Psycho-Oncology in Palliative Care:
Mental Health in Cancer Patients Receiving Palliative and End of Life Care

Jessica Molinaro, MD

Assistant Professor

Department of Psychiatry and Behavioral Medicine

Medical College of Wisconsin

Disclosure

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Objectives

- Describe depressive, anxiety and adjustment disorders in cancer patients receiving palliative and end of life care
- Review prevalence of these disorders and their common clinical manifestations in this population
- Outline approach to assessment, including identifying differential diagnosis that consider both medical and psychologic contributions
- Describe clinical management of these disorders, including pharmacologic and nonpharmacologic treatment approaches

Distress

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

Distress

- Distress is prevalent in patients with advanced illness and at end of life
- Emotional distress can be a normal and appropriate reaction to the stressors related to coping with advanced illness
- However, it can also lead to worse psychopathology including major depression and anxiety → associated with poor outcomes if left untreated

Distress in Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families who are facing problems with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment, and treatment of pain and other problems, whether physical, psychosocial, or spiritual. Addressing suffering involves taking care of issues beyond physical symptoms.

World Health Organization 2020

Distress in Palliative Care

- High burden of psychological problems among palliative care patients
- Prevalence rates of anxiety and depression in 381 cancer patients receiving palliative care were 13.9% and 20.7% (Wilson et al. 2007)
- Dual burden of anxiety and depression found in 25% of 266 palliative care patients (O'Conner et al 2010)
- In a meta-analytic review in patients receiving heme/onc and palliative care: 16.5% with depression, 14.3% major depression, 10.3% anxiety, 19.4% adjustment disorder and 38.2% with any mood disorder (Mitchell et al 2011)

Sultana et al. 2021

Depressive Disorders

Prevalence of Depressive Disorders

- Depression is common in patients with life-threatening illness
- Rates are higher in patients with more advanced illness, with greater levels of disability, and/or unrelieved pain. (Brietbart B & Dickerman A. 2023)
- Prevalence rates in the literature vary widely:
  - In meta-analysis of 15 studies, prevalence of depression reported to vary from 7%-49% in palliative care patients (Walker et al. 2013)
  - In a systematic review of 59 studies conducted in several settings (hospital/oncology department, hospice/palliative care units, and outpatient services) showed a 2-56% prevalence of depression (Janberdize et al. 2014)
- Compared to the general population, rates are 2-3x higher in patients with cancer

Kissane et al. 2023

Impact of Depression in Patients with Advanced Illness

- Depression causes comparable reductions in quality of life as seen with major physical symptom burden and with decreased performance status

- Associated with poorer outcomes in cancer patients
  - Reduced quality of life
  - Reduced patient satisfaction with care
  - Impaired adherence with treatment
  - Poorer self-care
  - Longer hospital stays
  - Increased sensitivity to/monitoring of physical sensations → increase pain
  - Effects on decision-making capacity
  - Shorter survival

- Significant contributor to desire for hastened death (suicide, physician-assisted suicide, euthanasia, declining treatment)

Chan et al 2015; Grassi et al 2012; Kissane et al 2023

Risk Factors of Depression

History of depression or other psychiatric disorders
Family history of depression
Advanced illness
Higher symptom burden
More frequent unmet needs (eg physical, social, psychological and spirtual)
Use of steroids or other medications associated with depression
Younger age
Female gender
Cancer Type
Treatment-related factors

Kissane et al 2023; Brietbart W & Dickerman A 2023

Symptomatology of Major Depressive Disorder

- Five symptoms from above required to make diagnosis of depression and must include either depressed mood and/or anhedonia
- Symptoms must be present most of the day, nearly every day, for at least two weeks
- Cannot be explained by other physical or psychiatric problems

Identifying Depression

Supporting symptoms of depressive disorders

- More pervasive symptoms of depression
- Loss of emotional reactivity to good news
- Irrational sense of self-guilt (patients believe it is their fault they have cancer)
- Wish for hastened death
- Suicidal thoughts including specific plans

Supporting signs of depressive disorders

- Social withdrawal
- Not participating in medical care
- Demeanor showing reduced facial reactivity and slowed thinking

Physical symptoms (“neurovegetative symptoms”) – more challenging

- Sleep disturbance
- Psychomotor retardation
- Appetite disturbance
- Poor concentration
- Fatigue

