Distress, Depression and Cancer

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Objectives

- The history of psychosocial oncology
- The emotional life cycle of living with cancer
- Normal reactions to having cancer
- Signs and symptoms of distress
- Signs and symptoms of depression
- Treatment options and resources

The History of Psycho-Oncology

- 19th century: the word cancer was unspeakable
- 2 stigmas: cancer and mental illness
- Early 1900's: anesthesia, surgery
- 1913: American Cancer Society was formed, "Fight Cancer with Knowledge" public campaign
- 1940's: chemo, radiation
- 1950's: first chemo cure
- Survey 1961: >90% Drs did not give cancer dx

The History of Psycho-Oncology

- 1960's: better prognosis, informed consent, patient rights, Kubler-Ross opens the dialogue
- 1970: P-O formally begins in the US, **C/L psychiatrists** first wave of researchers, psychologists and health medicine second wave, later on nurse researchers)
- 1970-1990's: conferences, training programs, journals, textbooks, scales (QOL)

The History of Psycho-Oncology

- New millennium:
- spiritual issues
- pain control
- behavioral interventions (meditation, hypnosis)
- complementary and alternative medicines
- group therapy
- NCCN: first clinical practice guidelines for psychosocial oncology, suggest monitoring of distress for all patients

The History of Psycho-Oncology Continuum

- Risk prevention (lifestyle changes)
- Early detection (behaviors/attitudes)
- Genetic risk and testing
- Symptom control during active treatment (depression, anxiety, delirium)
- **Survivorship** psychological sequalae
- Palliative and End-of-Life issues

The History of Psycho-Oncology

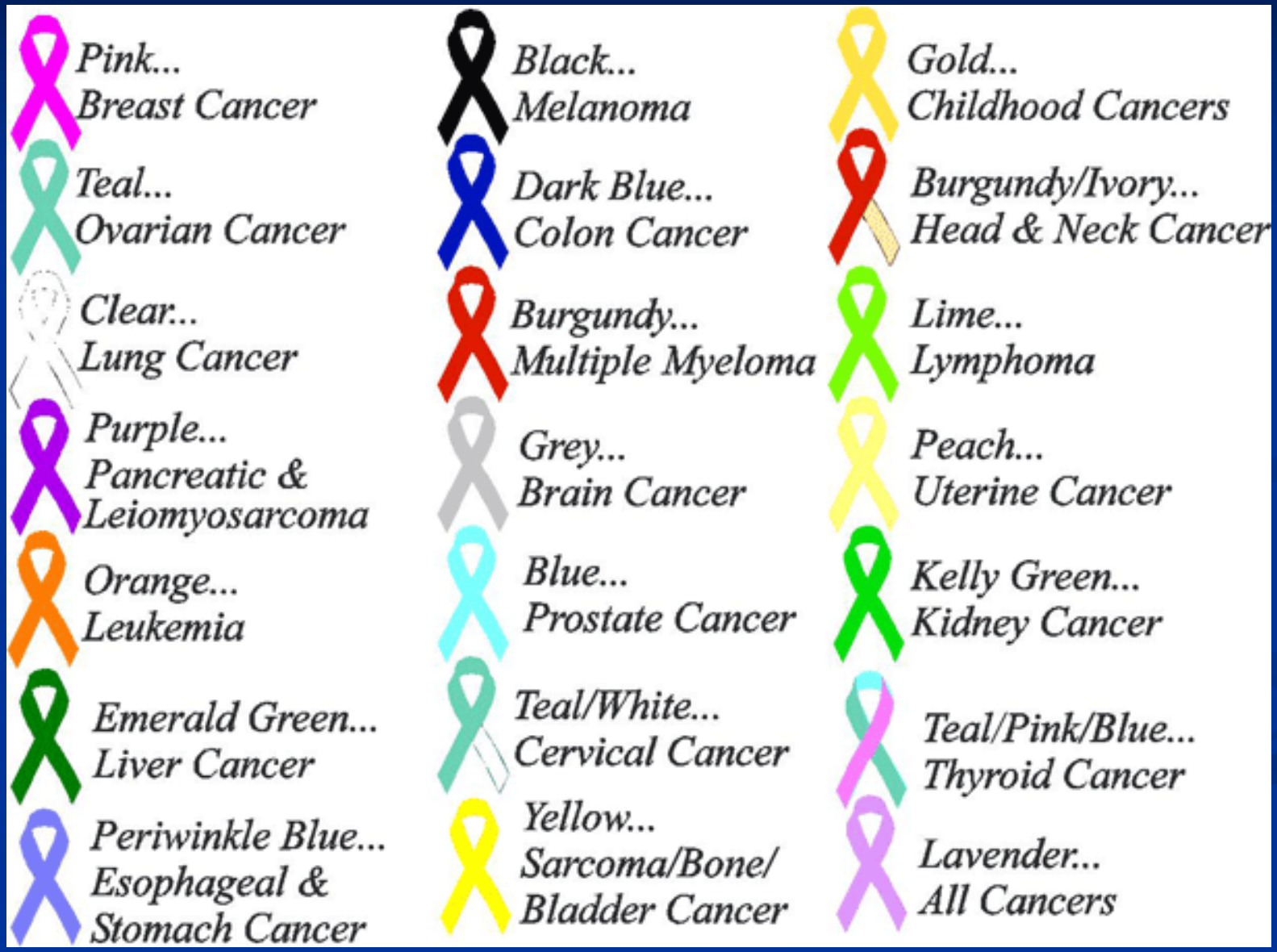
- The need for an Integrative Model
- Multidisciplinary approach
- One of the youngest subspecialties in oncology
- Almost all cancer centers have P-O units
- Trainees from psychiatry are needed in P-O

