



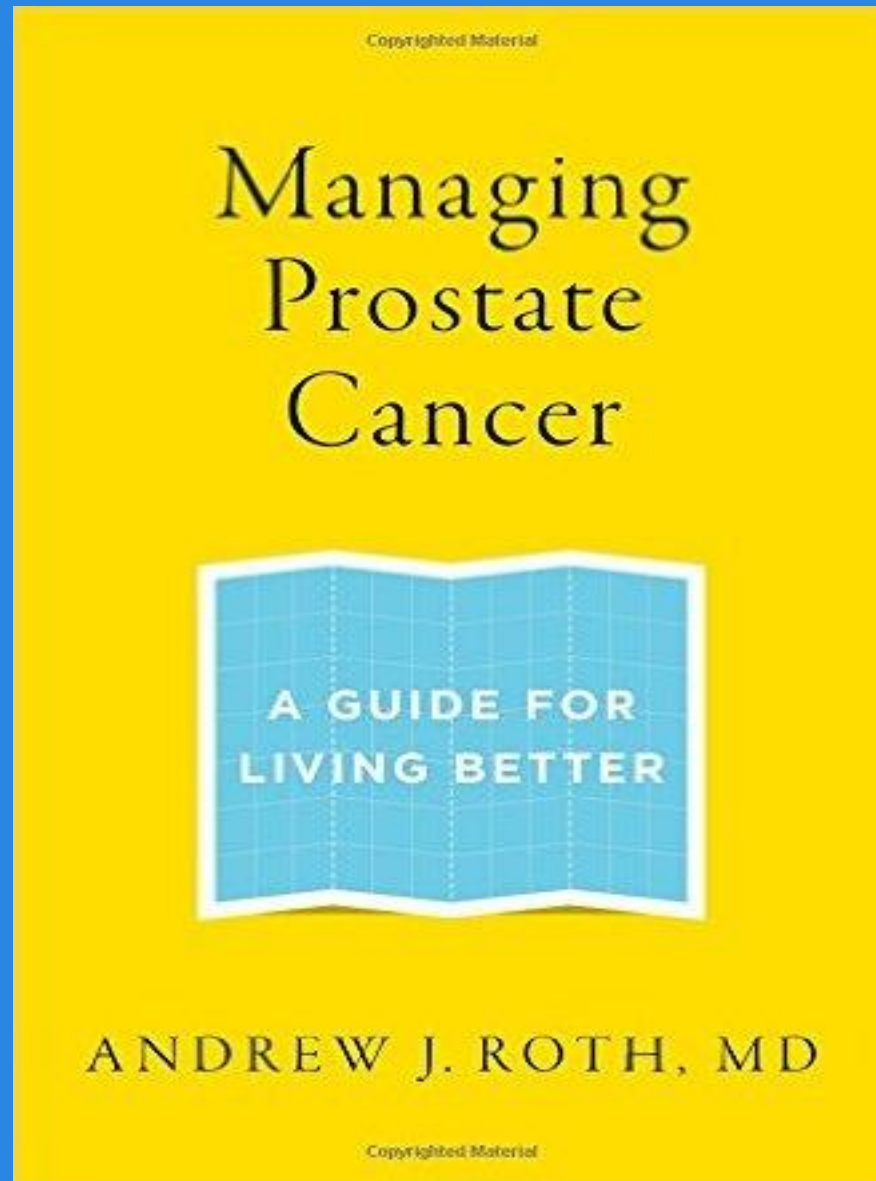
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# Psychotherapy for Older Cancer Patients: The CARE Project

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Palliative and Supportive Care in Cancer  
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# Disclosure



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# Geriatric Group Acknowledgment

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APOS CLINICAL REFERENCE HANDBOOKS

# Geriatric Psycho-Oncology

A Quick Reference on the Psychosocial  
Dimensions of Cancer Symptom Management

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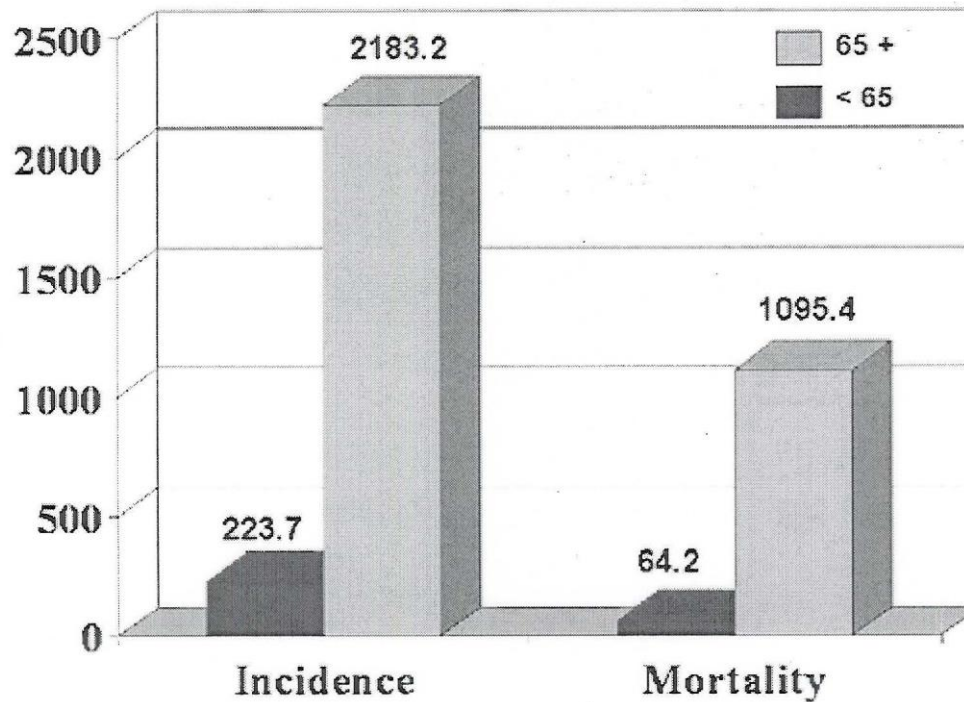
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# Take Home Points

- The elderly appear to cope better than younger people with cancer in some studies
- However, it is more difficult to assess psychiatric distress in the elderly, so it may go unrecognized
- Many elderly patients, are less willing to accept psychiatric and psychological treatment in the cancer and palliative care setting, when needed
- Psychotherapy and psychiatric medications can be very helpful, but may need to be modified to accommodate the elderly and end of life.
- The CARE Model addresses these issues



# Cancer is a Geriatric Issue



**FIGURE 2-2** Age-adjusted incidence and death rates, all cancers.

SOURCE: Adapted by Yancik from NCI SEER Program Data 2000–2003.

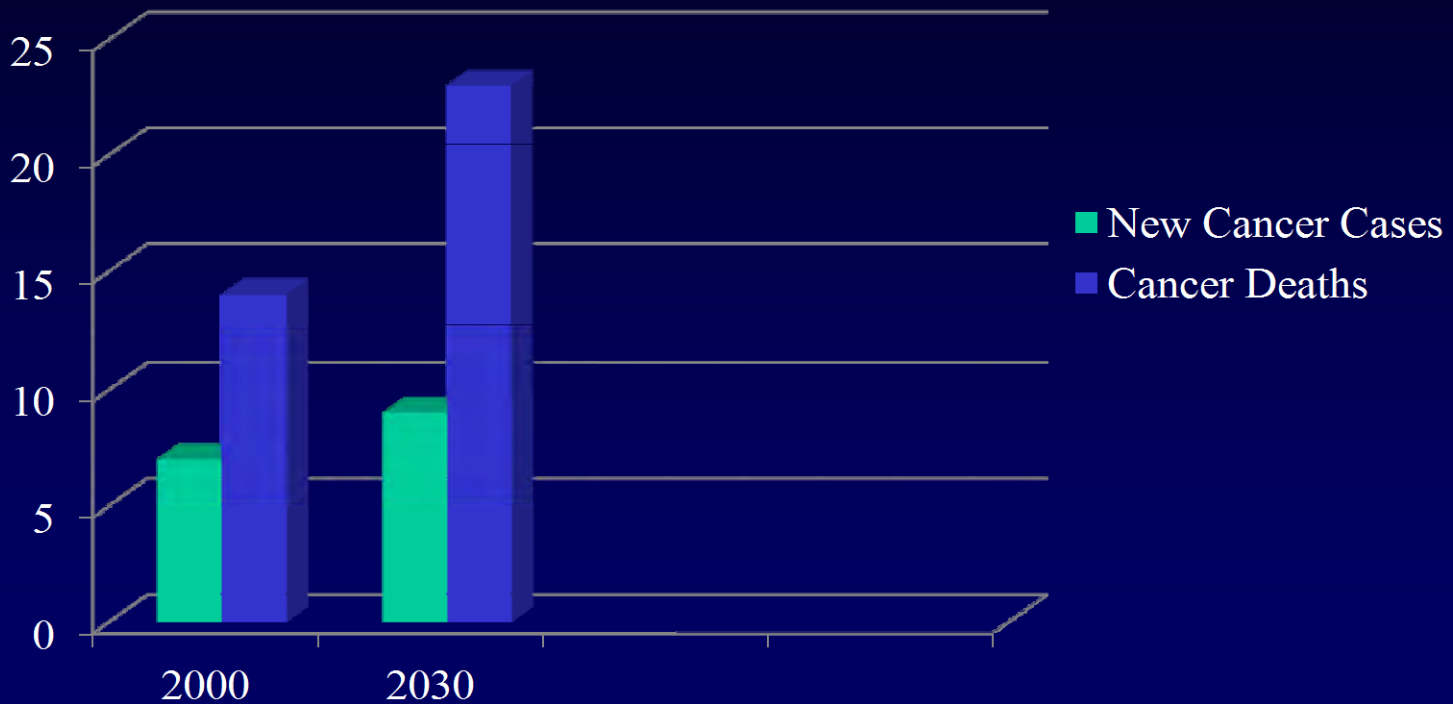


# Prevalence

- Half of cancer cases occur in people above 66 years of age.
- One-quarter of new cancer cases are diagnosed in people 65 to 74
- We soon will have more older people than children, and more people at extreme old age than ever before.
- The proportion of older people and the length of life will continue to increase throughout the world.