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Anticipatory Grief versus MDD

Anticipatory Grief	Major Depressive Disorder
Comes in waves	Constant
Retains capacity for pleasure	Anhedonia
Passive wishes for death	Intense, persistent suicidal thoughts
Able to look forward to the future – except often with uncertainty and worry	No sense of anything to look forward to

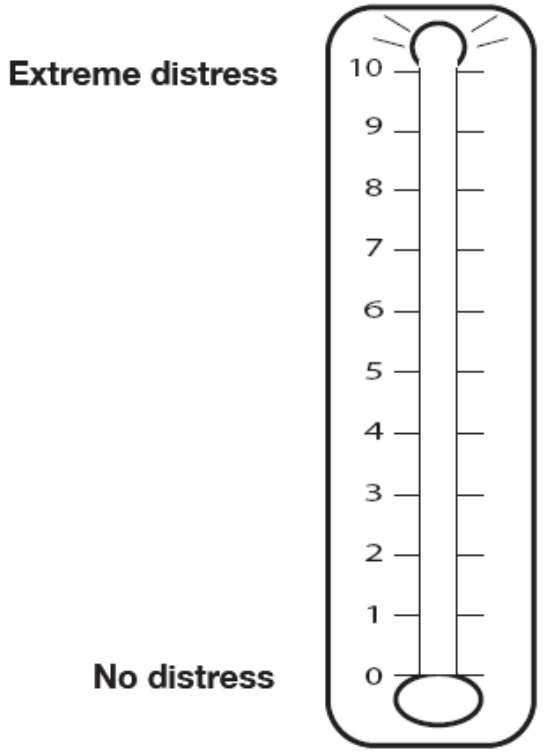
Kissane et al 2023

Screening Tools

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Patient Health Questionnaire - 9



Distress Thermometer

Clinical Assessment

- Detailed history and physical exam – help discern psychological versus physical contributing factors, including medications and/or lifestyle contributions
- Laboratory testing, including the measurement of electrolytes, blood cell counts, relevant hormones, and toxicology
- Collateral history obtained from family, friends and other members of the interdisciplinary team

Key Differential Diagnoses

- Physical Conditions
  - Unsolved physical distress (i.e. pain, nausea)
  - Endocrine dysfunction
  - Anemia
  - Diabetes Mellitus
  - Nutritional deficiency
  - Electrolyte imbalance
  - Cancer-related fatigue
  - Other physical conditions (cardiac dysfunction, hepatic dysfunction, infection, pulmonary dysfunction)

- Organic Brain Disorders
  - Cancer-related: brain tumor or metastases (especially frontal lobe apathy); leptomeningeal disease; paraneoplastic syndrome
  - Other neurological disorders: Parkinson's syndrome, CVA, MS
  - Changed mental status: Delirium

- Other psychiatric/psychological states
  - Alcohol/substance abuse
  - Normal grief
  - Demoralization syndrome

- Medications (side effects)
  - Steroids, interferon, beta-adrenergic blockers, calcium-channel blockers, benzodiazepines, barbiturate, cholinergic medications, estrogens
  - Late effect of anticancer agents ("chemo brain")

- Medications (withdrawal)
  - Steroids
  - Stimulants

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Factors that can contribute to misdiagnosis or inappropriate care

Distinguishing from illness or treatment-related factors

Recognizing delirium – especially hypoactive delirium

Depression and Suicide

- Individuals with depression and advanced illness are at higher risk for suicide and suicidal ideation and for desire to hasten death
- Risk factors for suicide in the terminally ill: clinical diagnosis of depression, greater severity of depressive symptoms, and sense of hopelessness
- Risk is higher after cancer diagnosis or recurrence, but also increases with increasing symptom burden or advanced disease

Suicide

- When the suicidal person develops plans to end their life, urgent management plans are required and ought to include:
  - Admission to a safe and monitored environment (i.e. inpatient psychiatric hospitalization)
  - Comprehensive assessment
  - Starting psychotropic medication to help agitation and treat depression

- Safety assessment should be made routinely and as needed in all patients regardless of depression symptoms. Agitation, anxiety, impulsivity, a recent loss and a terminal illness are all risk factors for suicide