- "Despite significant increases in treatment effectiveness, the diagnosis and treatment of cancer remains one of the most emotionally distressing events in medical care"

- (Baider et al., 1994, D'Arrigo et al.,2000, Derogatis et al.,1983, Pruitt et al.,1992, Roth et al.,1998)

- "Emotional distress and depression/anxiety are common in cancer patients but often go unreported, unrecognized and untreated"

Cancer


Pink...
Breast Cancer
Teal...
Ovarian Cancer
Clear...
Lung Cancer
Purple...
Pancreatic &
Leiomyosarcoma
Orange...
Leukemia
Emerald Green...
Liver Cancer
Periwinkle Blue...
Esophageal &
Stomach Cancer
Black...
Melanoma
Dark Blue...
Colon Cancer
Burgundy...
Multiple Myeloma
Grey...
Brain Cancer
Blue...
Prostate Cancer
Teal/White...
Cervical Cancer
Yellow...
Sarcoma/Bone/
Bladder Cancer
Gold...
Childhood Cancers
Burgundy/Ivory...
Head & Neck Cancer
Lime...
Lymphoma
Peach...
Uterine Cancer
Kelly Green...
Kidney Cancer
Teal/Pink/Blue...
Thyroid Cancer
Lavender...
All Cancers

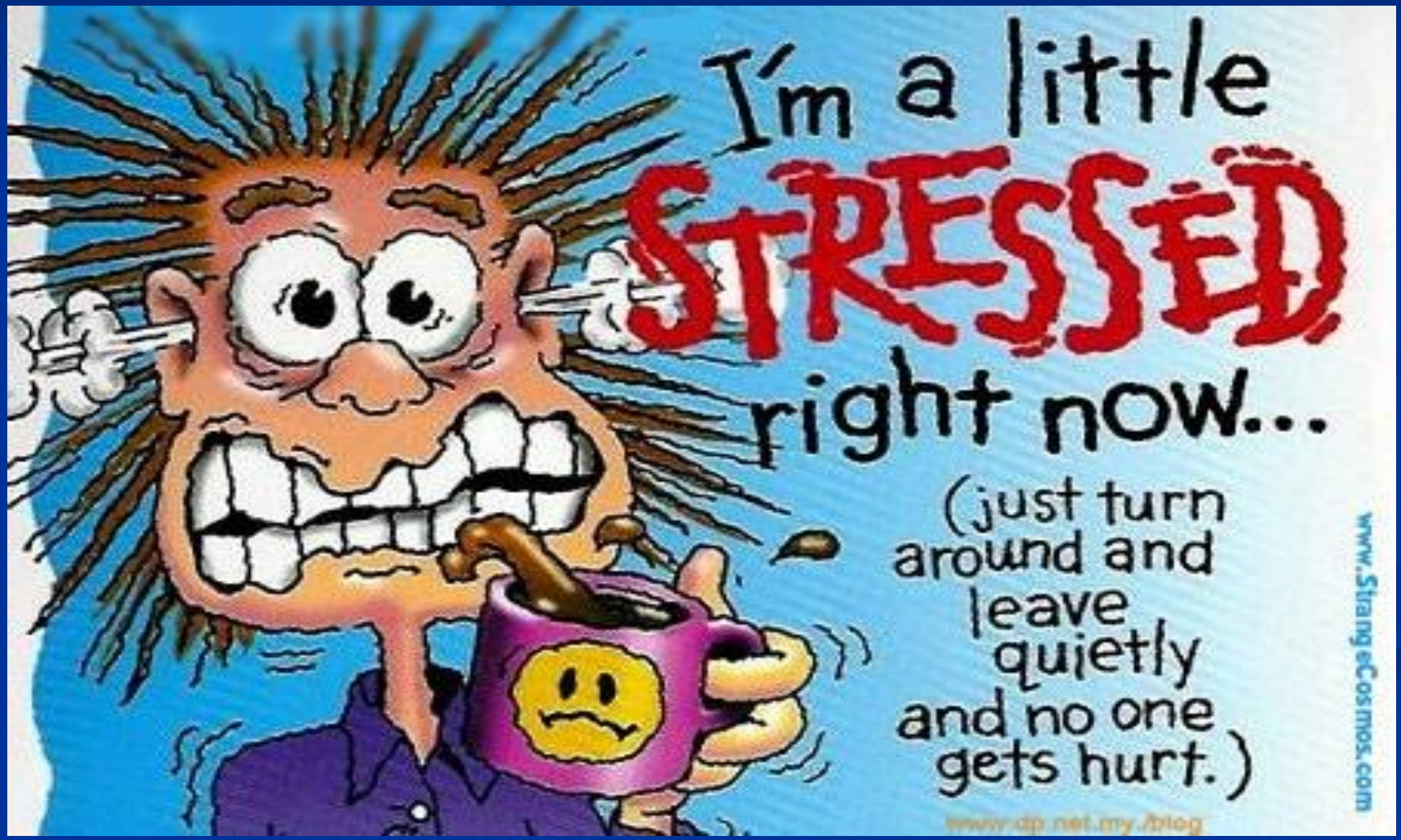
The Cancer Trajectory

- Diagnosis
- Acute Treatment
- Remission
- Follow-up
- Relapse
- “Chronic illness” or “Survivorship”
- Palliation/End of life

Most Common Fears in Cancer Patients: "7 D's"

- Death
- Disability
- Disfigurement
- Dependency on family
- Discomfort
- Disruption of interpersonal relationships
- Disengagement from treatment and re-entry into normal life

The "normal" response to having cancer



"Normal Response" to Diagnosis, Relapse or Failure of treatment

- Initial shock
- Period of Turmoil (depressive, anxiety sx)
- Disruption of life patterns and routine
- Intrusive thoughts about diagnosis
- Fears about the future
- Usually resolves over several weeks
- Emotional distress is the natural response

Other Reactions…

- Disbelief
- Denial
- Awkwardness
- Panic
- Anger
- Guilt
- Frustration and loss of control (uncertainty)
- Despair
- Humor
- Shame
