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Ruth Adewuya, M...: Hello, you're listening to Stanford Medcast, Stanford CME's Podcast, where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya.

In today's episode of our Hot Topics Mini-Series, I will be chatting with Dr. Sheila Lahijani on psychosocial oncology. Dr. Sheila Lahijani is a clinical associate professor in the Department of Psychiatry and Behavioral Sciences here at Stanford University. In 2019, she was appointed as the medical director of the Stanford Cancer Center Psychosocial Oncology Program, where she works in Stanford Cancer Center leadership and oversees the development and operationalization of psychiatric consultation for patients with cancer. Her clinical and scholarly interests include the interface of medicine and psychiatry, pharmacology, psycho-oncology, collaborative care models, psychotherapy for the medically ill, interdisciplinary medical education, teaching and writing. Thanks for chatting with me today.

Sheila Lahijani...: Thanks Ruth. It's such a joy to be here with you. I really appreciate this invitation.

Ruth Adewuya, M...: Of course, and I'm really excited to chat with you about this topic; psychosocial oncology, a growing field within medicine. Let's start with how would you describe psychosocial oncology?

Sheila Lahijani...: Psychosocial oncology is also known as psycho-oncology, psychiatric oncology. There are a number of different names by which the subspecialty goes, but simply stated it's a medical sub-specialty where inpatients with cancer who have emotional distress and/or psychiatric symptoms are cared for. This area of medicine developed over the last three decades with evidence-based interventions, textbooks, journals, dedicated professional organizations, we

work very collaboratively with oncology providers to contribute to and provide comprehensive cancer care.

Ruth Adewuya, M...: You'd mentioned that this specialty is focused around the psychological impacts of cancer. Can you elaborate on what those are?

Sheila Lahijani...: Definitely. Any patient who's diagnosed with cancer can develop an array of psychological reactions and emotional responses. By psychological reactions, I'm speaking primarily to a lot of the different thoughts that people develop, different kinds of thinking patterns. Sometimes there are distortions in their thinking, as well as the emotional responses.

So largely people experience symptoms of anxiety, like fear, which is based on either a real or a perceived threat, worrying, nervousness, in addition to feelings of sadness, guilt, not wanting to burden others. And then from the outset, many people have death anxiety because cancer continues to carry a stigma. Mortality related concerns are prominent, existential angst is very common as a theme.

We do a lot of high-level medical care that a lot of people don't have knowledge or understanding of. We see patients who have significant neuropsychiatric symptoms from their cancer therapies among which is immunotherapy, consequences related to stem cell transplants, graft-versus-host disease, more recently cancer cell therapies, such as CAR T-cell therapy. And we take care of patients who develop significant drug-to-drug interactions. There's such a prevalence of serotonin toxicity. People are at risk for things like tremors, akathisia. And to add to that, many of our patients have a significant cognitive burden from the stress of their cancer illness, sleep disturbances, sleep disorders are prevalent. I've diagnosed so many patients with sleep apnea.

We see so many patients with substance use disorders that otherwise weren't known. Very recently, I took care of a patient over the summer, and none of his other providers knew that he had a significant alcohol use disorder. There's plenty of medication side effects. And so not infrequently we're doing neuropsychiatric evaluations and having to determine does this patient need more extensive testing? And that comes up quite a bit in our consultations with patients. We may be referred a patient who's "depressed", and we diagnose that patient with being delirious or having a mild cognitive impairment.

And yet having said that, each person brings himself or herself to the diagnosis. And so that means everyone with his or her own upbringing, educational background, personality, attachment styles, psychosocial components of his or her life, all of that can affect how someone responds to a cancer diagnosis and experiences a cancer illness.

Ruth Adewuya, M...: You had also mentioned earlier that the evidence-based background has been foundational for this field. Can you share some of the current literature

regarding epidemiology and treatment approaches for psychiatry in cancer patients?