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Desire for Hastened Death

- *Wish to Hasten Death (WTHD):* reaction to suffering, in the context of a life-threatening condition, from which the patient can see no way out other than to accelerate his or her death
  - Emerge in context of physical, psychological, spiritual, and existential suffering
  - Suffering related to ”loss of self”: loss of function, of control, of meaning in life, or of perceived dignity
  - Fear both of death itself and of the process of dying – patient can experience hopelessness and intense emotional distress
- Must be distinguished from acceptance from impending death or from a wish to die naturally
- Depression, hopelessness, and loss of meaning are independent risk factors for WTHD. Hopelessness and loss of meaning were significant independent and synergistic factors in predicting high levels of WTHD

Anxiety Disorders

Anxiety

- Feelings of helplessness, fear, and loss of control can be a normal and expected experience in patients with advanced illness
- Many patients may experience symptoms of anxiety – not all these patients meet criteria for an anxiety disorder
- Symptoms of anxiety are thought to occur in more than 70% of medically ill patients, especially those approaching end of life
- Anxiety rising to level of disorder likely impacts about 10% of patients in palliative care
- Persistent high levels of anxiety can cause significant distress and functional impairment and are associated with poorer outcomes

Clinical Manifestations

- *Emotional symptoms*: edginess, feelings of impending doom or terror
- *Cognitive difficulties:* apprehension, dread, fear, obsession, uncertainty or worry
- *Behavioral Problems*: avoidance, compulsion, or psychomotor agitation
- *Autonomic symptoms:* diaphoresis, diarrhea, nausea, dizziness, tachycardia, or tachypnea

Irwin & Hirst. 2022

Contributory Physical Disease Factors

- Strong association between physical symptom burden and symptoms of anxiety/depression
  - Raw number of symptoms is associated with greater anxiety and depression → particularly relevant for patients at the end of life
  - Certain physical symptoms can predict higher rates of anxiety
  - Reduced mobility or inability to participate in ADLs can trigger anxiety

- Reducing physical symptoms tends to reduce anxiety *and* treating anxiety reduces physical symptoms and bodily discomfort

Medication-related Contributory Factors

- Akathisia: inner restlessness occurring as a side effect of anti-nausea meds or antipsychotics

- Medication tolerance/withdrawal
  - Rebound anxiety with the habitual use of benzodiazepines is also very common – causing insomnia, physical restlessness, and body discomfort
  - Cessation of dopamine blocking agents used to prevent and treatment nausea may precipitate anxiety

Delirium/Agitation

- Patients with advanced cancer and other advanced diseases experience delirium and agitation
- Most patients (88%) at end of life experience delirium and cognitive impairment
- Delirium is highly anxiety-provoking: mental faculties, ability to rationalize and understand the world are compromised
- Array of medication withdrawal can precipitate delirium and anxiety
- Important to address delirium first – investigating cause and treating etiology
- Antipsychotic medications can be helpful: restore the sleep-wake cycle, ameliorate delirium, and/or behavioral outbursts as well as relieve anxiety

Clinical Assessment

- Detailed history and physical exam – help discern psychological versus physical contributing factors, including medications and/or lifestyle contributions
- Laboratory testing, including measurement of electrolytes, blood cell counts, relevant hormones, and toxicologies
- Collateral history obtained from family, friends and other members of the interdisciplinary team

Clinical Assessment

- Important to evaluate for worrisome “red flags” of anxiety and their consequences:
  - social withdrawal
  - loss of executive functioning
  - preoccupation with mortality and other morbid outcomes

Screening Tools

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

Extensive etiology

- Anxiety symptoms in cancer and other medical settings can have an extensive etiology
  - Psychological stressors and baseline personality characteristics
  - Underlying physiology
  - Altered hormone functioning (i.e. hyperthyroidism)
  - Physical symptoms (tachycardia, dyspnea)
  - Direct cancer involvement (primary brain tumor or metastases)
  - Medication side effects (beta-agonist inhalers, steroids, excessive thyroid replacement, encephalopathy from cyclosporine or other chemotherapy, renal or other organ dysfunction)
  - Stopping medication or chemical substances (alcohol, benzodiazepines, tobacco, anxiolytics, or anxiolytic medications like baclofen)

- Rule out anxiety due to another medical condition and substance/medication-induced anxiety disorder

Adjustment Disorders and Demoralization

Adjustment Disorder

- “situational crisis”

- DSM-5-TR criteria
  - Distress should be intense, preoccupying, and out of proportion to what would be expected, with excessive worry or rumination about will happen
  - Resultant poor coping causes functional impairment in living, work, social relationships and other key aspects of functioning
  - Onset follows a stressful event, diagnosis, or disease progression, typically within 3 months and disorder improved by 6 months after stressor resolves.

