Recognising and managing mental health conditions in those affected by a brain tumour

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Talk outline

- Background
- Depression and anxiety
- Delirium and cognition
- Personality change
- "Positive framing"
Brain tumours increase the risk of mental ill-health

Frequency > population norms

Frequency > some other cancers (but not all)

Highest risk for psychiatric contact pre-cancer diagnosis

3rd highest risk of suicide post-cancer diagnosis

Refs #1-4
Distress is common and persistent following brain tumour diagnosis

Ref #5
Distress may peak at several points after diagnosis:

- Diagnosis
- End 1’ treatment
- Recurrence
- Palliation

Ref #6
Distress is multifactorial

“I feel like I’m a burden. I’m no longer the capable man I once was.”
64 year-old man with a high grade tumour

“I feel frightened by how I behave sometimes. It’s like it isn’t really me.”
45 year-old woman with a low grade tumour

“Seizures have made me lose all my confidence. They make me scared to be alone and I have huge anxiety problems.”
55 year-old man with a high grade tumour

“I split from my partner of five years following diagnosis. It put so much strain on our relationship and we were unable to deal with it.”
39 year-old woman with a low grade tumour

Ref #7
Patients have multiple concerns and unanswered questions

**Theme of patients’ questions**

Symptoms or social issues  
73/105 (69.5%)

MRI / recurrence / prognosis / surgery  
20/105 (19.0%)

Ref #8
Background

Depression and anxiety

Delirium and cognition

Personality change

“Positive framing”
Clinical depression is a huge hidden morbidity

6-month prevalence 21% in UK = over 2000 depressed new patients per year

Persists for >3 months in most cases

Well-known adverse modulator of QoL

Refs #9-10
Depression is a syndrome - diagnosis requires multiple symptoms

“I’d be depressed if I had a brain tumour!”

“Looks like it could be depression.”
Depression is a syndrome - diagnosis requires multiple symptoms

- Depressed mood
- Loss of interest
- Appetite changes
- Sleep changes
- Fatigue
- Concentration problems
- Guilt
- Physical/mental slowing
- Suicidal thoughts

“Looks like it could be depression.”
What we call ‘depression’ is really a heterogeneous syndrome.

<table>
<thead>
<tr>
<th>Mood</th>
<th>Anhedonia</th>
<th>Appetite</th>
<th>Sleep</th>
<th>PsyMot</th>
<th>Fatigue</th>
<th>Guilt</th>
<th>Conc</th>
<th>Suicide</th>
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‘Heatmap’ of symptoms present (green) or absent in individuals with depression.
Diagnosing depression is a matter of clinical judgement

- Wait at least one month from diagnosis
- Focus on severity and persistence of symptoms
- Grief comes in waves; depression is pervasive
- Some degree of loss of interest and guilt is normal
- Suicidal thoughts are rare - always take seriously
- Get a collateral history

**Screening**
- HADS
- PHQ-9
- DASS-21

**Adjustment disorder**
- Delirium / cognitive impairment
- Organic personality change
- Anaemia, thyroid, pituitary,…
The best way to treat depressed patients with a brain tumor is not known.

NO RCT-proven effective treatments in clinically depressed brain tumor patients.

- Antidepressants
- Talking therapy
- Exercise?
- Methylphenidate
- Oxcarbazapine
- Gingko biloba
- Donepezil
- Massage therapy
- Acceptance therapy
- Telephone based support
- Some low quality evidence

Internet-based guided self-help: negative RCT (but underpowered)
Tailored, multicomponent psychosocial intervention: some RCT evidence for reducing depressive symptoms measured by rating scale.

Antidepressants
Talking therapy
Exercise?

Refs #11-12
Background
Depression and anxiety
Delirium and cognition
Personality change
“Positive framing”
Cognitive impairment is common and takes different forms

- Delirium
- Impaired capacity
- Chronic impairment
Cognitive impairment is common and takes different forms

Delirium

Sudden onset fluctuating confusion

Screen using 4AT
Delirium

Soon after diagnosis

- post-op
- steroids
- infection
- radiotherapy

End of life phase

- steroids
- infection
- opiates
- disease progression
- catheterisation

Older age
Cognitive impairment
Infection
Medications
Immobility
Catheter
Treatment of delirium

Treat the cause
Supportive treatment of delirium

Non-pharmacological supportive measures

Side-room
Well-lit
Clock / calendar
Sensory aids
Rationalise medication
Well-known staff / carers
Familiar objects from home

Medication (where necessary to maintain safety)

Low-dose regular antipsychotic (e.g. haloperidol 1mg, or olanzapine 2.5mg)
Avoid benzodiazepines
Stop opiate and anticholinergic meds
Background
Depression and anxiety
Delirium and cognition
Personality change
“Positive framing”
Personality change is a challenging complication for families

“How can we understand each other’s point of view?

