Distress Management


NCCN.org
**Clinical Trials:** NCCN believes that the best management for any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged. To find clinical trials online at NCCN Member Institutions, click here: nccn.org/clinical_trials/physician.html.

**NCCN Categories of Evidence and Consensus:** All recommendations are category 2A unless otherwise specified. See NCCN Categories of Evidence and Consensus.

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Updates in Version 2.2016 of the NCCN Guidelines for Distress Management from Version 1.2016 include:

• The Discussion text has been updated to reflect the changes in the algorithm (MS-1).

Updates in Version 1.2016 of the NCCN Guidelines for Distress Management from Version 3.2015 include:

Global Changes
• The response assessment language changed from “No response” to “No/partial response” throughout the Psychological/Psychiatric Treatment Guidelines.

DIS-3 Standards of Care For Distress Management
• Third bullet revised: “Ideally, patients should be screened for distress at every medical visit as a hallmark of patient-centered care. At a minimum, patients should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status (ie, remission, recurrence, progression, treatment-related complications).”
• Eighth bullet revised: “Medical care contracts should include adequate reimbursement for services provided by mental health professionals.”

DIS-4 Overview of Evaluation and Treatment Process
• Footnote b is new: “See Discussion (MS-8) for information about other validated screening tools.”

DIS-5 Management of Expected Distress Symptoms
• Interventions: First bullet revised, “Acknowledge/validate distress.”

DIS-7 Neurocognitive Disorders (NCD): Dementia
• Second column: Recommendation revised, “Neurologic/cognitive and mental status examination...”

DIS-9 Delirium
• Treatment recommendation revised: “Antipsychotics + behavioral management + family support/education environment.”
• New footnote f added: “Management of withdrawal states may vary depending upon the substance.”
Depressive Disorders

• “No danger to self or others” pathway:
  ‣ Evaluation
    ◊ Under “Evaluation, diagnostic studies...”
      – New arrow sub-bullet added: “Poor concentration.”
    ◊ New bullet added: “Evaluate alcohol and recreational drug use.” (Also for Bipolar and Related Disorders on [DIS-12] and Anxiety Disorders on [DIS-16])
  ‣ Treatment: Recommendation revised for both pathways: “Psychiatric treatment and follow-up/patient and family education.” (Also for Bipolar and Related Disorders on [DIS-12])

• “Danger to self or others” pathway:
  ‣ Evaluation
    ◊ Recommendations under first bullet, “Assure patient safety,” revised as follows:
      – Consider Order psychiatric consultation (Also for DIS-12 and Trauma-and Stressor-Related Disorders: Adjustment Disorders on DIS-18)
      – Consider Removing dangerous objects (Also for DIS-12 and DIS-18)
    ◊ New bullet added: “Evaluate suicide and homicide risk.” (Also for DIS-12 and DIS-18)

Schizophrenia Spectrum and Other Psychotic Disorders

DIS-14
• After “Signs and symptoms...”; Second column; Second bullet revised: “Obtain history of medications/substances (such as corticosteroid) use.”

DIS-15
• Treatment: Second bullet revised, “Consider anti-psychotic medications (urgently administer if necessary).”

Trauma and Stressor-Related Disorders

DIS-17
• First column: “Acute stress disorder” was added to the list of signs and symptoms.

Recommended Readings for Implementation of Psychosocial Care into the Routine Care of Patients with Cancer

DIS-34
The term “distress” was chosen because it:

• Is more acceptable and less stigmatizing than “psychiatric,” “psychosocial,” or “emotional”

• Sounds “normal” and less embarrassing

• Can be defined and measured by self-report
DEFINITION OF DISTRESS IN CANCER

Distress is a multifactorial unpleasant emotional experience of a psychological (ie, cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.
STANDARDS OF CARE FOR DISTRESS MANAGEMENT

- Distress should be recognized, monitored, documented, and treated promptly at all stages of disease and in all settings.