Demoralization

- State of poor coping characterized by symptoms of low morale, hopelessness, loss of meaning and purpose in life causing patient distress and/or functional impairment
- Strongly associated with adjustment disorders, but also incorporates key phenomena of existential distress
- Clinical syndrome that can be differentiated from depression
- Has strong association with suicidal thinking (independent of anhedonia)

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Prevalence

Adjustment Disorders

- 15% of patients who are medically ill suffer with adjustment disorder
- In cancer patients, adjustment disorders were found in 15-20% depending on phase of illness

Demoralization

- 15% of palliative care patients (Robinson et al 2015)
- 25% of medically ill patients (Tecuta et al 2015)
- And up to 50% of psychiatrically ill patients (Tang et al 2015)
- Aforementioned systematic reviews have clarified its differentiation from depression – highlighting its importance as its own entity.

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Risk Factors for Demoralization

- Physical and mental illness with high symptom burden that challenge coping
- Burdensome treatments
- Prolonged or repeated hospitalizations
- Poorer education and health literacy
- Lower income and socioeconomic deprivation
- Being female
- Single status (unmarried, separated, divorced, widowed)
- Lacking social supports

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Protective Factors

- Open communication, openness to new experience, adaptability, flexibility
- Strong religious belief and availability of a faith community
- Resilient character strengths with strong education, maturity and wisdom
- Patient experience of life with meaning and fulfillment

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Clinical Management

Treatment Approach to Depression

Psychotherapy

- Indicated for all levels of depression severity, but preferred in milder cases → takes longer time before it becomes effective
- Has relapse-prevention effect: sustained effect even after the treatment has stopped

Pharmacotherapy

- Takes shorter time to be effective than psychotherapy
- Effects size is larger in more severe than in mild cases
- Special consideration should be given regarding patients' physical condition and prognosis
- May be limited by patient's physical condition/medical co-morbidities

Pharmacotherapy for Depression

- Antidepressants are first-choice drugs for adult depression -- SSRIs are most frequently prescribed
- In palliative care and end of life, psychotropics other than antidepressants, such as benzodiazepines, antipsychotics or psychostimulants– can be used as adjunctive agents or sometimes as substitutes for antidepressants
- Choice of an agent: No single antidepressant is universally accepted as more effective than another, despite some variation in their effectiveness and acceptability
- Initial choice of an agent should be based on medication side effect profile, interactions with other medications, dosing schedule, and history of effective response

Treatment Approach to Anxiety

- Address underlying cause of anxiety (when possible)

- Tailored to the individual patient
  - Considering underlying illness and prognosis
  - History of anxiety and past treatments
  - Psychosocial factors
  - Other medical comorbidities

- Multilayered: combining supportive care, psychotherapy, complementary and alternative therapies, and the judicious use of psychopharmacotherapy

Pharmacotherapy for Anxiety

- Medications have an important role in managing symptoms of anxiety and anxiety disorders
- Generally reserved for patients with greater severity of anxiety or functional impairment, require quicker response, and are able to tolerate the side effects
- Psychopharmacologic mainstay of treatment for acute and chronic anxiety: benzodiazepines and antidepressants
- SSRIs are first-line
- Multiple medication classes have anxiolytic properties
  - Anticonvulsants: gabapentin, pregabalin
  - Antipsychotics: quetiapine, olanzapine

General Pharmacotherapy Principles

- Consider side effect profile of medication when making selection
- Monitor treatment adherence/response regularly
- Start low and go slow with regards to initiating dose/dose titration
- Meds should be continued for at least 6 months until symptom remission to prevent relapse of depression
- Treatment failure should not be declared before a minimum of 4-6 weeks of treatment once the maximum dose is administered
- Most common reason for poor response is inadequate titration of the dosage upward
- Rotating medications (i.e. SSRI to SNRI) or considering augmentation should be considered if no response by 8-12 weeks at maximal dose

Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs

- First-line treatment in depressive and anxiety disorders due to their safety, tolerability, and efficacy (ie versus TCAs and MAOIs)

