


Strategies for Addressing Psychosocial Needs in the Rehabilitation Setting

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Objectives


- Understand the history of cancer-related psychosocial care
- Identify psychosocial issues pediatric and adult cancer patients may experience during treatment
- Describe the importance of multidisciplinary communication
- Identify appropriate evaluation tools used to assess psychosocial functioning during cancer treatment
- Identify effective coping strategies to maximize psychosocial well-being



History of Cancer Related Psychosocial Care



- During the last 40 years, a subspecialty devoted to cancer related psychosocial care has been established
- Late development is result of 2 things:
 - Only then (1970's) had the stigma attached to cancer diminished to the extent that most patients were told their diagnosis
 - Negative stigma attached to mental illness and psychological problems ¹



Recent Developments¹

- Formulation of standards of cancer care by Institute of Medicine (IOM) and other professional organizations and accrediting bodies to include psychosocial aspect of care.
- Development of clinical practice guidelines by the National Comprehensive Cancer Network (NCCN) and other organizations to include specific recommendations for the psychosocial care of a patient.
- Formulation and implementation of measurable indicators of the quality of psychosocial care in oncology settings including those used as part of the American Society of Clinical Oncology's Quality Oncology Practice Initiative.




Issues Addressed in Standards¹

- Distress
 - Emotional distress
 - Sexual dysfunction
 - Employment and insurance concerns
- Depression
- Delirium
- Anxiety




National Comprehensive Cancer Network (NCCN)²

- Developed and revised guidelines for distress management in cancer patients
- Tool for measuring distress:
 - Distress Thermometer (DT)




NCCN Distress Thermometer³

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American College of Surgeons Commission on Cancer (CoC)²

- In 2011, a new accreditation standard for all cancer centers was created.
- Standard 3.2 requires screening for psychosocial concerns at least once during cancer care and documented guidelines for treatment or referral




Periods of Increased Vulnerability²

- Treatment failure
- Recurrence
- Progression of disease
- Transition to survivorship




Incidence⁴

- Vodermaier *et al.* collected data on 4,156 mixed adult patient cohort
- Psychosocial Screen for Cancer (PSSCAN)
 - Breast
 - Gastrointestinal
 - Lung
 - Prostate




Vodermaier et al. Results⁴

<p>Anxiety</p> <ul style="list-style-type: none"> • Women 22.4% • Men 11.6% • Lung: most anxious • Breast: disease stage not significant • Prostate: least anxious 	<p>Depression</p> <ul style="list-style-type: none"> • Woman 15.9% • Men 7.7% • Breast: highest rates of depression; disease stage unrelated • Prostate: lowest rate of depressive symptoms
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Patel et al.⁵

- Studied 91 pediatric patients between ages 2-34 (majority between 5-18 years)
 - Distress Rating Scale (DRS)
 - Children’s Depression Inventory (CDI)
 - Pediatric Quality of Life Generic Core Scales Cancer Modules (PedsQL)
 - Brief Symptom Inventory = 18 items (BSI – 18)
 - Intensity of Treatment Rating Scale 2nd Edition (ITR-2)
 - Cumulative tri-level Distress Classification




Patel et al Results⁵




Patel *et al.* Results⁵

- Significant predictors of self-reported distress:
 - Older age of patient
 - Less time since diagnosis
 - Scheduled for bone marrow transplant
 - Having unscheduled hospitalizations



Age Specific Psychosocial Development and Cancer Related Issues




Pediatric Psychosocial Development

- Birth – 18 months⁶
 - Sensorimotor
 - Attachment
- Preschool age (2-6 years)^{6,7}
 - Egocentric
 - Associated logic
 - Family is primary domain of social support
- School age (7-12 years)^{6,7}
 - "Mastery of skills"
 - Logical thinking
 - Proud to participate in care




Adolescence Psychosocial Development^{6,7,10}

- Ages 13-18 years
- Think abstractly and can understand complexity of illness
- Develop independence from family
- Establish interpersonal relationships
- Development of individual sense of identity
- Pursue education and employment goals




Adolescent Specific Burdens^{10,11}

- Patients are thrown back into dependence on family for practical (self care, hospital appointments) and emotional support (fear of illness and death)
- Fatigue, compromised immune function and altered body image can lower self esteem and limit participation and enjoyment during social activities
- Educational plans may be disrupted and career plans may change