Sheila Lahijani...:

Over the years what we've learned from many studies is that anywhere from 30 to 50% of patients with cancer experience some form of distress that can take on the form of anxiety, depression, post-traumatic stress symptoms, even cognitive changes. We know delirium is very prevalent in our patients, especially those who are hospitalized or experience advanced disease. We also know that patients with cancer are at an increased risk for suicidal ideation. In fact, there've been some studies in the last few years that have shown various increased prevalence of anywhere from three to five times the general population. So therefore screening patients, as well as making sure they receive the appropriate specialized care is critical.

We also know that caregivers suffer from tremendous emotional and psychological distress. And the challenge is there are so many different screening tools and measures that can assess and elicit these symptoms. And so there's various epidemiology related to these different populations of patients. And we also know that there are various forms of treatment, largely in the form of psychotherapy, such as cognitive behavioral therapy, acceptance commitment therapy, simply problem-solving approaches. There are also newer therapies in the last number of years called meaning-centered therapy and dignity therapy. These are all very effective and have evidence backing them as well.

And we use a lot of medications and I'd like to usually frame that as treating clusters of symptoms. So we see patients who oftentimes not only present with emotional symptoms, psychiatric symptoms of distress, but may have pain, may have sleep disturbances, may have other things like hot flashes or basal motor symptoms. So we often try to think creatively about using one medication that potentially can treat a cluster of symptoms.

So having said all of that, there are plenty of options available in terms of what we can offer and how we can intervene. And I also speak to patients about the importance of maintaining routines, behavioral activation, sleep health management. And of course, we know that there's robust evidence for the role of physical activity as well.

Ruth Adewuya, M...:

Clearly cancer treatment is multidisciplinary. In this collaborative cancer care model, what is unique about the relationships that you build with your patients compared to other medical specialties that are caring for a cancer patient?

Sheila Lahijani...:

I think that's a great question, Ruth, and it reminds me of something a peer of mine once said. And that was, "Wow, you have access to the crevices of people's minds." And at the time, I didn't appreciate that. I don't think I really liked that statement or understood it, but I realized what was being said to me is that I learn so much about people in my role of taking care of them, that they

may otherwise not tell others or reveal to any of their other providers. And that's a function of the space that we in psychosocial oncology hold with patients the time we have with them in any given encounter, and that we invite them to express this vulnerability because that's how we can actually provide quality care. We ask those questions with the aim of adding some sort of understanding and value.

Ruth Adewuya, M...: Yeah.

Sheila Lahijani...: That's what it boils down to. If we don't do the appropriate medical psychiatric evaluation, we're not doing due diligence. It's not enough to write a prescription or say, "I'll see you next week and we can talk about this further." We really have to come up with some formulation. And I think that's what distinguishes us from other supportive care programs, is that we really do take an inventory of someone's medical and psychiatric presentation. We're expected to not only help with patients suffering, but also how to navigate their care oftentimes within a medical system, serve as an advocate for them when they're not being heard or understood. And I know this isn't specific to our specialty, but in my opinion, it oftentimes really distinguishes us.

Ruth Adewuya, M...: How does psychosocial oncology differ from other medical specialties that also treat the whole patient during severe illness, such as palliative care?

Sheila Lahijani...: Thanks for asking that, Ruth. That comes up quite a bit and because psychosocial oncology is such a generalized term, I think it's very easy to see other specialists and clinicians as psychosocial oncologists as well. Within my field, we have psychiatrists, we have psychologists, we have clinical social workers. Palliative care is also multidisciplinary. We're both supportive care specialty programs within cancer. Generally speaking though, palliative medicine specialists are not trained or certified mental health clinicians. They focus largely on supporting patients and managing their symptoms, as well as goals of care and advanced care planning.

Having said that, we work very closely with our colleagues in palliative medicine here at the Stanford Cancer Center. And there is often an overlap in the symptoms that we manage and the treatments that we offer, but our roles are still distinct. While there is an overlap, I do think it's important to respect and regard what each of our different training is and scope of practice is and how we compliment each other. And this is why in the last few years, my colleagues in palliative medicine in my program, we have met with some cadence to actually talk about the patients that we're co-managing, but also learn from each other about patients we are not managing so that we can work as collaboratively as possible.

