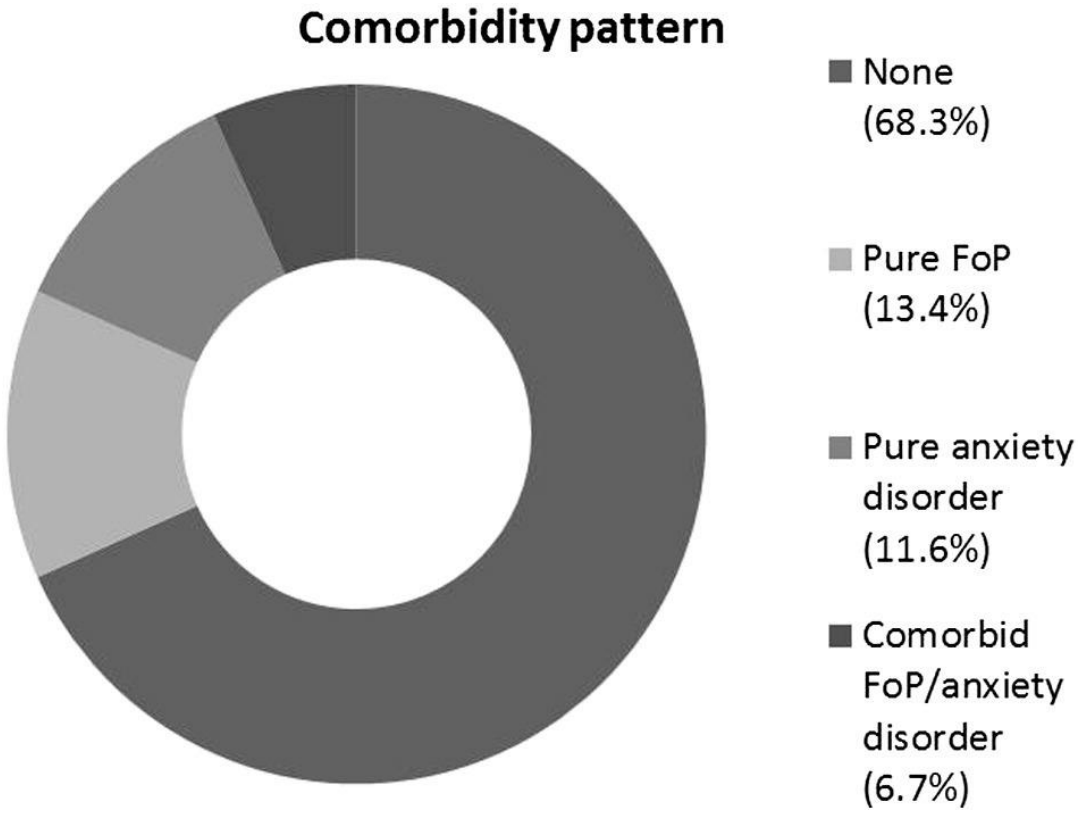
Anxiety

- Adjustment Disorder with Anxious Mood
  - Focus on presence of symptoms that are excessive for the situation AND impair functioning and are not explained by another disorder
- Panic Attacks
  - May occur independently or in the context of another disorder (ie. GAD, Panic Disorder, PTSD)
  - Symptoms often mimic other medical conditions
  - May interfere with care: Radiation Oncology, Infusions, Routine Office Visits
  - May lead to more frequent presentations to acute care or emergency department
- Generalized Anxiety Disorder
  - Limitation: Requires 6 months of symptoms prior to making diagnosis
  - Screen for pre-existing generalized anxiety disorder and ask if this is an exacerbation
- Panic Disorder
  - Panic attacks may be triggered or occur spontaneously
  - May lead to avoidance, self-medication
  - Contribute to patient and provider distress



Dinkel et al., 2014

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Trauma

- Acute Stress Disorder - Up to 33% of patients
  - Approximately 50% of patients will progress to PTSD
- Post-Traumatic Stress Disorder - 14% to 17%
  - May be acute or chronic
  - Approximately 50% of patients will have spontaneous remission of symptoms at 1 year
  - Challenging in psycho-oncology due to repeated exposure to stimuli that resemble initial trauma
- Some patients will not meet criteria for either diagnosis, however trauma of cancer often underlies the cause of other psychiatric disorders (ie. MDD, GAD, Panic Disorder)

Stressor	• Complex, protracted nature of cancer • Diagnosis, waiting for results, waiting for surgery • Noxious treatment • Injury/loss of integrity is not immediate but threatened • Outcome is based on what will happen in future
Chronicity of threat	• Cumulative response to multiple traumatic experiences
Triggers	• Diagnosis • Treatment procedures • Witness adverse course of other patients • Routine follow-up
Unpredictable course	• Remission interrupted by acute episodes
Internality of threat	• Perceived inescapability • Bodily signs as persistent reminders

French-Rosas et al., 2011

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Impact of Unmanaged Psychosocial Issues

- Poorer quality of life
- Hypervigilance
- Avoidance of health professionals, office visits, and procedures (“scanxiety”)
- Increased healthcare utilization, including higher number of outpatient, acute care, and ED visits
- Increased likelihood of high-risk behaviors
- Poor sleep and fatigue
- Reduced rates of treatment adherence
- Increased risk for all-cause mortality
- Long-term financial issues, e.g., inability to resume employment
- Interpersonal consequences
- Caregiver burnout
- Medical Personnel Burnout

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Psychosocial interventions can help modify these behaviors, and thus may help moderate their impact on outcomes.