- FDA indications for MDD, GAD, social anxiety disorder, OCD, PMDD, and bulimia nervosa

- Consider possible side effects
  - GI side effects – typically transient and can be reduced with taking with meal
  - Sexual dysfunction
  - Fatigue, insomnia, headache
  - Bleeding risk – risk factors: history of abnormal bleeding, people with peptic ulcers/cirrhosis, significant thrombocytopenia, NSAID use
  - SIADH – risk factors: older age, diuretic use

- Caution: rare risk of Serotonin Syndrome – typically seen when used in combination of multiple serotonergic agents

SSRIs

- “Activation Syndrome”: irritability, agitation, or dysphoria at beginning of treatment → alleviate by decreasing the dose, switching medicine, or concurrently taking benzodiazepines

- “Withdrawal Syndrome”: abruptly stopping can present with severe dizziness, fatigue, and dysphoria arising from readaptation of receptors - thus they should be tapered rather than stopped abruptly

SSRIs

SSRIs	Initial dose (mg/day)	Dosing range (mg/day)	Comments
Escitalopram (Lexapro)	5-10mg	10-20mg	
Citalopram (Celexa)	10-20mg	20-40mg (max 20mg for >60yo)	Consider Qtc prolongation
Sertraline (Zoloft)	25-50mg	50-200mg	More significant GI side effects with initiation
Fluoxetine (Prozac)	10-20mg	20-80mg	More activating profile. Multiple DDIs
Paroxetine (Paxil)	10-20mg	20-60mg	More sedating profile. Multiple DDIs

Selective Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)

SNRIs

Blocks reuptake of serotonin and norepinephrine at serotonin and norepinephrine transporter

Prescribed for depressive disorders, anxiety disorders and pain

Duloxetine is FDA approved for diabetic peripheral neuropathic pain, fibromyalgia, and chronic musculoskeletal pain

Venlafaxine can have greater norepinephrine blockade at higher doses and can also help with pain

SNRIs

SNRIs	Initial dose (mg/day)	Dosing range (mg/day)	Comments/Considerations
Venlafaxine (Effexor)	37.5mg	75- 225mg	Caution with uncontrolled hypertension Associated with more significant withdrawal symptoms
Duloxetine (Cymbalta)	30mg	30-60mg	Caution with hepatic impairment
Desvenlafaxine (Pristiq)	25-50mg	50-100mg	
Milnacipran (Savella)	12.5mg	30-200mg	Approved for fibromyalgia, off-label for depression
Levomilnacipran (Fetzima)	20mg	40-120mg	

Mirtazapine

- Tetracyclic antidepressant that antagonizes alpha 2 adrenergic receptors
- Targets depression and anxiety
- Favorable profile: sedating properties to help with insomnia, associated with increased appetite more so than other antidepressants, and can help diminish nausea
- Actions on insomnia and anxiety can start shortly after initiation of dosing
- Onset of benefit for depression is usually not immediate and can take 2-4 weeks for full effect
- Dose range: 15-45mg
- Side effects: dry mouth, constipation, increased appetite, weight gain, sedating, abnormal dreams, dizziness

Anxiety Specific Therapies

Benzodiazepines

- Demonstrated efficacy for anxiety and can reduce anxiety symptoms quickly
- Most suited for as-needed use
- When choosing a benzodiazepine: consider half-life and excretion patterns to prevent rebound anxiety and in patients with any evidence or potential for organ failure
- Can cause respiratory suppression – effects are augmented by drug-drug interactions and presence of other psychoactive agents such as narcotics and alcohol
- Consider addiction potential

Benzodiazepines

	Route	Dosage	Half-life (hours)	Comments
Lorazepam (Ativan)	Oral, IM, IV	2-6mg/day in divided doses	10-20	• Not metabolized in liver • Fewer drug-drug interactions • Approved for chemotherapy-induced nausea and vomiting
Clonazepam (Klonopin)	Oral	0.5-2mg in divided doses or qhs	30-40	• Seizure indications • Longer half-life
Alprazolam (Xanax)	Oral	1-4mg/day	12-15	• Shorter half-life • Abuse risk
Diazepam (Valium)	Oral, Rectal, IV	4-40mg in divided doses (2-4x/day)	20-50	• Anticonvulsant • Muscle relaxant