Ruth Adewuya, M...: When does a patient see you versus see a palliative care specialist?

Sheila Lahijani...: A patient can see both of us depending on what the patient's needs are and what the question is that the referring provider is asking. Generally speaking, when questions come up about prognostic clarification, goals of care, advanced care planning, it's best to refer to palliative medicine because they have the training and expertise more specifically to address that. When there is more of a prominence of emotional health related phenomena symptoms, distressed patients who are clearly presenting with psychiatric symptomatology, ideally it's best for them to be referred to us. But having said that, there are occasions where we can't see those patients and sometimes insurance is a barrier, or there are occasions where patients are more likely to be referred to let's say our service because of the concern about talking about end of life care, goals of care. So we oftentimes see patients that we either co-manage, or that we refer to each of our own specialties. I think there's space for both of our specialties to provide services within cancer care.

Ruth Adewuya, M...: And as part of this patient's cancer journey, how do you collaborate with other clinicians that are part of their care team, such as their oncologist or radiologist?

Sheila Lahijani...: It's really different based on the environment you're practicing in, or there are many colleagues who work within a community. They're not co-located like we are. Our services are located within our cancer center. So it makes it much easier for us to collaborate directly versus if we're a practice that providers refer out to. And so it's very easy for us to review charts, reach out to providers ahead of time. That also includes our colleagues in social work, whom we work with very closely. And it's our duty to assess and evaluate these patients and come up with some defined recommendations as early as the first visit. We really work within our program not to work in silos. It's really important for us to maintain consistent and clear communication and to make sure that the expectations are set and that our roles are defined too, because there is of course so much that we can do as sub-specialty providers.

I think a lot of the respect that I've garnered from my colleagues has been because they've either seen me with patients, they've read my notes, or I've enlightened them in some way to think about something differently. And that's what excites me. That's what challenges me. That's what motivates me. I'm inspired to do this work because I think there's so much opportunity to understand what is going on with that patient. What's physiologically taking place for that person to be suffering in the way that he or she is suffering.

I hope that in the coming year, we can pilot a collaborative care model for which there is a significant evidence base that will really help to meet the triple aim of health care, which would really improve outcomes, really allow us to take care of more patients to meet the population health needs, and also improve both the provider satisfaction as well as the patient satisfaction.

Ruth Adewuya, M...: What about the scenario if a patient has a psychiatrist or is already seeing a psychiatrist due to a pre-existing mental health condition then gets the

diagnosis of cancer. How do you collaborate with that initial psychiatrist? Do you collaborate with them?

Sheila Lahijani...: I'm so glad you're bringing this up, Ruth, because I think this is a population of patients that oftentimes many people don't really consider or think about. So patients who have preexisting mental health conditions can also be diagnosed with cancer. And just as an aside, there's quite a lot of literature and some studies done over the years that demonstrate that many patients with serious mental illness, unfortunately do not go through some of their preventative health screening and oftentimes are not unfortunately offered standard of care or not enrolled in clinical trials. So this is a particular area of importance and interest to me.

Having said that, we do have patients who are referred to us, who do have preexisting psychiatric disorders and not all of them are in care. So for those who are in care, we're very clear to distinguish what our roles are at the cancer center, because we cannot necessarily assume the care or continue the care of their providers, but we can provide sub-specialty expertise and recommendations for a defined period of time because we want to be helpful. We want to help our peers in oncology, but also in the community if they have specific questions related to certain chemotherapy regimens or other treatments, which we have more familiarity with.

So it's really case-based, but as I said, we're a very small team and we can't necessarily take on the care of patients who are already in care. I will say, though, there are patients who are not in care, who've previously not sought psychiatric care or been diagnosed formally, and we actually diagnose them in the consultation. And so that requires a lot of communication and diligence as well as coordination to make sure that the care is as seamless as possible. And ultimately our goal is really to get people set up with longer-term care because the hope and expectation is they go through their cancer illness with the best outcomes possible and then transition back into the community.