- Screening should identify the level and nature of the distress.

- Ideally, patients should be screened for distress at every medical visit as a hallmark of patient-centered care. At a minimum, patients should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status (ie, remission, recurrence, progression, treatment-related complications).

- Distress should be assessed and managed according to clinical practice guidelines.

- Interdisciplinary institutional committees should be formed to implement standards for distress management.

- Educational and training programs should be developed to ensure that health care professionals and certified chaplains have knowledge and skills in the assessment and management of distress.

- Licensed mental health professionals and certified chaplains experienced in psychosocial aspects of cancer should be readily available as staff members or by referral.

- Medical care contracts should include adequate reimbursement for services provided by mental health professionals.

- Clinical health outcomes measurement should include assessment of the psychosocial domain (eg, quality of life and patient and family satisfaction).

- Patients, families, and treatment teams should be informed that distress management is an integral part of total medical care and is provided with appropriate information about psychosocial services in the treatment center and the community.

- Quality of distress management programs/services should be included in institutional continuous quality improvement (CQI) projects.
**Clinical evidence of moderate to severe distress or score of 4 or more on screening tool (DIS-A)**

- Clinical evidence of unrelieved physical symptoms, treat as per disease-specific or supportive care guidelines (DIS-A)

**Brief screening for distress (DIS-A):**
- Screening tool
- Problem list

**Unrelieved physical symptoms, treat as per disease-specific or supportive care guidelines**

**Clinical evidence of mild distress or score of less than 4 on screening tool (DIS-A)**

**OVERVIEW OF EVALUATION AND TREATMENT PROCESS**

**EVALUATION**

- Clinical assessment (which may include clinical interviews, and validated scales/screeners for anxiety and depression) by primary oncology team of oncologist, nurse, social worker for:
  - High-risk patients
  - Periods of vulnerability
  - Risk factors for distress
  - Practical problems
  - Family problems
  - Spiritual/religious concerns
  - Physical problems
  - Social problems
  - Emotional problems, including anxiety and depression

**TREATMENT**

- Mental health professional
- Social work and counseling services
- Chaplaincy care
- Primary oncology team + resources available
- See Expected Distress Symptoms (DIS-5)

**Referral**

If necessary

- Follow-up and communication with primary oncology team and family/caregivers
- See Psychological/Psychiatric Treatment Guidelines (DIS-6)
- See Social Work and Counseling Services (DIS-24)
- See Chaplaincy Care (DIS-26)

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*aThe Problem List of the NCCN Distress Thermometer Screening Tool may be modified to fit the needs of the local population.

*bSee Discussion (MS-8) for information about other validated screening tools.

*cConsider referral for palliative care management (See NCCN Guidelines for Palliative Care).

*dSee Psychosocial Distress Patient Characteristics (DIS-B).

*ePsychiatrist, psychologist, advanced practice clinicians, and/or social worker.
### Distress Management

### MANAGEMENT OF EXPECTED DISTRESS SYMPTOMS

<table>
<thead>
<tr>
<th>EXPECTED DISTRESS SYMPTOMS</th>
<th>INTERVENTIONS</th>
<th>RE-EVALUATION</th>
</tr>
</thead>
</table>
| **Patients at increased risk for distress**
  - Signs and symptoms of fear and worry about the future and uncertainty
    - Concerns about illness
    - Sadness about loss of usual health
    - Anger, feeling out of control
    - Poor sleep
    - Poor appetite
    - Poor concentration
    - Preoccupation with thoughts of illness and death
    - Disease or treatment side effects
    - Concerns about social role (ie, as father, mother)
| • Acknowledge/validate distress
  • Clarify diagnosis, treatment options, and side effects
    - Be sure patient understands disease and treatment options
    - Refer to appropriate patient education materials (eg, [NCCN Guidelines for Patients](http://www.nccn.org/professionals/physician_gls/pdf/patients.pdf))
  • Educate patient that points of transition may bring increased vulnerability to distress
  • Build trust
  • Ensure continuity of care
  • Mobilize resources
  • Consider medication to manage symptoms:
    - Analgesics ([See NCCN Guidelines for Adult Cancer Pain](http://www.nccn.org/patients/guidelines/pdfs/AdultCancerPain.pdf))
    - Anxiolytics
    - Hypnotics
    - Antidepressants
  • Support groups and/or individual counseling
  • Family support and counseling
  • Relaxation, meditation, creative therapies (eg, art, dance, music)
  • Spiritual support
  • Exercise | **Stable or diminished distress**
  | **Monitor functional level and reevaluate at each visit**
  | **Increased or persistent distress**
  | **See Distress Score ≥4 or moderate to severe distress (DIS-4)**
  | **Continue monitoring and support**