…

Why do the problems cause strain on partnerships?

…

Why do we hurt the people closest to us?

…

Why can’t we ask them to help?

…

Do I say too much or not enough?”

For answers… come to BNOS
### Personality change is frequent and cross-cuts histological diagnoses

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>In a nutshell</th>
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<tbody>
<tr>
<td>Herrlinger</td>
<td>1999</td>
<td>Up to 73% with personality change at presentation with PCNSL</td>
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<tr>
<td>Allam</td>
<td>2000</td>
<td>16% reported behavioural changes at presentation with oligodendroglioma</td>
</tr>
<tr>
<td>Davies</td>
<td>2005</td>
<td>Personality change independently predicted lower QoL for carers of patients with HGG</td>
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<tr>
<td>Wilne</td>
<td>2007</td>
<td>Marked irritability in 24% of children aged &lt;4yrs presenting with BT</td>
</tr>
<tr>
<td>Tiemensma</td>
<td>2010</td>
<td>More apathy and irritability than controls 13 years after treatment for NFPMA</td>
</tr>
<tr>
<td>Gofton</td>
<td>2012</td>
<td>61.9% with cognitive / personality changes in palliative care primary / metastatic BT</td>
</tr>
<tr>
<td>Sterckx</td>
<td>2013</td>
<td>Several qualitative studies highlight personality change as of significant impact</td>
</tr>
<tr>
<td>Collins</td>
<td>2014</td>
<td>Significant cognitive /behavioural change at presentation  = OR 3.1 (1.9-4.5) for death without being discharged from hospital</td>
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</tbody>
</table>
There is little evidence to guide management in adults.
Behavioural programs to address personality change are being studied.

Tamara Ownsworth

MSoBT program

- Individually tailored
- Psychoeducation
- Cognitive rehabilitation
- Psychotherapy
- Couple and family support

Ownsworth (2014 - the only RCT)

Siew Koh

Behavioural consultancy

- Home-based psychoeducation
- Communications skills
- Relaxation techniques

Carer training workshop

Whiting (2012)

Refs #12-13
Functional Analysis in dementia

- Antecedent - Behaviour - Consequence (ABC)
- Probably effective as part of a multicomponent intervention

Drug treatment of agitation and aggression in ABI

- Best evidence is for beta blockers (propranolol)
- Antipsychotics etc - last resort; a few case reports for Risperidone in BT

Cognitive reframing for carers in dementia

- Targets distressing cognitions about patient behaviours / carer role
- Significantly reduced anxiety (SMD -0.21) and depression (SMD -0.66)
Background

Depression and anxiety

Delirium and cognition

Personality change

“Positive framing”
The World Health Organisation defines mental health in a positive way

“A state of well-being in which every individual realises their potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”
Do we take a positive approach to mental health in brain tumours?

Examples

Do we help patients realise their potential after treatment?
To cope adaptively with the daily stress of having cancer?
To work (or function) productively?
To make a contribution to their community?

- Neurorehabilitation? (see Ref #15)
- Screening for mental distress?
- Carer support?
- Research funding?

Obstacles
• Having a brain tumour increases the risk of mental ill-health from diagnosis to palliation.

• Clinical depression should be diagnosed by clinical interview. Antidepressants are empirical first-line treatment.

• Delirium presents with acute onset and fluctuating confusion. Treatment consists of reversing likely underlying causes.

• Personality change may be amenable to behavioural management strategies.

• A positive goal of achieving “mental health” may trump one of treating “mental disorder”.
Useful links

Screening for depression or anxiety: http://www.bgs.org.uk/pdfs/assessment/hads_mood.pdf
Screening for delirium: http://www.the4at.com (free download)

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