# Cancer in the Oldest Old ( $\geq 85$ ) in the USA





# Estimated Number of US Cancer Survivors by Sex and Age at Prevalence as of January 1, 2016: (Male and Female)

	Number	Percent	Cumulative Percent
All ages			
0–14	65,190	<1%	<1%
15–19	47,180	<1%	1%
20–29	187,490	1%	2%
30–39	408,790	3%	5%
40–49	958,600	6%	11%
50–59	2,389,670	15%	26%
60–69	3,500,000	22%	48%
70–79	3,500,000	22%	70%
80–89	2,500,000	16%	86%
90+	1,000,000	6%	92%

Note: Percentages do not sum to 100% due to rounding.

**Source:** Surveillance Research Program, Division of Cancer Control and Population Sciences,  
National Cancer Institute.



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# Challenges in Psycho-Oncology for Elderly Cancer Patients

- Elderly cancer patients are at increased risk for undetected and untreated depression, anxiety, pain, delirium, fatigue, and suicide at the end of life due to:
  - Comorbid medical conditions
  - Cognitive deficits
  - Poor access to (mental) health care
  - Decreased self-report
  - Differences in assessment and treatment



# Psychosocial Issues of *The Double Whammy*: Cancer + Aging

- Combining losses of aging with:
  - Coping with cancer diagnosis
  - Decisions on treatment—to treat or not to treat
  - Side effects of treatment
  - Ageism
- Elderly do not easily express their loneliness or depression so that these symptoms go unnoticed (~25%)
- *Urgency* to review life and deal with practical matters of what to pass on to whom, with concern about uptake.



# Psychotherapeutic Challenges with Older Patients

- “I’m old. Should I have treatment for the cancer or not?”
- “Which treatment is best for me?”
  - In terms of cure? In terms of quality of life?
- “I don’t have the energy to do what I used to do, so I don’t do anything.”
- “I’ve lived my whole life without seeing a therapist, and it has been a tough life.
  - Why do I need you now?”
- “I don’t want to be a burden on anyone; let me die.”
- “I have a lot of pain.
  - If I can’t do what I used to do, what’s the point of living?”



# Underdiagnosis & Undertreatment of Depression in Older Adults

- Depression/dysthymia underdiagnosed in the elderly
  - “Don’t ask, don’t tell”
    - Feel stigma of “mental” issues
    - Minimize depressive symptoms and blame on illness
  - Common depressive symptoms are:
    - Somatic complaints
    - ↓ sleep
    - ↓ appetite
    - fatigue
  - Physicians often assume these are related to “old age” reflecting the cultural negative attitudes of ageism



# Interventions for Depression

- Older patients respond to both medication and psychotherapy interventions.
- Strong evidence base in primary care that depression can be treated.

*Lapid et al, 2007*

*Rao A, Cohen HJ, 2004*

*Lander M et al 2000*

*Donnelly J et al, 2004*

*Gooen-Piels J et al 2007*



# Psychotherapeutic Treatments that Help Older Depressed People: Cochrane Database

Wilson et al, 2008

- Only a small number of studies and patients
- Findings do not provide strong support for psychotherapeutic treatments in the management of depression in older people
- CBT may be of potential benefit
- *Interventions not geared to elderly specifically.*



# Interventions that Help Older Cancer Patients

Lapid et al, 2007

- Improving the quality of life of geriatric cancer patients with a structured multidisciplinary QOL intervention while getting radiation therapy:
  - A randomized controlled trial.
- A multidisciplinary team offered treatment to older adults with cancer, including physical therapy exercises, cognitive behavioral training, education regarding issues such as symptoms, spiritual guidance and financial resources, and a 200 page manual
- *Intervention not geared to elderly specifically.*





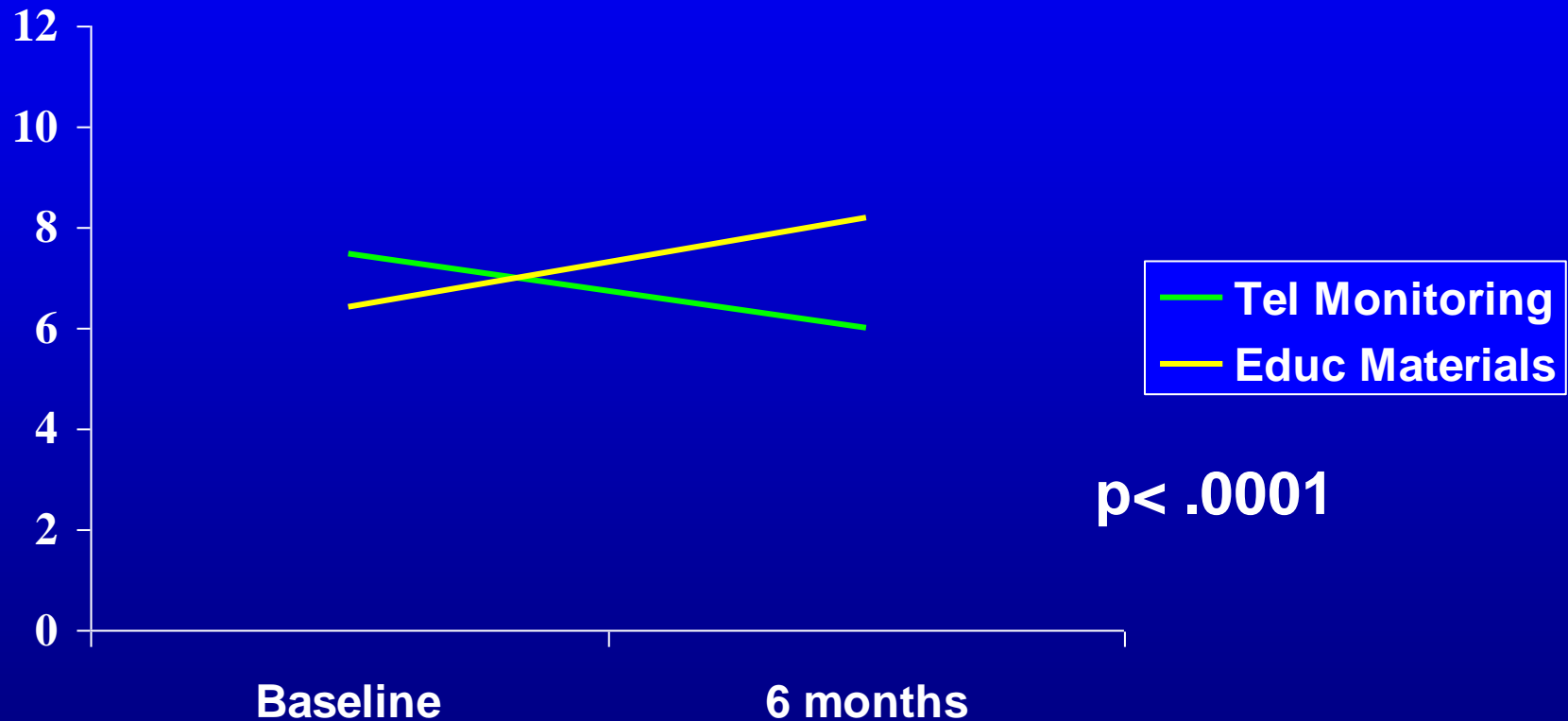
# IMPACT Model in Older Depressed Cancer Patients

Fann 2009

- Primary care clinics
- Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) program vs Usual Care
  - Education; Care Management; Support of antidepressant management; Brief, structured psychosocial interventions including behavioral activation and problem-solving treatment.
- *Intervention not geared to elderly specifically.*



# Hospital Anxiety & Depression Scale: Total Distress Score



# Psychotherapeutic Flexibility

- May need to decrease length or frequency of sessions
- May need to focus on physical and psychological symptom interplay and relief
- May need to be flexible with therapy style:
  - Education
  - Support
  - Cognitive-behaviorally oriented
  - Insight-oriented
  - Existential: Dignity; Meaning-Centered
- May need to have spouse in session