Young Adult Psychosocial Development¹¹

- Approx ~20-39 years old
- Develop long term relationships
- Seek out creative and meaningful work
- Manage issues surrounding family
- Establish significant relationships at work, in community and with family




Young Adult Specific Burdens^{11,12}

- Infertility
- Loss of career
- Limited ability to achieve intimacy and opportunities to socialize
- Concerns for family
- Changes in sexual behaviors and desires




Adult Psychosocial Development¹¹

- Approx ~35 years
- Focus on creative and meaningful work
- Work to establish and guide next generation
- Deal with issues surrounding family



Adult Specific Burdens

- Sense of loss¹³
 - Physical capacity¹⁴
 - Loss of control over well being of children¹¹
 - Self esteem, self image
 - Job roles, life roles
 - Friends and support
 - Marriage¹⁵
- Depression, anxiety, distress²
- Information overload
- Hopelessness¹³




Older Adult Psychosocial Development¹⁶

- Ages 65+ years
- Fewer competing demands
- Increased life experiences prepare people to confront cancer
- Potential for diminished social and economic resources
- Older than 85 years of age often required assistance with at least 1 ADL
- The most physically and socially vulnerable



Older Adult Specific Burdens¹⁶

- Increase in cancer rates
- Need for compression of morbidity
- Co morbidities
- Bereavement related to other losses
- At risk for dementia, delirium and depression



Multidisciplinary Approach




Psychiatry¹⁶

- Consultative basis
- Evaluate and treat depression, anxiety and delirium
- Pharmacologic treatment:
 - Depression: Antidepressants (Serotonin re-uptake inhibitors)
 - Anxiety: Short to intermediate acting benzodiazepines (alprazolam and lorazepam)
 - Delirium: High-potency antipsychotics (haloperidol)



Social Work¹⁶

- Counseling and coping
- Discharge planning, referral to community agencies
- Ongoing case management
- Reduce barriers to treatment
- Help balance competing obligations
- Assist with navigation through healthcare system
- Coordinate support groups in the hospital and community




Psychologist¹⁷

- Psychotherapy
- Cognitive behavioral therapy
- Provide support services to both patients and families



Nursing^{2,7}

- Provide supportive care
- Assess patient psychosocial concerns
- Pursue further assessment for significant concerns or changes in functioning
- Spend most time with patient and detect changes in mood, thinking or feeling in the hospital
- Anti-nausea and pain medication



Integrative Medicine^{18,19}

- Compliments mainstream cancer care to promote relaxation
- Categories of Complementary and Alternative Medicines (CAM) identified by the National Cancer Institute:
 - Alternative medical systems, energy therapies
 - Manipulative and body-based methods
 - Mind-body interventions
 - Pharmacologic and biologic therapies
 - Music and dance therapy




Child Life Specialist^{6,20}

- Specialize in preparing young patients and families for coping and adjusting to treatment
- Target social and emotional needs
- Prepare young children for procedures
- Decrease burden of isolation by encouraging play and participation in leisure activities



Family

- Should be treated as a “family” disease
- Cancer alters the equilibrium of the family unit⁶
- Caregiver stress directly impacts care of patient¹
- May develop caregiver burden and require counseling services due to competing obligations^{7,16}



Spiritual Care²¹

- Chaplaincy service provides religious support regardless of formal affiliation
- Especially important during crisis points in care
 - Surgery
 - Recurrence
 - Terminal illness
 - Issues of mortality



Additional Services

- Nutrition Services²²
- Recreation Services²³
- Music and Dance Therapy²⁴
- Volunteer program²⁵
 - Canine Program
 - Look Good Feel Better
 - Patient to Patient Support Program
 - Writing Program: Visible Ink




Role of Rehabilitation



“Getting Back to Normal”²⁶

- Physical
- Psychological
- Work
- Social
- Sexual




Rehabilitation Team²⁶

- Psychiatrist
- Rehabilitation Nurse
- Physical Therapist
- Occupational Therapist



- “Front line” of psychological care for patients to receive good psychosocial care
 - Important to identify relationship between functional loss and symptoms of distress
 - Pain management²⁶