Ruth Adewuya, M...: Yeah. Most cancer patients navigate their cancer journey with the help of others. How do you meet the psychosocial needs of the family of a cancer patient? Do you interact with the family of a cancer patient?

Sheila Lahijani...: The field of psychosocial oncology is also committed to giving attention to cancer caregivers. So that includes family as well as non-family members who are providing care and taking care of the patient. And now even the term caregiver, there's a lot of question about if that's the best term to identify that person in that role, but in any case, we do not provide formal services as part of our psychosocial oncology program. There are supportive care services for caregivers and family members within the cancer center. I will say, however, we do see a lot of family members and caregivers as part of the patient visits, especially now that we are doing telemedicine, it has just become much more common due to its feasibility. And we know and we recognize that cancer

affects not just the patient diagnosed with a disease, but his or her entire family, community network.

So we need to give attention to those disruptions that have been caused in the daily routines, the different role functions. We're really working on developing this facet of our program, but in general, my colleague and I, she's a NP, but she's also in LMFT, Nicole Barr. She and I have made arrangements over time to co-manage patients when there's a need to more directly involved with family members. So we cannot not give attention to that. So in other words, we must give attention to the entire unit affected by the illness and whatever emotional distress may be taking place in the associated disruptions, but we don't have a formal arrangement [inaudible 00:19:56].

Ruth Adewuya, M...: That makes sense. On a personal note, I'm actually curious to hear from you a little bit about your journey to the specialty of psychosocial oncology. Will you be willing to share with us how you decided to pursue this specialty?

Sheila Lahijani...: I'm happy to Ruth. I was a combined internal medicine and psychiatry resident in Chicago and I remember working on the heme-onc wards. I remember how challenging it was to bear witness to the suffering that patients experienced, and at the same time, really have such praise and respect for those who were providing care under some of those most vulnerable circumstances. And so that really stuck with me in residency. And while I wasn't planning on pursuing oncology or working as a psychosocial oncology clinician, in a way I was set up for it because of my background on those wards and my combined training. But more personally, I left my residency because my mom actually got diagnosed with leukemia. And over the 18 months of her illness, I was her primary caregiver and I realized how important it is to really address the whole person as part of cancer care.

And instead of going into endocrinology, which is what I had a fellowship, I decided to really redirect my path and my career to focus on the med psych interface and specifically in oncology, because there's plenty of opportunity to do a lot of really meaningful, important work. For me, I am also a psychopharmacologist, and so plenty of opportunity to really understand drug-to-drug interactions and mechanisms, et cetera, especially since oncology is such a dynamic field. So I pursued a fellowship during that fellowship. I worked at the oncology center at Northwestern. I also worked at Memorial Sloan Kettering. And then when I completed my fellowship, I actually came to Stanford with the expectation and understanding that part of my role is really to work as the psychiatric oncologist at the cancer center. And since then, thankfully, I've been given the opportunity to really develop this program. So for me, it wasn't a direct path per se, but in looking back at the experiences I've had in my education, jobs that I've held as well as my personal lived experiences, this makes sense. It's a privilege to be doing what I'm doing quite frankly.

Ruth Adewuya, M...: Obviously Stanford is incredibly fortunate to have you and your team and your leadership in this area. I'm curious with psychosocial oncology growing over the past few decades, how common is it now for cancer centers to have psychosocial oncology programs?

Sheila Lahijani...: That's a great question. And surprisingly yet again, Ruth, this is a subspecialty. And so access to care throughout this country to mental health care is very challenging to begin with, let alone those of us who have maybe some additional training or have had experiences working with this population. In general terms, I know that I have a lot of colleagues at other academic medical institutions, as well as other community hospitals and organizations. All that being said, it is being recognized more and more as being necessary if not critical to cancer care. And in fact, there have been a number of cancer agencies and quality organizations that have been forced screening for distress, screening for suicidal ideation. So there's even more of a need to have these programs available and in place.