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See Psychosocial Distress Patient Characteristics (DIS-B).

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See Distress Score ≥4 or moderate to severe distress (DIS-4).
Distress Management

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress
0
1
2
3
4
5
6
7
8
9
10

No distress

PROBLEM LIST
Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES NO

Practical Problems

- Child care
- Housing
- Insurance/financial
- Transportation
- Work/school
- Treatment decisions

Physical Problems

- Appearance
- Bathing/dressing
- Breathing
- Changes in urination
- Constipation
- Diarrhea
- Eating
- Fatigue
- Feeling swollen
- Fevers
- Getting around
- Indigestion
- Memory/concentration
- Mouth sores
- Nausea
- Nose dry/congested
- Pain
- Sexual
- Skin dry/itchy
- Sleep
- Substance abuse
- Tingling in hands/feet

Family Problems

- Dealing with children
- Dealing with partner
- Ability to have children
- Family health issues

Emotional Problems

- Depression
- Fears
- Nervousness
- Sadness
- Worry
- Loss of interest in usual activities

Spiritual/religious concerns

Other Problems: ________________________________
PATIENTS AT INCREASED RISK FOR DISTRESS

- History of psychiatric disorder/substance abuse
- History of depression/suicide attempt
- Cognitive impairment
- Communication barriers
- Severe comorbid illnesses
- Social issues
  - Family/caregiver conflicts
  - Inadequate social support
  - Living alone
  - Financial problems
  - Limited access to medical care
  - Young or dependent children
  - Younger age
  - Female
  - History of abuse (physical, sexual)
  - Other stressors
- Spiritual/religious concerns
- Uncontrolled symptoms

PERIODS OF INCREASED VULNERABILITY

- Finding a suspicious symptom
- During diagnostic workup
- Finding out the diagnosis
- Awaiting treatment
- Change in treatment modality
- Significant treatment-related complication(s)
- End of treatment
- Discharge from hospital following treatment
- Transition to survivorship
- Medical follow-up and surveillance
- Treatment failure
- Recurrence/progression
- Advanced cancer
- End of life


From the NCCN Guidelines for Palliative Care.

Communication barriers include language, literacy, and physical barriers.
Referral by oncology team to mental health team\(^e\)

**PSYCHOLOGICAL/PSYCHIATRIC TREATMENT GUIDELINES**

Evaluation for:
- Distress
- Behavior symptoms
- Psychiatric history/medications
- Pain and symptom control (NCCN Guidelines for Adult Cancer Pain)
- Body image/sexuality
- Impaired capacity
- Safety
- Psychological/psychiatric disorder
- Medical causes (refer to primary oncology team)

Follow-up and communication with primary oncology team and family/caregivers

- Neurocognitive Disorders: Dementia (DIS-7)
- Neurocognitive Disorders: Delirium (DIS-9)
- Depressive Disorders (DIS-10)
- Bipolar and Related Disorders (DIS-12)
- Schizophrenia Spectrum and Other Psychotic Disorders (DIS-14)
- Anxiety Disorders (DIS-16)
- Trauma and Stressor-Related Disorders (DIS-17)
- Trauma and Stressor-Related Disorders: Adjustment Disorders (DIS-18)
- Obsessive Compulsive Disorder (DIS-20)
- Substance-Related and Addictive Disorders (DIS-21)
- Personality Disorders (DIS-23)

\(^e\)Psychiatrist, psychologist, advanced practice clinicians, and/or social worker.