Buspirone

- Serotonin partial agonist at type 1A receptors
- Targets anxiety
- Takes 2-4 weeks to achieve efficacy
- Dose range: 20-30mg daily
- Advantages: safety profile, lack of dependence/withdrawal, lack of sexual dysfunction or weight gain
- Disadvantages: can take up to 4 weeks for benefit

Additional Considerations for Anxiety

- Gabapentin
- Pregabalin
- Trazodone
- Low-dose antipsychotic – quetiapine, olanzapine

Depression Specific Therapies

Bupropion

- Blocks norepinephrine and dopamine reuptake
- Prescribed for: major depressive disorder, seasonal affective disorder, nicotine addiction
- Targets low mood, fatigue, low motivation, and inattention
- Can be particularly beneficial for patients who are concerned about sexual dysfunction, weight gain, or those who have prominent symptoms of hypersomnia/fatigue or cognitive slowing
- Side effects: insomnia, decreased appetite, dry mouth, headache, tremor, agitation
- Avoid in patients with history of seizures or eating disorder (anorexia/bulimia)*

Psychostimulants

- Faster onset of activity compared to other antidepressants
- May be the preferred initial option to treat depression in patients whose life expectancy is less than two to four months or those in need of urgent treatment
- Can counter fatigue/sedation from opioids
- Evidence to support for use for cancer-related fatigue and cognitive impairment (“chemo brain”)
- Methylphenidate, modafinil

Antipsychotics

- Can be useful in augmentation therapy for depression or as an alterative for anxiolytic
- Patients with anxiety accompanied by agitation, delirium, and psychosis may particularly benefit from antipsychotic
- Low-dose quetiapine (Seroquel) and olanzapine (Zyprexa) can be used as PRN agent for anxiety or for insomnia
- Aripiprazole (Abilify) for augmentation for depression
- Adverse effects to consider: EPS, metabolic syndrome

Psychological Therapies

Psychological Therapies

- Robust evidence supporting psychological treatments for patients with cancer
- Several psychological frameworks and related therapies have been applied in palliative care and end of life settings in treatment of anxiety
  - Psychoeducational
  - Supportive
  - Cognitive Behavioral Therapy
  - Mind-body, existential, family-centered, or complementary approaches
- Psychological therapies for depression/anxiety tend to be focused on specific symptom control and gaining new tools to alleviate depression/anxiety and should be focused on specific needs of patient
- Consider patient's motivation and willingness to engage

Psychological Therapies

- Training of palliative care nurses and other frontline allied health care professionals shows clinical benefit:
  - Lifestyle interventions (reducing caffeine intake, enhancing sleep hygiene protocols, obtaining regular exercise when bedbound)
  - Complementary therapies: relaxation training, mindfulness, meditation, and aromatherapy
  - Other complementary therapies available in palliative care include acupuncture, music or art therapy and massage

Relaxation Techniques

- Meta-analysis demonstrate effectiveness for various physical and psychological conditions including depression, anxiety, breathlessness
- Three typical techniques
  - Progressive Muscle Relaxation
  - Breathing Techniques
  - Imagery
- Evidence indicates this is most helpful for management of anxiety rather than depression
- Often a component of a more structured program of psychotherapy (such as cognitive-behavioral therapy) or problem-solving therapy (PST)

Cognitive-Behavioral Therapy

- Structured psychotherapy based on hypothesis that one's emotional and somatic responses (mood and physical symptoms) are determined by how one perceives a situation rather than the situation itself
- CBT involves identifying and correcting inaccurate or dysfunctional thoughts and behaviors associated with negative feelings (i.e. depression and/or anxiety) and distressing physical symptoms (i.e. pain, fatigue), practicing relaxation techniques, and enhancing problem-solving techniques
- Behavioral Activation – rooted in CBT – shown to decrease depression in patients with cancer