# How Do Older Men Cope with Prostate Cancer?

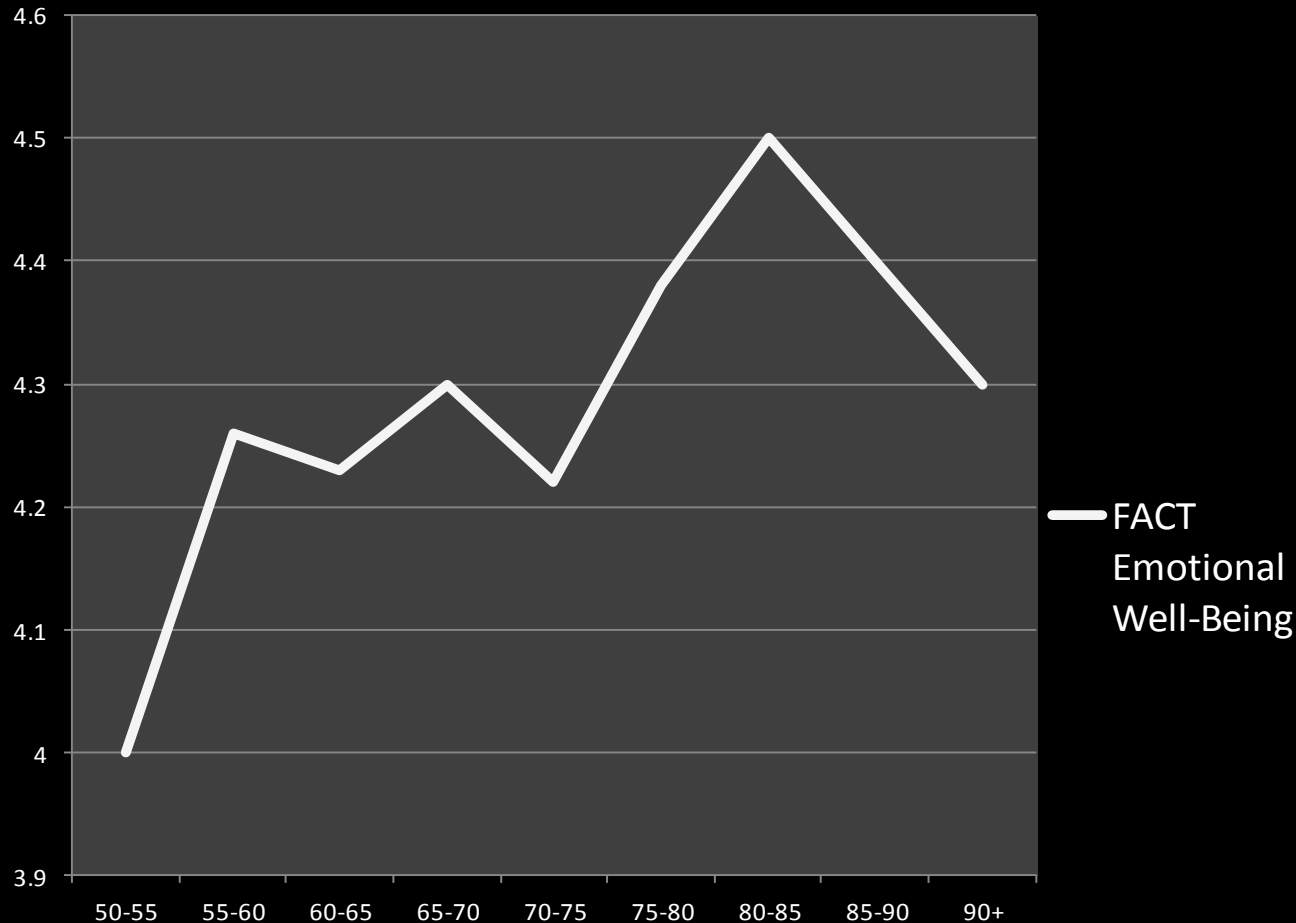
- Cross sectional
- Archival data
- Prostate cancer patients
- Two validation studies of the MAX-PC<sup>1,2</sup>
  - Memorial AnXxiety Scale Prostate Cancer (MAX-PC)
  - Anxiety scale specific to prostate cancer
  - Questionnaires completed in waiting room
  - Inclusion: PC, PSA test

<sup>1</sup>Roth, Cancer, 2003; <sup>2</sup>Roth, Psychosomatics, 2006



# FACT Emotional Well-Being Mean Score by Age Group

(Nelson et al 2008)



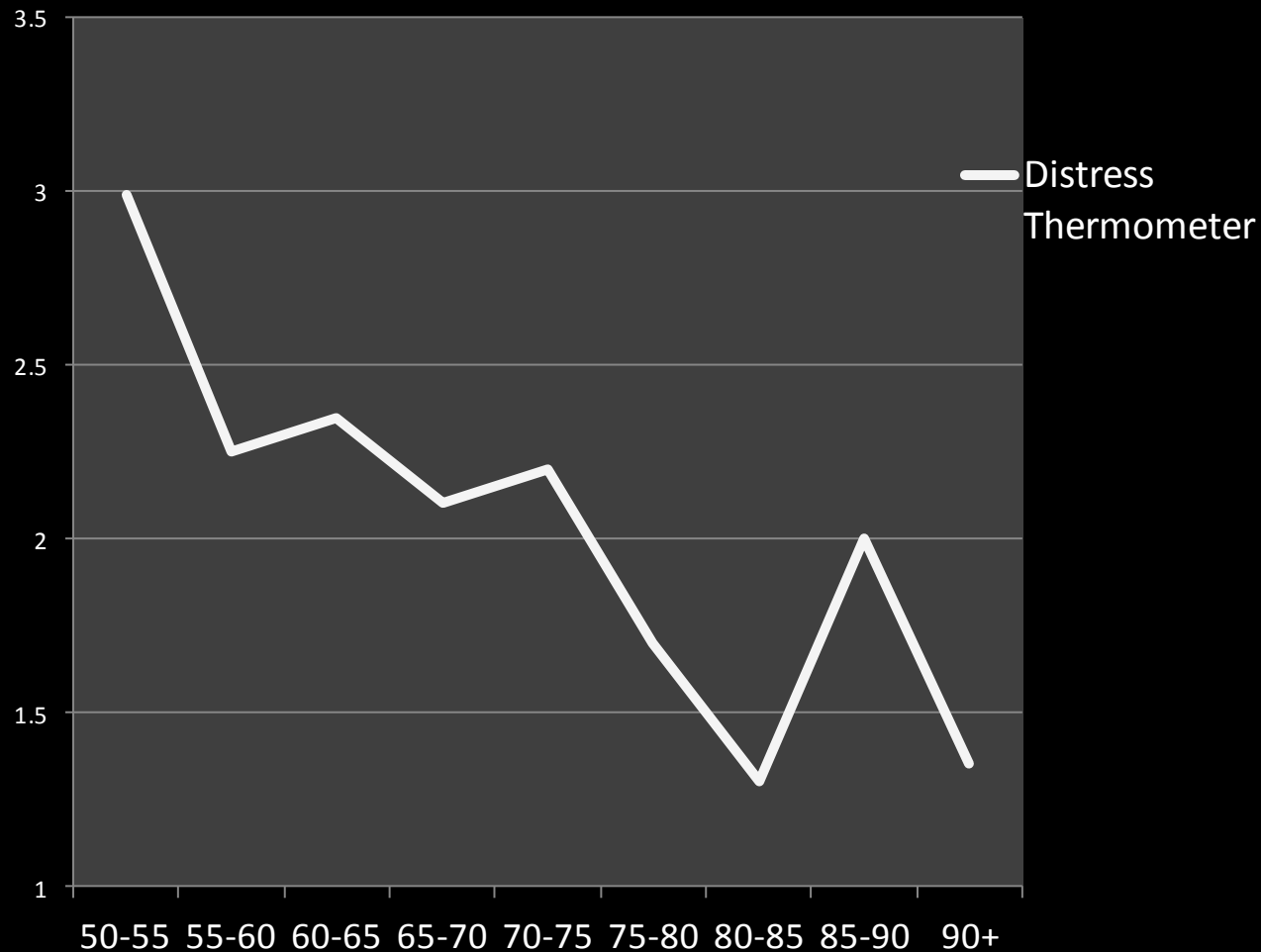
$r = 0.13, p < .01$



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# Distress Thermometer by Age Group

(Nelson et al 2008)