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NEUROCOGNITIVE DISORDERS (NCD):
DEMENTIA

Signs and symptoms of dementia in cancer

Neurologic/cognitive and mental status examination ± neuropsychological testing

No impairment

Evaluate for depression

Negative

Observe

Positive

See Depressive Disorders (DIS-10)

Impairment present

Evaluate for
- NCD: Delirium
- NCD: Dementia
- Assess safety
- Assess capacity to make decisions

NCD: Delirium

See NCD: Delirium (DIS-9)

NCD: Dementia

See NCD: Dementia (DIS-8)

Decision-making capacity and safety impaired

Document and refer to institutional policies and procedures

Thought disorder/psychosis

Arrange for ongoing primary psychiatric management

Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)
NEUROCOGNITIVE DISORDERS (NCD):
DEMENTIA

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications
  - Medical causes
  - Withdrawal states
  - Pain, fatigue, sleep problems, and other symptoms
- Assess safety
- Assess family/caregiver resources

TREATMENT

Cognitive rehabilitation ± medications

No/partial response

Response

FOLLOW-UP

- Reevaluate
- Attend to patient safety
- Consider capacity to make decisions
- Refer to social services
- Consider alternate level of care

Follow-up and communication with primary oncology team and family/caregivers

Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)
<table>
<thead>
<tr>
<th>Signs and symptoms of delirium in cancer</th>
<th>Evaluation, diagnostic studies, and modification of factors related to:</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Treatment</td>
</tr>
<tr>
<td>Medications</td>
<td>Medical causes</td>
</tr>
<tr>
<td>Withdrawal states</td>
<td>Pain and other symptoms</td>
</tr>
<tr>
<td>Assessment</td>
<td>Assessment of decision-making capacity</td>
</tr>
</tbody>
</table>

Antipsychotics + behavioral management + family support/education environment

Response

Response

Augment medication
Continue:
- Support
- Education
- Safety
- Assess decision-making capacity
- Re-evaluate cause of delirium

Follow-up and communication with primary oncology team and family/caregivers

Consider NCD: dementia

No/partial response

Reevaluate

Management of withdrawal states may vary depending upon the substance.

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Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)
DEPRESSIVE DISORDERS

Signs and symptoms of depressive disorders in cancer including:
- Depressive disorders related to medical illness
- Major depressive disorders
- Dysthymia

EVALUATION

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications
  - Medical causes
  - Withdrawal states
  - Pain
  - Fatigue
  - Insomnia
  - Anorexia
  - Anhedonia
  - Decreased interest in activities
  - Wish to die
  - Suicidal thoughts
  - Mood swings
  - Poor concentration
  - Consider psychosocial and spiritual concerns
  - Assess decision-making capacity
  - Assess safety
  - Evaluate family/home environment
  - Evaluate alcohol and recreational drug use

TREATMENT

- Psychotherapy
- Psychotropic medication (category 1)
- Psychiatric treatment and follow-up/patient and family education
- Consider referral to social work services or chaplaincy care
  See Social Work and Counseling Services (DIS-24) or Chaplaincy Care (DIS-26)

FOLLOW-UP

No/partial response → See (DIS-11)

Response → Follow-up and communication with primary oncology team and family/caregivers

- Psychediatric treatment and follow-up/patient and family education

No danger to self or others

Danger to self or others

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DEPRESSIVE DISORDERS
(continued)

**EVALUATION**

- Reevaluate diagnosis and response/adjust medications as indicated ± psychotherapy