Pediatric Assessment Tools

Pediatric Quality of Life Inventory²⁷

- Patient Report
- Parent Report
 - Physical Health, Psychosocial Health, Total Health Related Quality of Life Score


Short Child Occupational Performance Evaluation (SCOPE)²⁸

- Occupation-focused assessment
- Determines how a child's volition, habituation, skills, and the environment facilitate or restrict participation




Adult Assessment Tools

- Geriatric Depression Scale
- Functional Assessment of Cancer Therapy – General Quality of Life Scale
- Canadian Occupational Performance Measure (COPM)
 - Performance
 - Satisfaction




Cognitive Assessment

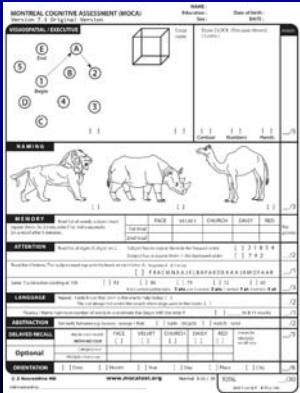
- Mini-Mental State Examination
- Montreal Cognitive Assessment (MOCA)
- CAM ICU (delirium assessment)
- Short Orientation Memory Concentration Test (SOMCT)



Geriatric Depression Scale²⁹


1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?






Montreal Cognitive Assessment (MOCA)³⁰

<http://www.mocatest.org/>




Acute Plan of Care Goals

- Pt will participate in OT session including OOB activity with no signs of distress to improve participation in play.
- Pt will initiate communication with friends via Skype 3x/week to maximize participation in social interaction and improve mood.
- Pt will participate in work related email exchange 5x/week to maximize participation in professional role.
- Pt will report satisfaction self rating 8/10 on COPM in area of performing role as mother/father to improve mood and motivation.



Acute Plan of Care Intervention

- Incorporate relaxation techniques and coping strategies
 - Deep breathing, visualization
- Modify environment to enhance mood and promote participation in meaningful tasks
 - ADL, play
- Promote activities specific to clients roles and occupations
- Family training
 - Home program
- Request appropriate referrals for additional support services if necessary



Outpatient Plan of Care Goals

- Patient will participate in 2 activities requiring sharing with OT during 2/2 sessions without distress to maximize age appropriate social interaction and play.
- Pt will initiate social activity (when cleared by medical team) with peers without fatigue or distress.
- Patient will be independent with incorporating 2 self calming activities (deep breathing) into daily routine to ease performance of ADL and work related tasks.
- Patient will be educated on energy conservation techniques to improve participation in all self identified life roles including mother, writer, wife, etc.



Outpatient Plan of Care Intervention

- Decrease burdens of cancer treatment including fatigue, pain, and decreased cognition through education/HEP
- Family training
 - Education on importance of independence, self directed activities, and need to encourage participation in activities
- DME recommendations to improve independence, modify tasks to set clients up for successful transition back to life roles
- Provide structured coping strategies to incorporate during daily routine to enhance participation in life roles and desired activities



Summary

- Professional organizations and accrediting bodies have established standards of care to address psychosocial needs of cancer patients.
- Patient experience age specific related burdens across the continuum of care.
- Rehabilitation can provide unique interventions to address psychosocial needs of patients.




Questions?



References

- 1) Jacobsen PB, Holland JC, Steensma DP. Caring for the Whole Patient: The Science of Psychosocial Care. *Journal of Clinical Oncology*. 2012;30:1151-1153.
- 2) Sheldon LK, Harris D, Arcieri C. Psychosocial Concerns in Cancer Care: The Role of the Oncology Nurse. *Clinical Journal of Oncology Nursing*. 2012;16:316-319.
- 3) National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Distress Management. http://www.nccn.org/professionals/physician_gls/pdf/distress.pdf; Accessed on April 28, 2013.
- 4) Vodermaier A, Linden W, McKenzie R, et al. Disease stage predicts post-diagnosis anxiety and depression only in some types of cancer. *British Journal of Cancer*. 2011; 105:1814-1817.
- 5) Patel SK, Mullins W, Turk A, et al. Distress screening, rater agreement, and services in pediatric oncology. *Psycho-oncology*. 2011;20:1324-1333.