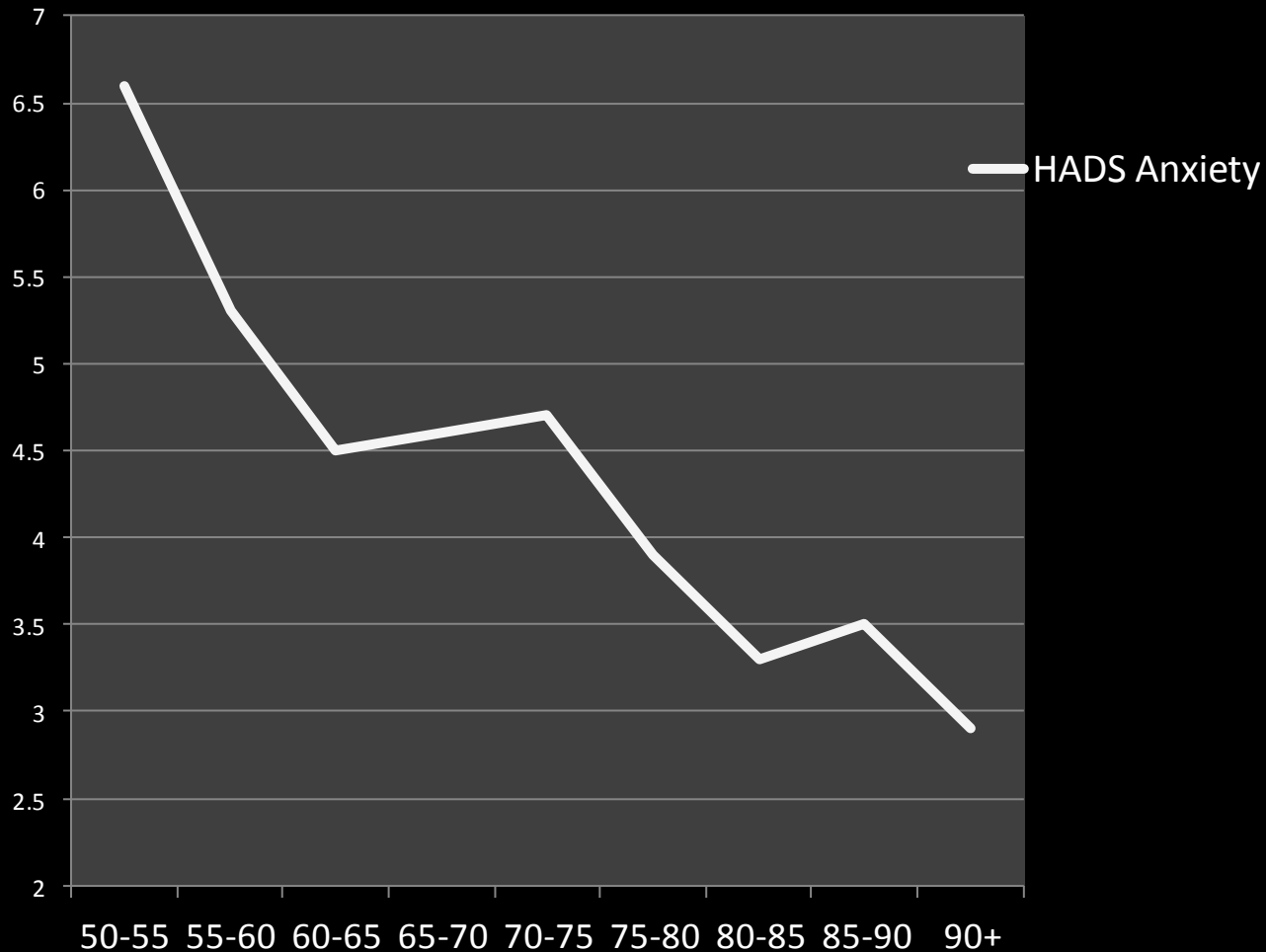
$r = -0.13, p < .01$



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# HADS Anxiety Total Score by Age Group

(Nelson et al 2008)



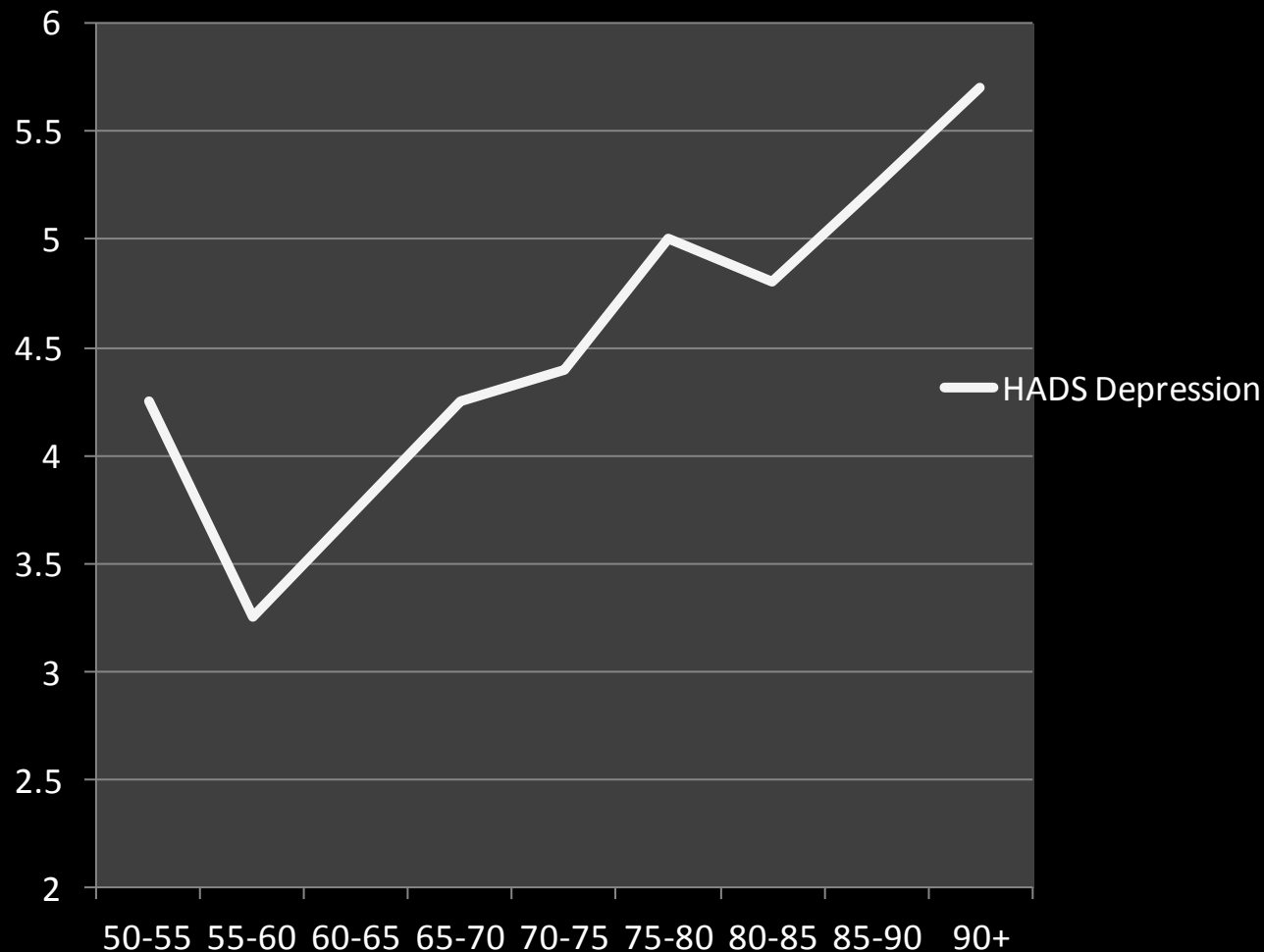
$r = -0.21, p < .01$



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# HADS Depression Total by Age Group

(Nelson et al 2008)



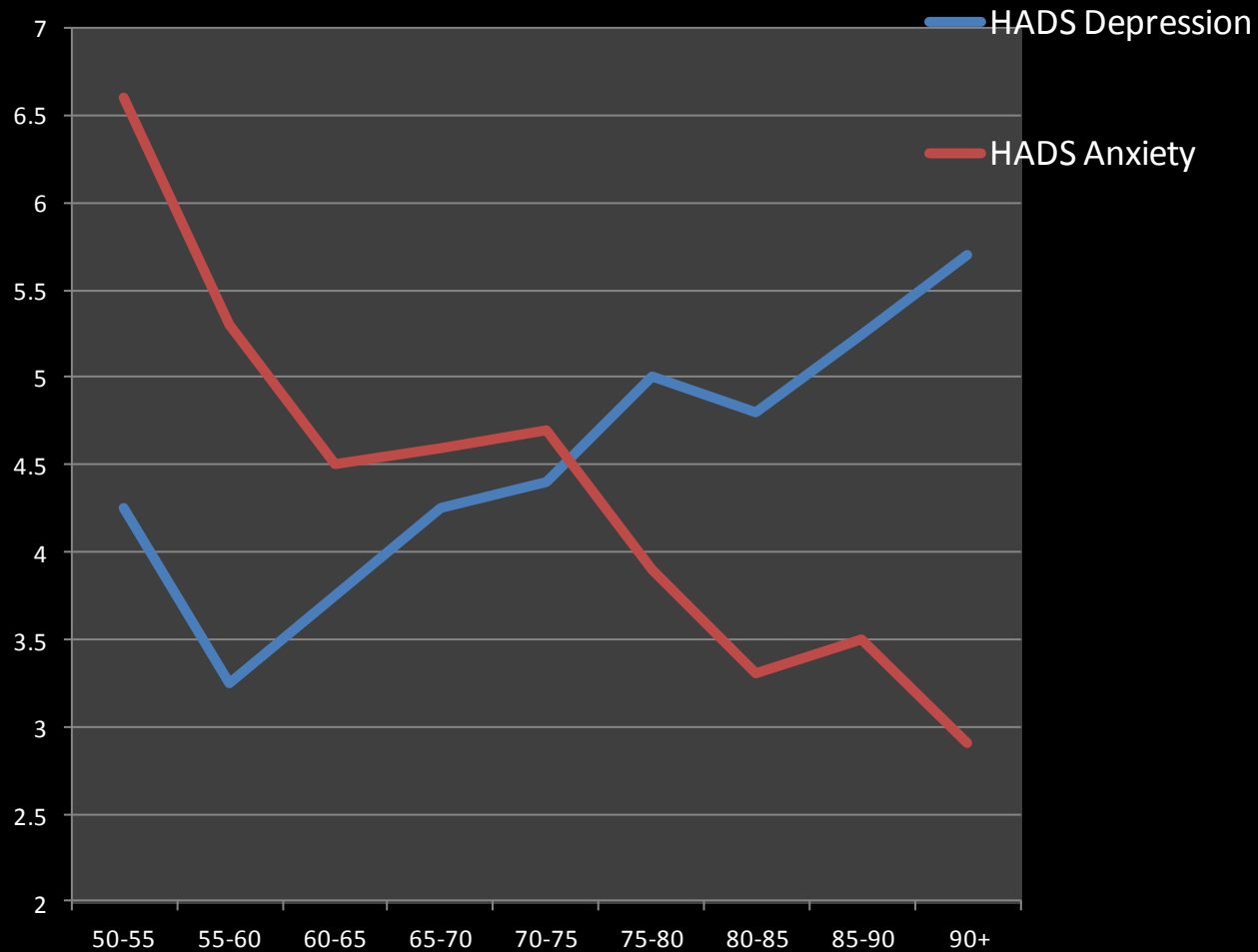
$r = 0.18, p < .01$





# HADS Depression and Anxiety by Age Group

(Nelson et al 2008)