- Role redefinition

DISTRESS

- Cancer-related distress: " psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment" (NCCN Guidelines)

- Prevalence: 28-87%

DISTRESS

- It is becoming widely recognized that the majority of cancer patients experience some degree of psychological distress (M Sharp et al., 2004, DP Stark, 2000)…

- and that they would potentially benefit from some form of psychological intervention, even when the distress is only moderate in severity or transient in duration (National Institute for Clinical Excellence 2004, NCCN 2005)

Possible Impact of Severe Distress or Depression in Cancer

- Amplifies pain (lowers the pain threshold)
- Increases ER visits, calls to clinic, time with oncologists
- Increases hospitalization rates
- Increases length of hospital stay
- Increases complications with therapy (adherence)

Possible Impact of Severe Distress or Depression in Cancer

- Impairs capacity for pleasure, meaning, and connection
- Reduces ability for self care
- Increases disability
- Can impair cognition and decision-making capacity
- Earlier admission to palliative care facilities

Possible Impact of Severe Distress or Depression in Cancer

- May worsen survival outcome (decreased compliance or immunological factors)
- Impairs the ability to participate in end-of-life planning
- Impairs the ability to do the emotional work of separating and saying goodbye
- Erodes remaining QOL

Possible Impact of Severe Distress or Depression in Cancer

- Increases desire for hastened death
- Suicide
- Causes anguish and worry in family members and friends
- Diminishes psychosocial functioning of caregivers

Screening for Distress

- The 6th Vital Sign
- ESAS (ISAAC) at TOH Cancer Centre

- Talk to you nurse or oncologists
- Talk to you family physician
- Resources: educational books, videos, support groups, peer support


FUTURE?
CAREER?
FAMILY?
HEALTH?
HOME?
LOVE?
BILLS?
SAVINGS?
SECURITY?