**TREATMENT**

- Consider augmenting or changing medications
- Consider electroconvulsive therapy
- Consider consult/second opinion

**FOLLOW-UP**

- Follow-up and communication with primary oncology team and family/caregivers

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**Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)**

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BIPOLAR AND RELATED DISORDERS

Signs and symptoms of bipolar and related disorders, including:
- Bipolar and related disorders due to medical illness
- Bipolar I and bipolar II
- Cyclothymic disorder

EVALUATION
- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications
  - Medical causes
  - Withdrawal states
  - Pain
  - Fatigue
  - Insomnia
  - Anorexia
  - Anhedonia
  - Decreased interest in activities
  - Wish to die
  - Suicidal thoughts
  - Mood swings
  - Consider psychosocial and spiritual concerns
  - Assess decision-making capacity
  - Assess safety
  - Evaluate family/home environment
  - Evaluate alcohol and recreational drug use

TREATMENT
- Psychotherapy
- Psychotropic medication (category 1)
- Psychiatric treatment and follow-up/patient and family education
- Consider referral to social work services or chaplaincy care

FOLLOW-UP
- No/partial response
- Follow-up and communication with primary oncology team and family/caregivers

No danger to self or others

Danger to self or others

Psychiatric treatment and follow-up/patient and family education

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BIPOLAR AND RELATED DISORDERS (continued)

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<thead>
<tr>
<th>EVALUATION</th>
<th>TREATMENT</th>
<th>FOLLOW-UP</th>
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<tbody>
<tr>
<td>No or partial response to treatment for signs and symptoms of bipolar and related disorders in cancer</td>
<td>• Reevaluate diagnosis and response/adjust medications as indicated ± psychotherapy</td>
<td>• Consider augmenting or changing medications • Consider electroconvulsive therapy • Consider consult/second opinion</td>
</tr>
</tbody>
</table>

- No/partial response
- Response

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SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

EVALUATION

No active signs of psychosis

Signs and symptoms of psychotic episode in cancer or history of schizophrenia/psychotic disorder

• Obtain history of psychosis/schizophrenia/affective psychosis
• Obtain history of medications/substances (such as corticosteroid)
• Neurologic and mental status examination

Psychotic signs on mental status examination (especially hallucination/delusion/thought disorder)

• Evaluate for:
  ‣ NCD: Delirium
  ‣ Steroid-induced psychosis
  ‣ Substance-related and addictive disorders
  ‣ New diagnosis or relapse of psychotic disorder
  ‣ Depressive disorders
  ‣ Bipolar and related disorders
  ‣ NCD: Dementia
  ‣ Akathisia from antipsychotics or antiemetics
• Assess safety
• Assess capacity to make decisions
• Evaluate family/home environment

Follow-up and communication with primary oncology team and family/caregivers

NCD: Dementia

See DIS-7

NCD: Delirium

See DIS-9

Depressive disorders

See DIS-10

Bipolar and related disorders

See DIS-12

Schizophrenia spectrum and other psychotic disorders

See DIS-15

Substance-related disorder and addictive disorders

See DIS-21

Decision-making capacity and safety impaired

Document and refer to institutional policies and procedures

Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)

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SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS (continued)

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications (particularly steroids)
  - NCD: Delirium
  - NCD: Dementia
  - Withdrawal states or substance abuse
  - New diagnosis of psychotic disorder
  - Relapse of psychotic disorder (eg, not taking maintenance antipsychotic medications)
    - Evaluate barriers to medication adherence
  - Assess safety
  - Assess capacity to make decisions
  - Assess family/caregiver resources including inpatient psychiatry hospitalization and community mental health team

TREATMENT

- Secure safety
- Consider antipsychotic medications (urgently administer)
- Consider medications for mood
- Consider transfer to psychiatric unit/hospital
- Consider role of electroconvulsive therapy in psychotic depression/mania, catatonia