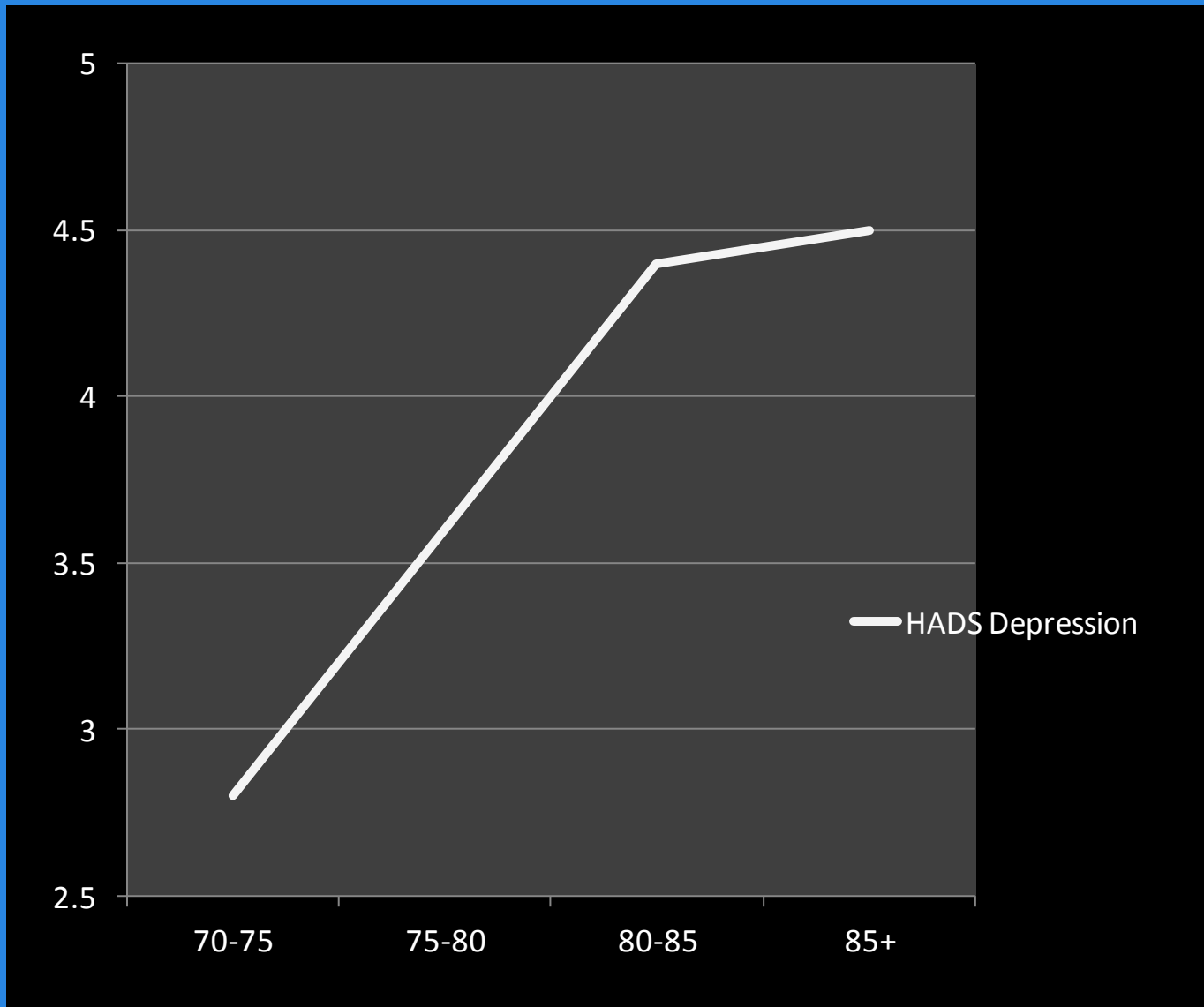
# The Relationship Among Age, Anxiety, and Depression in Older Adults with Cancer

(Weiss, JCO ASCO, 2012)

- Secondary analysis of a prospective longitudinal study investigating chemotherapy toxicity in older adults with cancer.
- Cross-sectional, pre-chemotherapy analysis
- This study supports previous research that anxiety decreases with age in older adults with cancer. However, depression remained constant with increasing age.



## HADS Depression by Age Group: Women w/Breast Cancer (Weiss, 2012)



# Would Older Depressed Cancer Patients Benefit From an Age-Specific Intervention?

- About 25% of older patients go untreated.
- Life experience of older adults leads to:
  - broader life perspective (i.e. wisdom)
  - shorter time perspective for goals
  - more careful selection of goals for improving emotion regulation
  - improved ability to manage emotions
- However, despite these strengths, older adults with cancer:
  - have to cope with significantly more physical limitations
  - potential cognitive declines
  - the reduction of social networks
  - unique issues of diagnosis and treatment of cancer
- Importantly, older patients are more likely to be homebound or alone.



Uncomfortable Emotions	Uncomfortable Thoughts	Uncomfortable Behaviors
Anxiety	Repetitive thought loops/PSA predictions	Drinking more alcohol
Fear	Unfocused	Smoking more
Worry	Difficulty concentrating	Not exercising
Panic	Preoccupied	Eating more junk food
Sadness	Forgetful	Using drugs/meds inappropriately
Depressed; unable to enjoy	"I'm going to die"	Apathy/not motivated
Demoralized	"Why me?"	Not productive at work
Hopeless	"This is unfair"	Stop planning for future
Anger	Upset at others' health	Arguing more
Irritability	"Why can't he get off his cell phone and take my order?"	Others say I yell more often for little reason
Loneliness	"Who would want to spend time with me?"	Social withdrawal/isolation

# Emotional Judo

(©2015 AJRoth; OUPress)

- EJ combines aspects of supportive psychotherapy, cognitive behaviorally oriented psychotherapy, problem-solving therapy, and Acceptance and Commitment Therapy into a practical method for easy teaching, understanding and practice for men with all stages of prostate cancer.
- Found to be successful in real clinic time with men with prostate cancer.



# Enter the DRAFT of Emotional Judo

(©2015 AJRoth; OUPress)

**Detect** uncomfortable emotions, thoughts, or behaviors.

**Recognize** the rational and irrational aspects of the emotions, thoughts, or behaviors.

**Acknowledge** and accept your current circumstances and the good that still exists and how the irrational aspects of your emotions, thoughts, or behaviors pull you away from what you really want.

**Flip** your attention away from the distress and back to the present with the *however* statement.

**Transform** through relaxation, distraction, or quick-list activities to a pleasurable or meaningful activity.



# Creation of a Geriatric Expert Panel

- Goal: To determine what elderly cancer patients need from a psychotherapy
  - Over 70 years,
  - Have/or had cancer, and
  - Were articulate, thoughtful and willing
- Two separate panels totaling 14 people participated in this initial phase
  - First group brainstormed on themes and content
  - Second group experienced group intervention and gave feedback





# Geriatric Expert Panel



# Geriatric Specific Psychotherapy Intervention

*C.A.R.E.*

*C*ancer and *A*ging: *R*eflections for *E*lders

- 5-session phone psychotherapy intervention
- Based on developmental stage and cognitive coping models
- Developed with input from older cancer patients
- Manualized



# Aims

## Primary Aims:

1. To test the feasibility of the intervention.
2. To examine the impact of this geriatric-specific psychotherapy primarily on depressive symptoms.

## Secondary Aim:

1. To examine the impact of this geriatric specific psychotherapy on anxiety, demoralization, spiritual well-being, and loneliness.