Depression and Cancer

Prevalence of Major Depression

- Some sx found in ¼ to 1/3 medical in and outpatients
- Severe depression in 4-18%, often in the more severely ill

- In cancer patients, prevalence rates reported range between 5% to 40% (0-46%)
- Advanced cancer, median prevalence: 15%
- Overall 2-3 times greater than in general population

Barriers to Diagnosing Depression

Barriers to Diagnosing Depression in Cancer Patients

- Reluctance of patients to disclose distress: STIGMA!
- Avoidance of medical staff to inquire
- Fear of upsetting the patient
- Belief that it is normal
- Difficult to diagnose on a single visit
- Apprehension about drug-drug interactions with AD

Barriers to Diagnosing Depression in Cancer Patients

- DSM-IV-TR criteria may not be so applicable in the medically ill (somatic sx are less diagnostically discriminative)

- Diagnostic scales used in research lose reliability in the presence of co-existing physical illness


What is
DEPRESSION?
by TherapyTribe

DSM-IV-TR Criteria for Major Depression

- ≥5 sx for 2 weeks: at least one is either depressed mood or loss of interest/pleasure
- Other sx: weight loss, insomnia/hypersomnia, psychomotor agitation/retardation, fatigue or energy loss, worthlessness or excess guilt, decreased concentration/indecisiveness, suicidal ideation
- (SIG E CAPS)
- Sx cause clinically significant distress or impairment of functioning, not due to substance or medical condition

Diagnosis of Depression in Cancer

- <u>May rest upon affective and cognitive sx:</u>

- Depressed mood, anhedonia, loss of interest/apathy, poor concentration or memory, slowed sluggish thoughts, pessimism/negativity, worthlessness, excessive **guilt**, **helplessness**, **hopelessness**, **suicidal ideation**

Endicott Substitution Method for Depression Criteria

(J Endicott, 1984)

- Weight loss substituted with depressed appearance
- Insomnia substituted with social withdrawal or decreased talkativeness
- Loss of energy substituted with brooding, self-pity or pessimism
- Poor concentration substituted with lack or reactivity/cannot be cheered up

Differential Diagnosis (in cancer patients)

- R/O uncontrolled pain (bi-directional relationship with depression)
- Differentiate from fatigue ("I want to but I can't)
- "Demoralization": concept by Kissane, in palliative care, existential despair, content in the present, still interactive with their environment

Cancer Illness and Treatment-related Factors

- Tumors or metastases to CNS
- Metabolic complications (hypercalcemia)
- Tumor-related toxins
- Autoimmune reactions
- Viral infections
- Nutritional deficiencies (B12, Folate)
- Radiation to brain or head and neck

Pharmacological Causes of Depression

- Cardiac and antihypertensives
- Sedatives and hypnotics
- Steroids and hormones
- Stimulants and appetite suppressants
- Psychotropic drugs (benzo)
- Neurological agents
- Analgesics/anti-inflammatory
- Antibacterial and antifungal
- NSAIDs
- Anticholinesterases
- Antineoplastic (vincristine, vinblastine, asparaginase, intrathecal methotrexate, interferon, tamoxifen)

Risk Factors for Major Depression in Cancer Patients

- Family history
- Past Psychiatric history
- Age (younger)
- Gender (equal)
- Advanced disease
- Oropharyngeal, pancreatic, (early) breast CA
- Physical immobility or dependency
- Poorly controlled pain
- Social isolation/few social supports
- ETOH
- Concurrent severe medical illness
- Medication
- Existential distress
- Other life stresses or losses

Suicide

- Frequency of suicide in the cancer population is higher than in the general population (2X)
- Highest risk in the months after diagnosis
- Risk decreases with survival time, very low in terminal phase
- Depression, uncontrolled pain, loss of control (helplessness), hopelessness, advanced disease (exhaustion), mild delirium, anxiety, pre-existing psychopathology
- Desire for hastened death is not necessarily synonymous with a request to hasten death

When to ask for help…

Indications for Psychiatric Referral

- Uncertainty about the diagnosis
- History of a Major Psychiatric Disorder
- Suicidal ideation, requesting assisted suicide or euthanasia
- Psychosis or confusion
- Unresponsive to therapy with first-line AD
- Dysfunctional family