What I will say is even with a program available, it does not mean that there's a physician that's a part of it, or a psychologist that's a part of it, or even a therapist. There's many different ways to go about providing these kinds of services. So while I wish that it were something available to each and every patient with cancer, unfortunately that's not the reality. And part of that also has to do, if not a lot of it, with funding as well.

Ruth Adewuya, M...: I want to touch on a point that you mentioned in your response, equity and access. What are some of the challenges that you're seeing in psychosocial oncology around equity and access?

Sheila Lahijani...: Thankfully, there is a lot of work in this area and a significant emphasis on equitable care. I would say particularly given the rise of recent events in the last two years that are pandemic related, that are sociopolitical and its context, as well as the emergence of telemedicine and its accessibility. So topics such as tele-equitability have come to the surface and really improving access for patients to receive mental health services as they undergo cancer care.

And we know there's tremendous importance and significance of language interpretation, cultural humility, the improvement of communication skills among clinicians, in addition to other factors such as food security, transportation barriers, housing-related problems. These are all relevant and important to how patients experience as well as undergo cancer care. And it's really our duty to see all of this through.

Ruth Adewuya, M...: Thank you for that. In our last episode of this podcast, I actually spoke with two clinicians around culturally sensitive and accessible care, specifically around your patient population. How do you navigate some of those cultural differences in either perceptions of cancer or psychiatry within your patient population?

Sheila Lahijani...: What I would say is that I ask my patients questions. I want to learn from them. I want to be able to understand what is playing a role in their experiences as a patient. And if we don't ask, we often assume, and that's fraught with different problems. We always have to keep in mind, we're taking care of people. And while some of us may work in more heterogeneous or potentially less diverse parts of the country or the world, we need to remind ourselves that the perceptions of cancer are still very stigma-ridden. And here in the Bay Area, I take care of many patients who are immigrants or who have families that are living abroad. And there are a lot of challenges in terms of how people may even disclose that they have a cancer illness and that they're going through treatment. That comes up a lot.

I've learned with each and every consultation to ask, "Who have you told? Who knows?" Because otherwise that does affect someone's burden of guilt, someone's way of communicating with his or her loved ones, just as a couple of examples. And these cultural dynamics and how they bring themselves to the cancer illness, all really do deserve attention. I think there ought to be more standardized approaches in terms of how we do this. I know there are different organizations between both medicine and psychiatry, as well as the behavioral sciences that are really trying to take a look at how we can standardize asking questions or listening the responses from our patients so that we can better understand how to take care of them.

Ruth Adewuya, M...: Thank you, Sheila. As we wrap up our conversation, what would you tell a clinician at an institution without your expertise on psychosocial oncology?

Sheila Lahijani...: I think it's really important to know that there is a place for behavioral health and mental health specialists in cancer care. We cannot deny that. And it doesn't necessarily mean someone has psychiatric symptomatology or someone has psychiatric illness per se. It means that patients are suffering from different kinds of distress beyond the physical distress and whatever burdens they have from the cancer diagnosis and treatment. And so it's important to be curious, it's important to ask your patients questions to know what resources you can access locally or on a more national level.

There are many organizations that are committed to psychosocial services and resources in this country. I already mentioned the American Psychosocial Oncology Society. There's CancerCare. There's cancer.net. There are several resources and conferences, and I really am always so excited to meet colleagues who are working in the community who are either the lone providers or providers part of really small institutions or practices who come to the conferences because we all can learn from one another and we all can work with one another to take care of these patients. And we need to feel empowered because there are times we may feel disempowered because we're taking care of patients at such a difficult time in their lives and there is a lot of potential for medical and psychiatric complexity. So in essence, what I'm saying

is be curious, know what's available, what you can access and never hesitate to reach out.

Ruth Adewuya, M...: Thank you for taking the time to share your insights on this growing field of psychosocial oncology.

Sheila Lahijani...: Thank you so much for this opportunity, Ruth, and I'm just so excited and pleased to be leading this program and to work with such remarkable clinicians and look forward to our future conversations.

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