# Theoretical Models & Framework

## COPING MODEL:

- **FOLKMAN** – Reappraisal through Meaning-Based Coping (Situational Meaning)

## DEVELOPMENTAL MODEL:

- **ERIKSON** – Psychosocial Tasks associated with the seventh & eighth final stages of life
- **VAILLANT** – Elaboration of Erikson's later stages of development (Book: '*Aging Well*' )



# Erikson's Psychosocial Tasks in Older Years

## MIDDLE ADULT

(50's - 60's)

### Developmental Task: *Generativity*

- Capacity to unselfishly guide the next generation
- “Care” for younger as mentor, guide, consultant

### ‘Keeper of Meaning’:

- Preserving the culture in which one lives
- Link between the past and future

**Life Lesson: CARE**

## OLDER AGE

(70's - onward)

### Developmental Task: *Ego Integrity*

- Making peace with one's life as a unified whole
- Wisdom through life's experience and lessons
- Concern with life in the face of death & teaching the young not to fear death
- Struggle to accept inalterability of past & unknowable future

**Life Lesson: WISDOM**

# CARE Model

## DISTRESS

- Poor coping with aging and illness/cancer
- Feelings of social isolation
- Regrets about life lived
- Bitterness facing uncertainty & mortality
- Sad/Depressed



## INTERVENTION

- Identify and use coping tools that worked before
- Reframe issues of aging/illness
- Problem solve daily challenges
- Strengthen social ties
- Put past in a tolerable perspective
- Process uncertainty about mortality



## OUTCOME

- ↑ COPING
- ↑ SOCIAL CONNECTION
- ↑ QOL
- ↓ DEPRESSION



## ACHIEVEMENT

- Coping well with infirmity and illness
- Maintaining connections
- Accepting life as lived
- Finding pleasure/ humor
- Living with equanimity despite uncertainty
- Decreased depressive symptoms



# CARE Sessions

## Session #1: Introductions & Overview

Introduce intervention, session themes, and story of cancer

## Session #2: Coping with Losses & Facing the Unknowns of Cancer & Aging

Theme: Dealing with the combined problems of illness and aging; Coping with present and future fears, concerns, & worries

## Session #3: Loneliness & the Experience of Cancer & Aging

Theme: Loneliness and reduced social circles in later years; Dealing with the stigma attached to aging in our society

## Session #4: Making Peace with One's Life and Acquiring Wisdom

Theme: Who am I?: Coming to terms with one's changing sense of self;  
Contributing to the greater good: Passing on one's worth and wisdom

## Session #5: Reflection & Review



# Pilot study

- Telephone intervention
- Randomized:
  - CARES Intervention
    - Five session intervention
  - Enhanced Social Work Control
    - Standard Social Work intake
    - Four “check-in” sessions
- Recruit by letter





# CARE: IDEA

- (I)ntroduce session topic and theme related to aging and cancer
- (D)efine problems or challenges associated with given session topic and theme
- (E)xplore ‘guiding questions’ in light of personal reflections, attitudes and stories
- (A)ppraise strategies and reappraise problems and challenges with new strategies identified during the session



# Session #2: Coping With Cancer & Aging

*Theme: Dealing with the combined problems of illness & aging*

## Problem or Challenge

**Looking at the Here &  
Now: Losses &  
Limitations of Aging  
and Illness**

### Guiding Questions:

What are the major losses that  
come with aging?  
With having cancer?

Reflecting on your illness, how has  
your life been changed?

What can 't you do?

What can you still do?

## Ways to Cope

**Adapting and making the  
most out of life and the  
present**

- Maintaining connections with family, friends, pets
- Engaging in pleasurable activities (theater, music, arts, entertainment, hobbies)
- Using humor
- Reappraise life goals
- Seeking meaning through prior beliefs and values



# Eligibility Criteria

- Age:  $\geq 70$  years
- Diagnosis: Prostate, Breast, Lymphoma, GYN, or Lung
- On active treatment or within 6 months post-treatment
- $> 6$  months post-diagnosis
- All Stages
- Documented Distress:
  - Distress Thermometer  $\geq 4$  or
  - Hospital Anxiety and Depression Scale (HADS)  $\geq 6$
- The Blessed Orientation-Memory-Concentration test  $\leq 11$



# Assessment Schedule

- Patients complete a battery of questionnaires
  - Hospital Anxiety and Depression Scale (HADS)
  - Demoralization Scale
  - UCLA Loneliness
  - FACIT Spiritual Well-Being Scale
- Complete at:
  - Baseline
  - End of intervention (2m)
  - 2-months after treatment (4m)

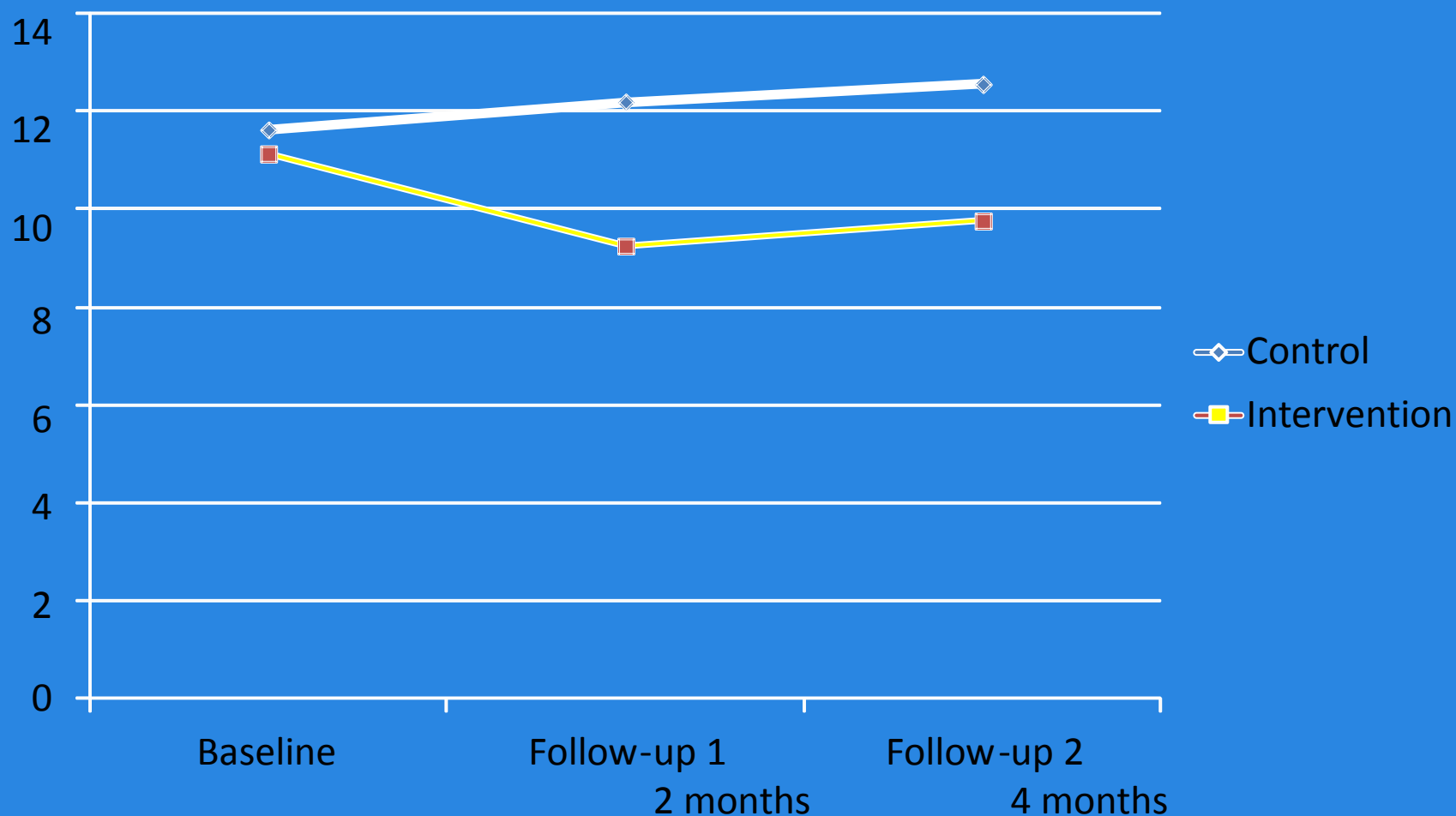


# Subject Characteristics

		Total Sample
N		61
N by Group	Intervention	32
	Control	29
Mean age (years)		76 $\pm$ 4
Race		95% Caucasian
Relationship Status		28% Married
		18% Single
		31% Divorced
		23% Widowed
Education		77% College Degree