Treatment of Depression

Treatment of Major Depression in Cancer

- Bio-Psycho-Social Approach
- Patient safety, therapeutic alliance and empathy
- Correct diagnosis to determine correct intervention
- "Most experts recommend a approach that combines supportive psychotherapy with patient and family education and judicious use of antidepressant medication", the effectiveness is up to 70-80% in the physically well

Medications

- For sleep (Trazodone, Imovane)
- For depression (Effexor, Cipralex, Celexa, Remeron, Cymbalta,…and many more)
- For anxiety (lorazepam short term, anti-depressant long term)

Antidepressants

- Proper assessment and monitoring are crucial
- Start low (half the dose) and go slow
- "Adequate Trial" of AD
- For patients completely intolerant or resistant to AD, ECT may be considered

- **Expanded role**: treat depression, anxiety, hot flashes, adjuvant analgesics and antiemetics

Treatment of Depression

PSYCHOSOCIAL INTERVENTIONS in Oncology

Landmark Study

- Spiegel et al., 1989
- 86 metastatic breast cancer patients
- 50 women treatment group, 36 controls
- Intervention: 90 minute weekly support group meetings over a one year period
- Initial outcome variable was mood changes
- 10 years later found that the treatment group lived an average of 18 months longer from time of randomization

PSYCHOSOCIAL INTERVIENTIONS in CANCER

- According to several reviews in the last decade, it appears that overall, psychosocial interventions may help patients with cancer, especially in those who are suffering from psychological distress

Psychotherapy

- Psychosocial interventions for depression in cancer patients result in moderate improvement in symptoms in the vast majority of cases (Pirl et al. 2004, a summary of 3 meta-analyses)

- Psychosocial interventions provide an overall positive effect on QOL (Fawzy et al. 1999)

Types of Psychosocial Interventions

- Many different types
- Individual or group format
- For the patient, family or significant others
- In hospital, community or web-based
- Throughout the cancer trajectory

- The basics:
- Education/information
- General counselling/support

6 Evidence-Based Interventions for Mild to Moderate Distress

- Cognitive-Behavioral Therapy
- Stress Reduction Exercises
- Problem-solving Approach
- Physical Exercise
- Support Groups
- Complementary Treatments

Types of Psychosocial Interventions…specific therapies

- *Cognitive-Behavioral
- Problem-solving
- Psychodynamic
- Existential
- Interpersonal
- Dignity-conserving
- Meaning-centered
- Behavioral (relaxation, imagery, visualization)
- Spiritual or pastoral counselling
- Creative therapies (art, music, dance)

Types of Psychosocial Interventions…for the body

- Exercise
- Diet/nutrition
- Physiotherapy
- Speech/language therapy
- Massage therapy
- Acupuncture
- Meditation, Yoga, Tai chi, Qi gong

Types of Psychosocial Interventions…for practical issues

- Financial counselling
- Vocational rehabilitation
- Occupational therapy
- Community resource linkages

Complementary Medicine

- Mind-body modalities are recommended as part of a multidisciplinary approach, to reduce anxiety, mood disturbance, chronic pain and improving quality of life

Society for Integrative Oncology Guideline Recommendations

- Mind-body modalities
- Massage therapy: anxiety, pain
- Acupuncture: pain, neuropathy, nausea, vomiting, fatigue
- Dieticians: increase basic health

TOP 10 LIST

Dr. Caroline's Top Ten List for Patients with Cancer

- It's not your fault
- Cancer does not define who you are
- At times, cancer is like a full time job and more
- It's OK to be "just good enough"
- Never say no to offers of help

Dr. Caroline's Top Ten List

- Carpe Diem (seize the day), "Life is not a dress rehearsal"
- Treat yourself every day with something special, you deserve it!
- Serenity Prayer, "We have no control over the cards we are dealt, only how we choose to play them"
- Life is about quality not quantity
- "Just do it"…Nike

Resilience

The Courage to Come Back

Components of Resilience

(D Charney, The Psychobiology of Resilience to Extreme Stress, Grand Rounds, Mass Gen Hospital, 2006)

- Optimism
- Altruism
- A moral compass
- Faith and Spirituality
- Humor
- A role model
- Social supports
- Facing fear
- A life mission
- Training

Post-Traumatic Growth

Resources

- Canadian Cancer Society
- TOH Cancer Centre, Psychosocial Oncology Program
- Maplesoft Cancer Survivorship Centre