No evidence to suggest psychosocial interventions directly improve survival outcomes.

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Interventions

- Supportive Services
  - Spiritual Counseling
  - Integrative Medicine
  - Nutrition
  - Physical Therapy, Occupational Therapy, SLP
  - Case Management and Social Work
- Psychotherapy
- Psychopharmacology

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Psychotherapy

Psychotherapy may look very similar to the general population, with particular emphasis on cancer-related issues:

- Motivational Interviewing
- Behavioral Activation
- Supportive Therapy
- Cognitive Behavioral Therapy
- Acceptance and Commitment Therapy
- Dignity Therapy
- Meaning Centered Psychotherapy
- Mindfulness
- Grief Therapy
- Group Therapy

This often changes for patients with advanced cancer or at end of life:

Goals:	Differences:
• Establish a bond that decreases feelings of isolation • Enhance self-worth • Correct misconceptions about the past, present, and future • Conceptualize death as a part of life, e.g., continuum of life experiences • Explore issues of separation, loss, and the unknown • Help mobilize inner resources • Help clarify values and modify plans for the future • Increase psychological comfort • Help the patient live at his/her highest level of functioning that is possible	• Values-focused with more finite goals • Deep insight or change may not be the goal • Working through all issues is not possible, working through some issues is possible • Lend stability to the patient/family • Help tie up loose ends • Help the patient to live while dying • Therapeutic relationship is established rapidly and is often more intense

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Psychopharmacology

- Instances when medication may be helpful:
  - Adjustment Disorder with anxious mood
  - Major Depressive Disorder
  - Generalized Anxiety Disorder
  - Panic Disorder
  - Post-traumatic Stress Disorder
  - Off-label Use
    - Sleep, Appetite, Energy, Nausea/Vomiting, Vasomotor Symptoms
- Palliative Psychiatry
  - Theoretical Framework for Prescribing Medications with the hopes of relieving suffering and less concern about long term risks of medications
    - Examples: Stimulants, Benzodiazepines, Hypnotics/Sleep Aids, Antipsychotics

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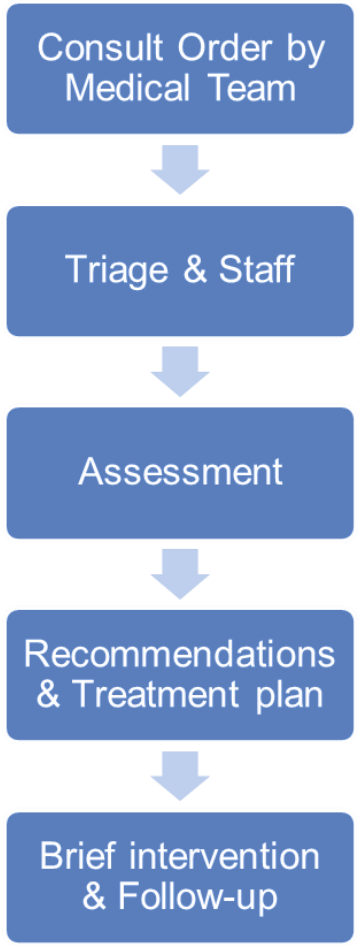
Consultation Models: Psychology

- Rates of distress are high, but so is ambivalence about treatment
- Traditional referrals insufficient
- Traditional C/L Psychiatry is limited
- Continuity of care
- Opportunity for interdisciplinary communication/education
- Benefits for the “Triple Aim” of healthcare



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Consultation Models: Psychiatry

- Direct Care
- Integrated Care
- Collaborative Care

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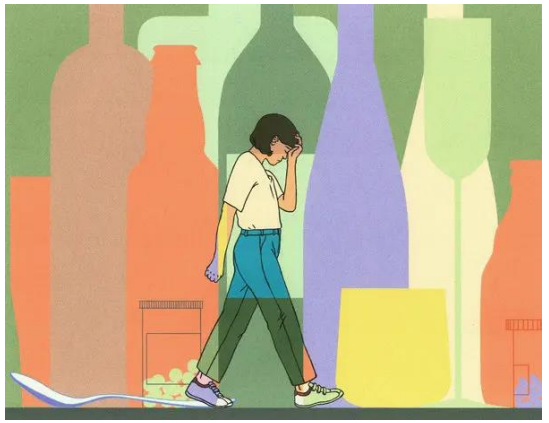
Special Populations

- AYA
- Transgender
- Geriatrics
- SUDs
- Pre-existing psychiatric conditions
- Access Limitations
  - Lower SES
  - Rural populations + transportation
  - Financial Toxicity



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Special Considerations

- Family and caregiver needs
- High burden of disease and end-of-life care
- Therapists' personal experience with cancer and burnout/compassion fatigue
- Multicultural issues
  - DEI and cancer screening + DEI and mental health access
  - Religious beliefs and decision-making about treatment

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Q&A With Dr. Rynar and Dr. Kaplan

- The presenters will now provide answers to select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

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