# HADS Total

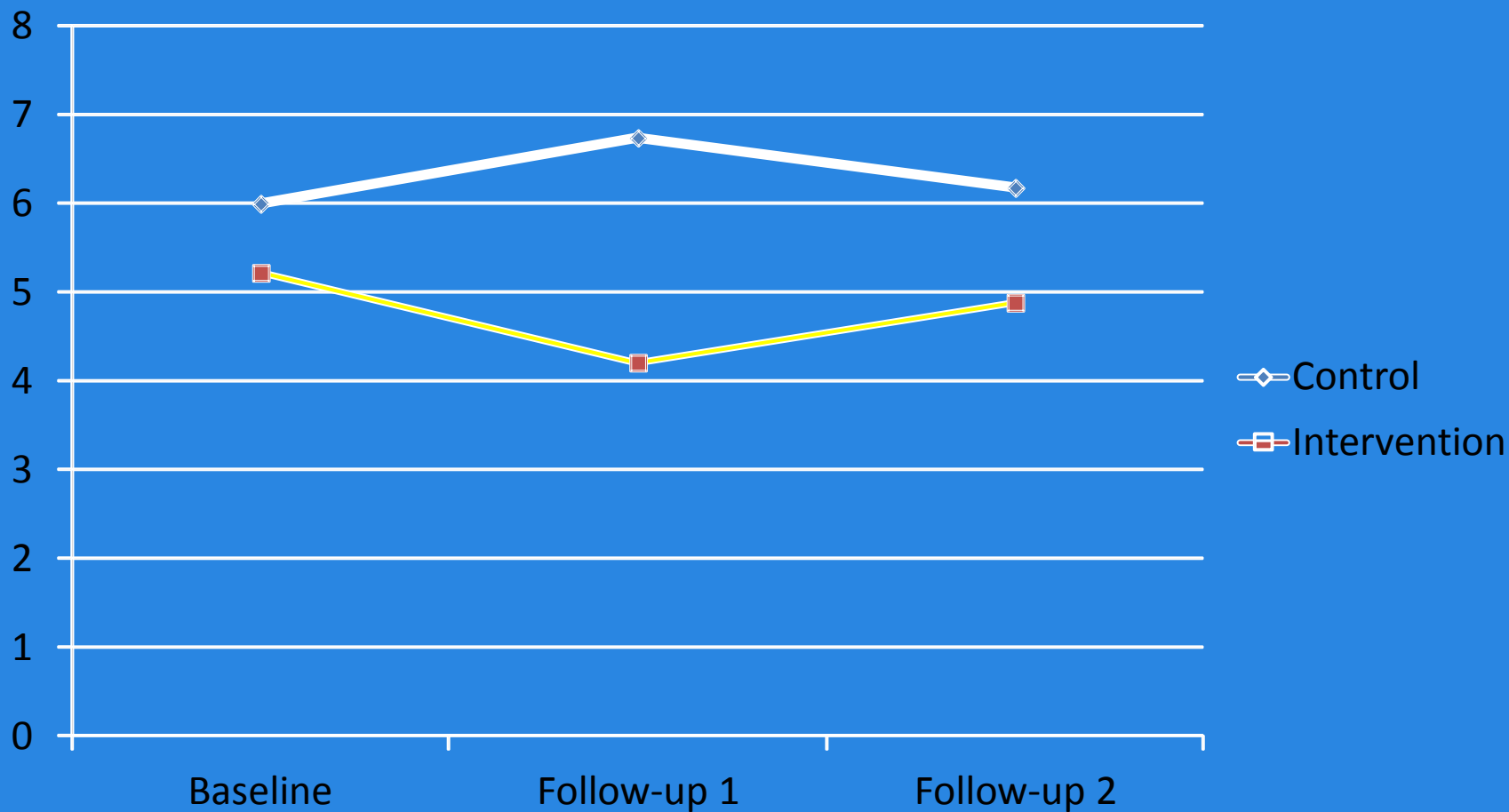


Baseline-Follow-up 1:  $p = 0.02$ ,  $d = 0.47$

Baseline-Follow-up 2:  $p = 0.09$ ,  $d = 0.41$



# HADS Depression

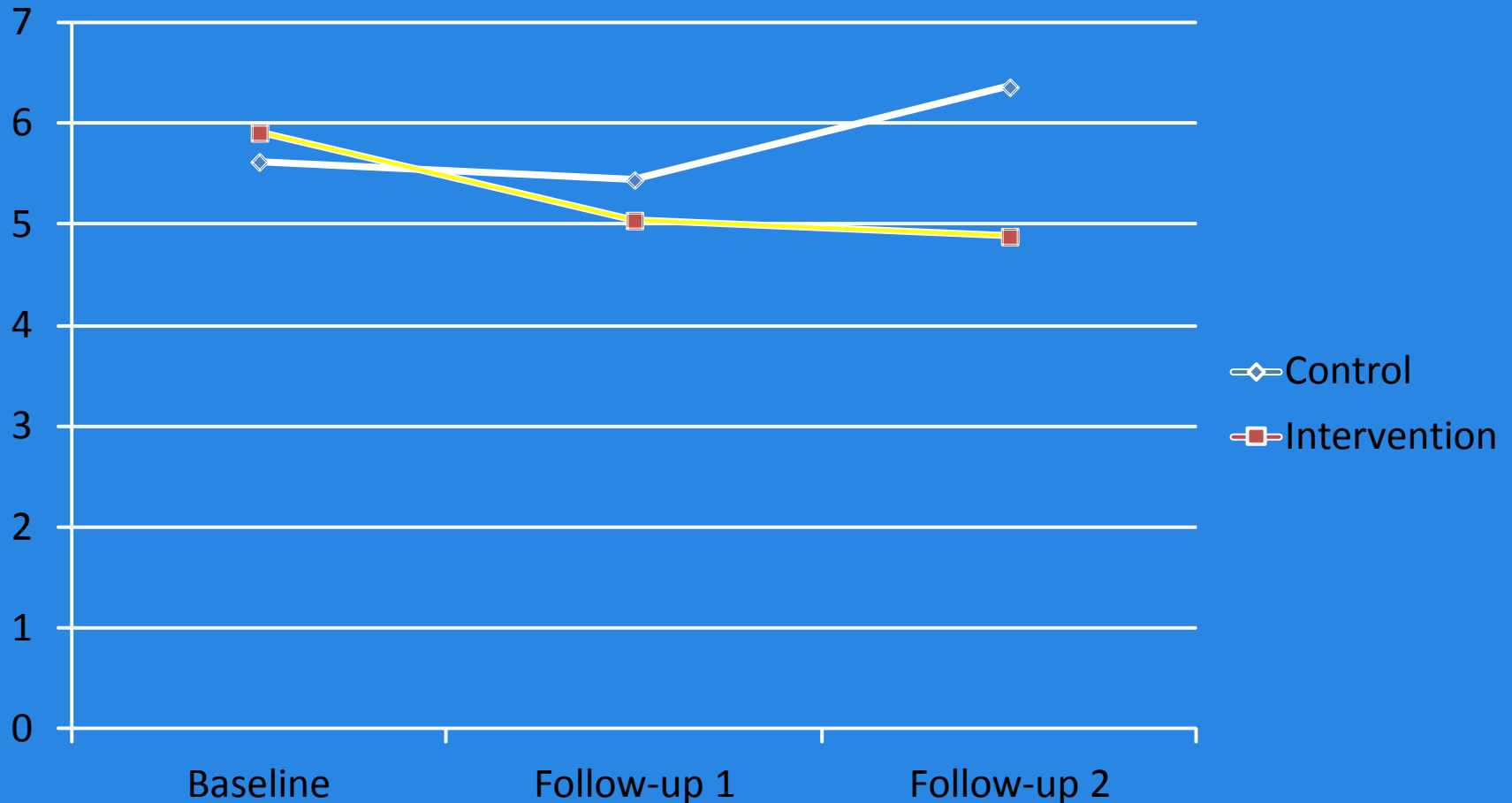


Baseline-Follow-up 1:  $p = 0.01$ ,  $d = 0.59$

Baseline-Follow-up 2:  $p = 0.20$ ,  $d = 0.27$



# HADS Anxiety



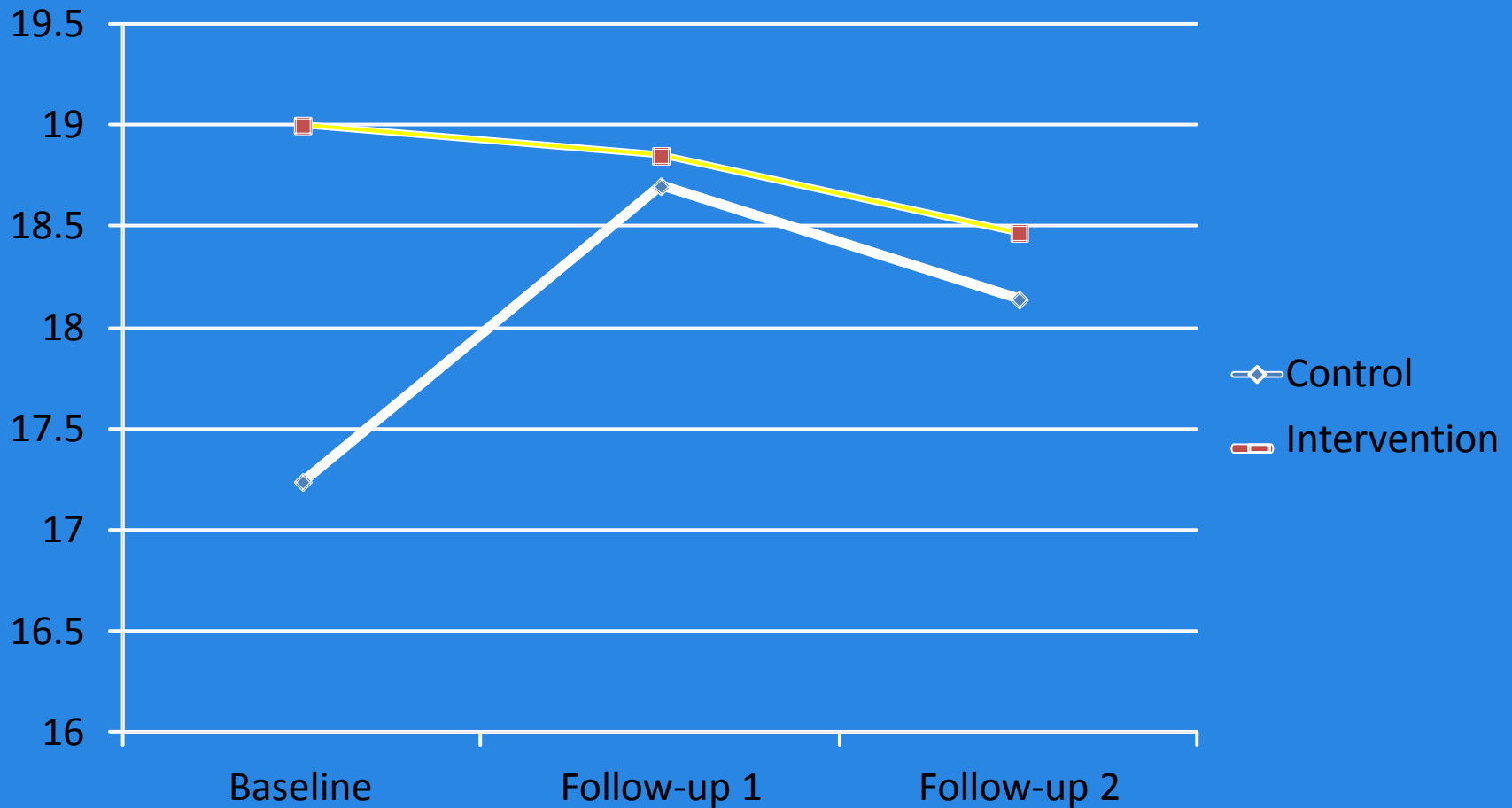
Baseline-Follow-up 1:  $p=0.44$ ,  $d=0.15$