FOLLOW-UP

- Reevaluate
- Attend to patient safety
- Consider capacity to make decisions
- Maintain communication with team for chronic psychotic disorder/psychiatric service
- Consider alternate level of care
- Follow-up and communication with primary oncology team and family/caregivers

No/partial response

Response

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### Anxiety Disorders

#### Signs and symptoms of anxiety disorder in cancer:
- Anxiety due to general medical condition
- Generalized anxiety disorder
- Panic disorder
- Phobic disorder
- Conditioned nausea/vomiting

(See NCCN Guidelines for Antiemesis)

#### Evaluation

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Nausea/vomiting
  - Medications
  - Medical causes
  - Withdrawal states
  - Pain
  - Poor concentration
  - Insomnia
  - Anxiety or panic attacks
  - Hypervigilance
  - Fears
  - Irritability
- Assess safety
- Assess decision-making capacity
- Evaluate family and home environment
- Evaluate alcohol and recreational drug use

#### Treatment

- Psychotherapy ± anxiolytic ± antidepressant (category 1)

#### Follow-up

- Evaluate for depression and other psychiatric comorbidity
- Reevaluate medication (consider antipsychotics), psychotherapy, support, education
- No/partial response
- Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)

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### Trauma and Stressor-Related Disorders

<table>
<thead>
<tr>
<th>Signs and symptoms of trauma and stressor-related disorders in cancer:</th>
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<tbody>
<tr>
<td>• Post-traumatic stress disorder</td>
</tr>
<tr>
<td>• Adjustment disorder</td>
</tr>
<tr>
<td>• Acute stress disorder</td>
</tr>
</tbody>
</table>

**Evaluation**

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications
  - Medical causes
  - Pain
  - Poor concentration
  - Insomnia
  - Anxiety or panic attacks
  - Hypervigilance
  - Fears
  - Irritability
- Assess safety
- Assess decision-making capacity
- Evaluate family and home environment

**Treatment**

- Psychotherapy ± anxiolytic ± antidepressant (category 1)

**Follow-Up**

- No/partial response
  - Reevaluate medication (consider antipsychotics), psychotherapy, support, education
  - Evaluate for depression and other psychiatric comorbidity
  - No/partial response
  - Response
  - Follow-up and communication with primary oncology team and family/caregivers

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**TRAUMA AND STRESSOR-RELATED DISORDERS: ADJUSTMENT DISORDERS**

**EVALUATION**

- **No danger to self or others**
  - Signs and symptoms of adjustment disorders in cancer (mixed anxiety and depressive symptoms)

- **Danger to self or others**
  - • Assure patient safety:
    - ‣ Order psychiatric consultation
    - ‣ Increase monitoring
    - ‣ Remove dangerous objects
    - ‣ Consider hospitalization
    - ‣ Evaluate suicide and homicide risk

**TREATMENT**

- **Moderate/severe adjustment disorder**
  - Medications prescribed and/or psychotherapy
  - No/partial response → Adjust medications/dosages
  - Response

- **Mild adjustment disorder**
  - No medications prescribed
  - Initiate psychotherapy/counseling
  - No/partial response → Follow-up and communication with primary oncology team and family/caregivers

**FOLLOW-UP**

- See Reevaluate moderate/severe adjustment (DIS-19)
- See Reevaluate mild adjustment (DIS-19)

Follow-up for hospitalized patients and outpatients

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TRAUMA AND STRESSOR-RELATED DISORDERS:
ADJUSTMENT DISORDERS (continued)

Reevaluate patients with moderate/severe adjustment disorders after adjusting medications/dosages

Response

- Another disorder without personality disorders
  - See appropriate psychological/psychiatric pathway (DIS-6)
- No/partial response
  - Personality disorders
    - See Personality Disorders (DIS-23)
  - Continue therapy
    - Reevaluate

Reevaluate patients with mild adjustment disorders after psychotherapy/counseling