Problem-Solving Therapy

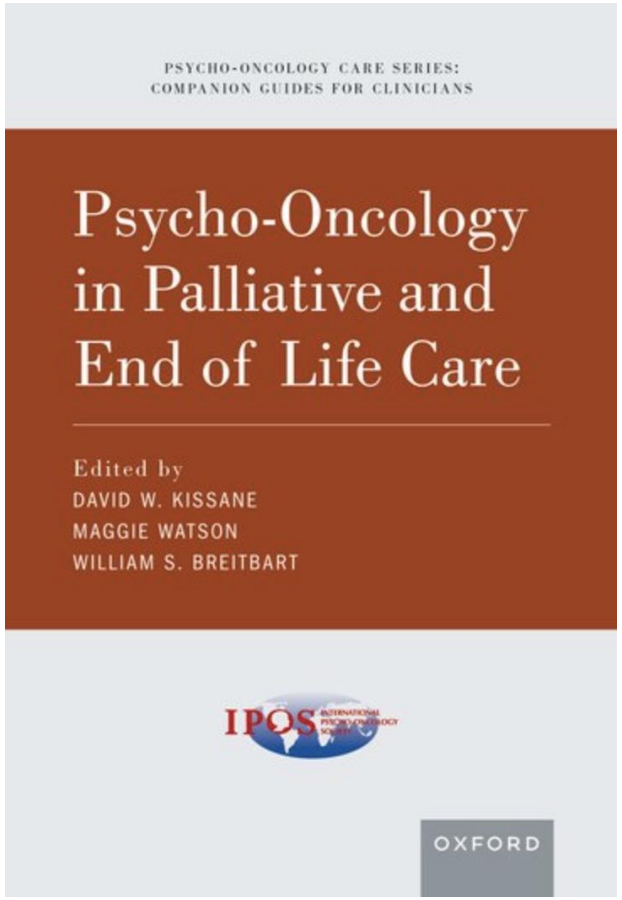
- Based on hypothesis that psychological distress is linked with unsolved problems: therefore, acquisition of efficient problem-solving (or coping) leads to decreased distress.

- Efficacious problem-solving
  - Defining the problem
  - Brainstorming possible options
  - Evaluating potential solutions by weighing the advantages and disadvantages of each solution
  - Implementing specific solutions
  - Evaluating degree of success
  - Fine-tuning them

Other Therapy Modalities

- Supportive Psychotherapy: Encourages patients to verbalize their emotions and supports them in pursuit of their goals
- Meaning-Centered Psychotherapy: aims to help patients with advanced cancer sustain or enhance a sense of meaning in their lives.
- Dignity Therapy: brief individual therapy designed to address existential distress in patients end of life.
  - Dignity: a fundamental of one's well-being → include themes of generativity and continuity of self, maintenance of pride and hope, role preservation, alleviation of concerns about being a burden to others, and aftermath of their death
- Managing Cancer and Living Meaningfully (CALM) Therapy
- Interpersonal Therapy
- Family and Couple Therapy

Recommended Texts



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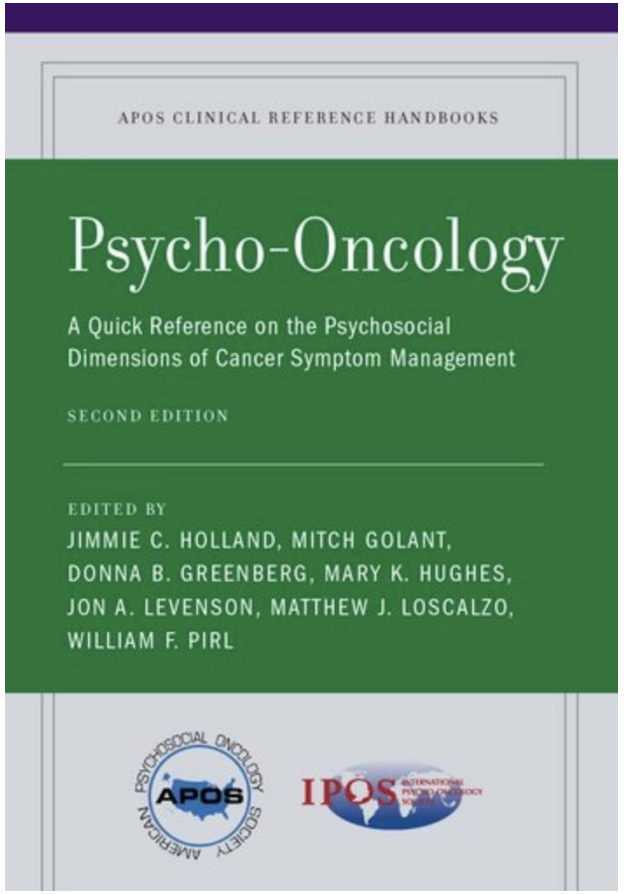

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Thank You

jmolinaro@mcw.edu

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