Baseline-Follow-up 2:  $p=0.10$ ,  $d=0.42$





# Loneliness

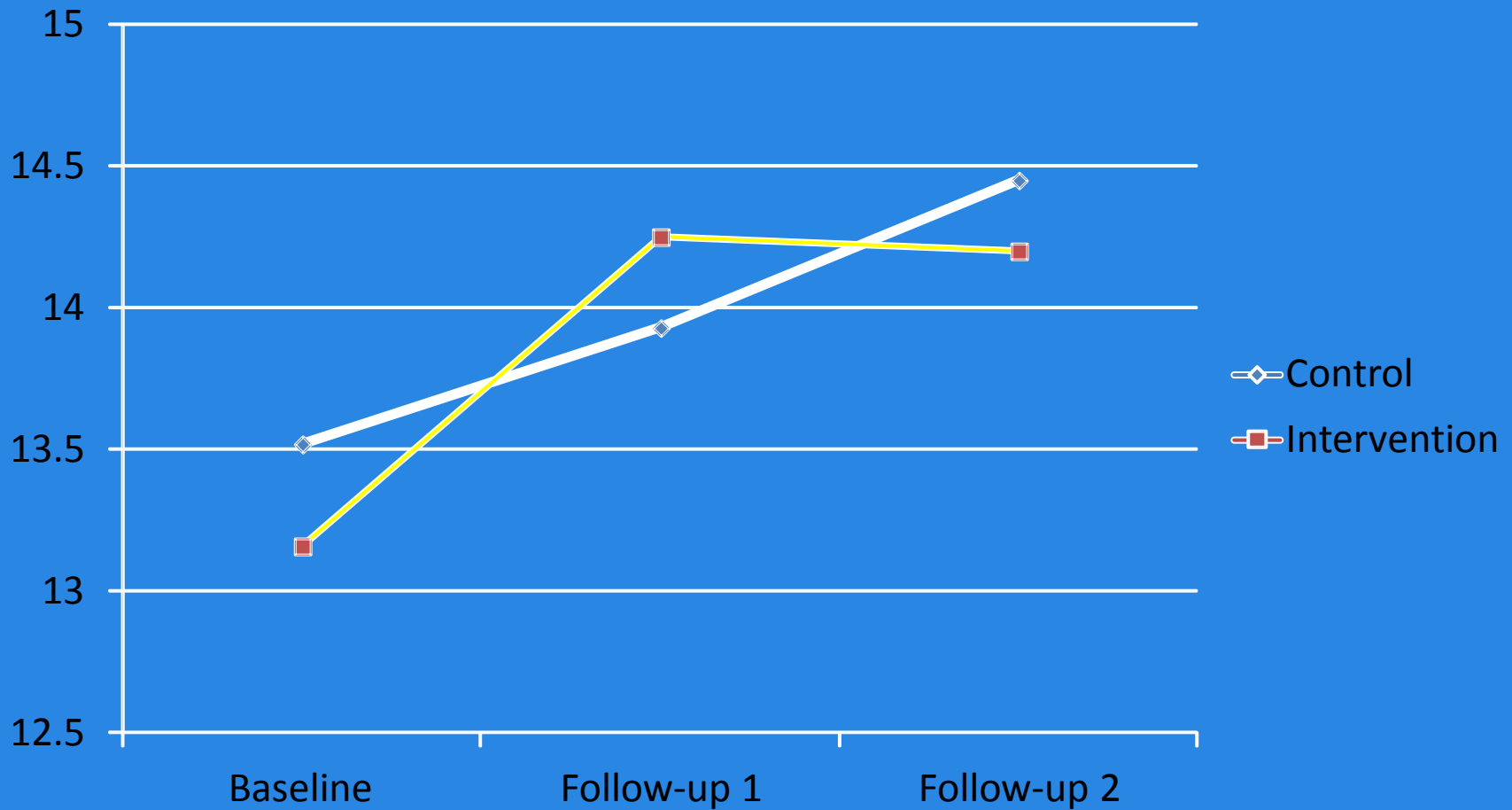


Baseline-Follow-up 1:  $p = 0.11$ ,  $d = 0.32$

Baseline-Follow-up 2:  $p = 0.46$ ,  $d = 0.17$



# COPE-Planning

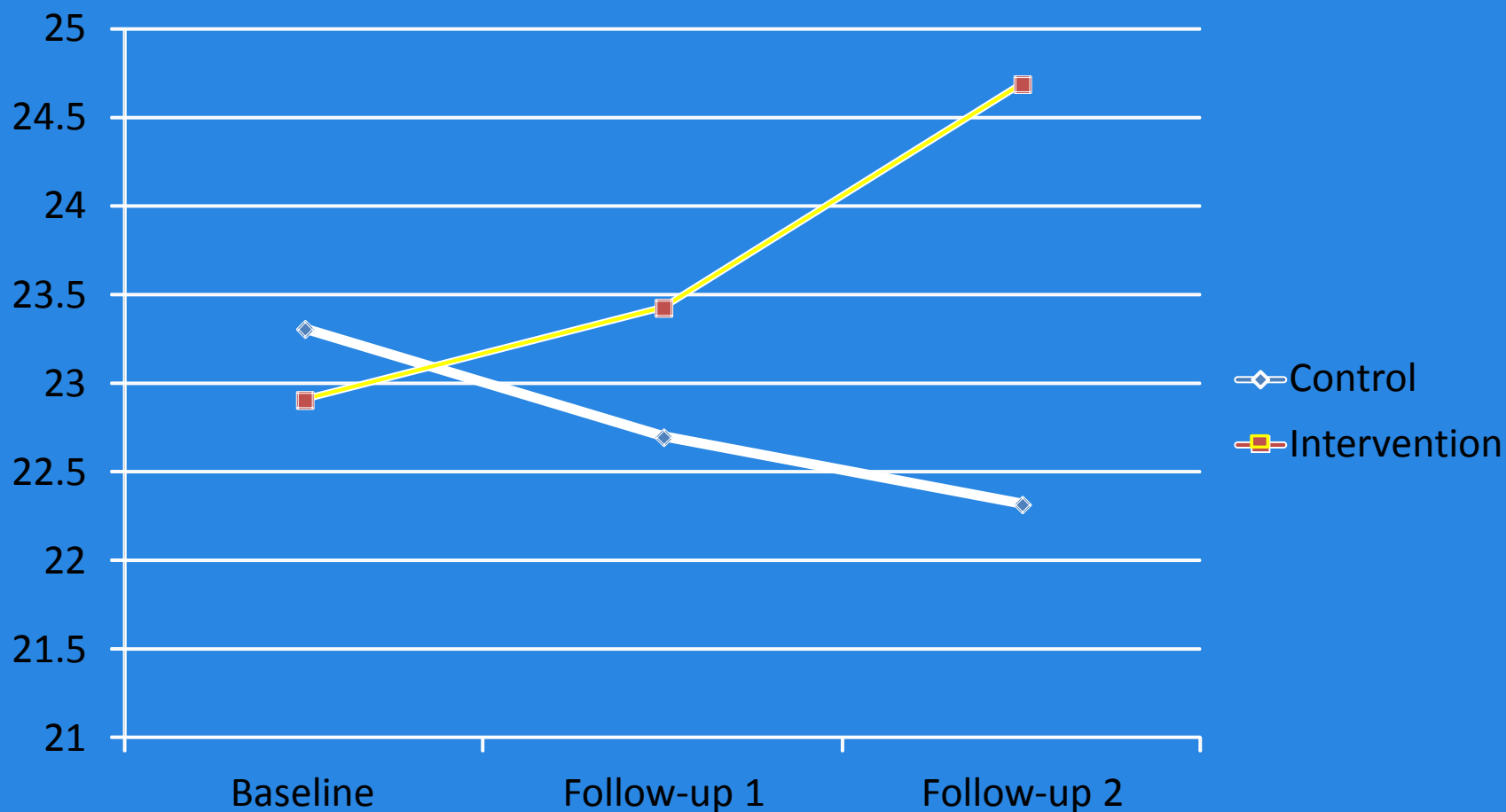


Baseline-Follow-up 1:  $p = 0.18$ ,  $d = 0.23$

Baseline-Follow-up 2:  $p = 0.88$ ,  $d = 0.03$



# Meaning



Baseline-Follow-up 1:  $p = 0.27$ ,  $d = 0.23$

Baseline-Follow-up 2:  $p = 0.04$ ,  $d = 0.46$



# Conclusions: CARE Model

- A brief psychotherapy intervention
  - Specifically designed for aging and cancer
  - Conducted by phone
  - Manualized
  - Delivered by those with counseling degrees (Master)
- Produced moderate effect sizes
- Additional strategies may be needed to help sustain intervention effects over time but started to break ground on achieving wisdom
- A larger study:
  - Partner with the Cancer Support Community
  - Utilize large volume cancer call center