References

- 6) Langton H. *The Child with Cancer*. London: Harcourt Publishers Limited; 2000.
- 7) Kurtz BP, Abrams AN. Psychiatric Aspects of Pediatric Cancer. *Pediatric Clinics of North America*. 2011;58:1003-1023.
- 8) Children's Hospice International. <http://www.chionline.org/resources/difference.php>. Accessed on April 29, 2013.
- 9) Uniform Data System for Medical Rehabilitation. *The WeeFIM II Clinical Guide, Version 6.0*. 2006. Buffalo: UDMSR.
- 10) D'Agostino NM, Penney A, Zebrack B. Providing Developmentally Appropriate Psychosocial Care to Adolescent and Young Adult Cancer Survivors. *Cancer*. 2011; 117:2329-34.
- 11) Eiser C, Penn A, Katz E, Barr R. Psychosocial Issues and Quality of Life. *Seminars in Oncology*. 2009;36:275-280.
- 12) Zebrack BJ. Psychological, Social, and Behavioral Issues for Young Adults with Cancer. *Cancer*. 2011;117:2289-94.



References

- 13) Block KI, Block P, Gyllenhaal C. The Role of Optimal Healing Environments in Patients Undergoing Cancer Treatment: Clinical Research Protocol Guidelines. *Journal of Alternative and Complementary Medicine*. 2004;10: S-157-S-170.
- 14) Brown JC, Huedo-Medina TB, Pescatello LS, et al. The Efficacy of Exercise in Reducing Depressive Symptoms among Cancer Survivors: A Meta-Analysis. *PLoS One*. 2012; 7(1): e30955.
- 15) Syse A, Aas GB. Marriage after cancer in older adulthood. *J Cancer Surviv*. 2009;3:66-71.
- 16) Wells NL, Balducci L. Geriatric Oncology: Medical and Social Perspectives. *Cancer Practice*. 1997;5:87-91.
- 17) Weis J. Support groups for cancer patients. *Support Care Cancer*. 2003;11:763-768.
- 18) Memorial Sloan-Kettering Cancer Center. Integrative Medicine. <http://www.mskcc.org/cancer-care/integrative-medicine>. Accessed April 28, 2013.



References

19) Robotin M, Holliday C, Bensoussan A. Defining research priorities in complementary medicine in oncology. *Complementary Therapies in Medicine*. 2012;20:345-352.


20) Memorial Sloan-Kettering Cancer Center. Child Life Services. <http://www.mskcc.org/pediatrics/child-life-services>. Accessed on April 28, 2013.

21) Memorial Sloan-Kettering Cancer Center. Support Services. <http://www.mskcc.org/search/site/chaplaincy>. Accessed on April 28, 2013.

22) Acreman S. Nutrition on Palliative Care. *British Journal of Community Nursing*. 2009; 14: 427-428.

23) Memorial Sloan-Kettering Cancer Center. Counseling and Support. <http://www.mskcc.org/cancer-care/counseling-support/patient-recreation-library>. Accessed April 28, 2013.

24) Memorial Sloan-Kettering Cancer Center. Pediatric Recreation Services. <http://www.mskcc.org/pediatrics/recreation>. Accessed on April 29, 2013.



References

25) Memorial Sloan-Kettering Cancer Center. Patient to Patient Support Program. <http://www.mskcc.org/cancer-care/counseling-support/patient-patient-support>. Accessed on April 29, 2013.

26) Stubblefield MD, O'Dell MW. *Cancer Rehabilitation Principles and Practice*. New York Demos Medical; 2009.

27) Varni JW, Seid M, Rode CA. The PedsQL™: Measurement Model for the Pediatric Quality of Life Inventory. *Medical Care* Issue.1999;37(2):126-139.

28) Bowyer P, Kramer J, Ploszaj A, et al. A user's manual for the short child occupational profile (SCOPE) version 2.2. 2008.

29) Geriatric Depression Scale. http://www.stanford.edu/~yesavage/GDS_english_short.html. Accessed April 29, 2013.

30) Montreal Cognitive Assessment. <http://www.mocatest.org/>. Accessed April 29, 2013.