- Adjustment disorders
  - Medications prescribed and/or psychotherapy (DIS-16)
- Another disorder without personality disorders
  - See appropriate psychological/psychiatric pathway (DIS-6)
- Personality disorders
  - See Personality Disorders (DIS-23)

Follow-up and communication with primary oncology team and family/caregivers

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OBSESSIVE COMPULSIVE AND RELATED DISORDERS

EVALUATION

- Evaluation, diagnostic studies, and modification of factors related to:
  - Cancer
  - Treatment
  - Medications
  - Medical causes
  - Withdrawal states
- Poor concentration
- Insomnia
- Anxiety or panic attacks
- Hypervigilance
- Fears
- Irritability
- Assess safety
- Assess decision-making capacity
- Evaluate family and home environment

TREATMENT

- Psychotherapy ± anxiolytic ± antidepressant (category 1)

FOLLOW-UP

- Evaluation for depression and other psychiatric comorbidity

Signs and symptoms of obsessive compulsive and related disorders in cancer:
- Obsessive-compulsive disorders

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## Distress Management

**SUBSTANCE-RELATED AND ADDICTIVE DISORDERS**

### Evaluation

- Signs, symptoms, and history of dependence, active abuse, or addiction[^1]  
  *(See NCCN Guidelines for Adult Cancer Pain)*

### Treatment

- Current substance abuse dependence
  - Treat symptoms
  - Substance abuse management program

- History of abuse
  - Discuss risk reduction strategies
  - Consider referral to risk reduction program or substance management program
  - Monitor for signs and symptoms of relapse

### Comments

- Opioids, alcohol, tobacco, or other.

### Note

All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

[^1]: Opioids, alcohol, tobacco, or other.
SUBSTANCE-RELATED AND ADDICTIVE DISORDERS (continued)

Following appropriate detoxification regimen:

- No/partial response: Evaluate for continued drug abuse → Treatment team meeting → Reevaluate for other psychiatric comorbidity → See appropriate psychological/psychiatric pathway (DIS-6)
- Response: Psychoeducation ± psychotherapy ± medications → Referral to specialized maintenance program or Discuss strategies for abuse prevention → Follow-up and communication with primary oncology team and family/caregivers

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Signs and symptoms of personality disorders in cancer:
- Personality change related to medical or treatment factors
  - Borderline
  - Dramatic/histrionic
  - Schizoid
  - Obsessive
  - Paranoid
  - Antisocial
  - Narcissistic

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.


Return to Psychological/Psychiatric Treatment Guidelines (DIS-6)
**Social Work and Counseling Services**

<table>
<thead>
<tr>
<th>Category</th>
<th>Type of Problem</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Practical problems| • Illness-related problems
• Concrete needs, including housing, food, financial assistance programs, assistance with activities of daily living, and transportation
• Employment/school/career concerns
• Cultural/language issues
• Family and caregiver availability | • Patient and family counseling/psychotherapy
• Community resource mobilization/linkage
• Problem-solving teaching
• Advocacy and patient/family education |
| Severe/moderate    |                                                                                   | Follow-up and communication with primary oncology team and family/caregivers |
| Mild               | • Patient/family education
• Education/support group sessions
• Resource lists    |                                                                                |

Social work and counseling services include mental health services using psychological/psychiatric treatment guidelines.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
**Psychosocial problems**

| CATEGORY | TYPE OF PROBLEM                                                                                                                                                                                                 | SOCIAL WORK AND COUNSELING
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------ |
| **Adjustment to illness** | - Family and social conflict/isolation  
- Treatment decisions, quality-of-life issues, and transitions in care  
- Advance directive  
- Abuse and neglect  
- Coping/communication  
- Functional changes including body image and sexuality  
- End of life/bereavement  
- Cultural concerns  
- Caregiver issues (mobilizing caregiver support) | - Patient and family counseling/psychotherapy, sex counseling, or grief counseling  
- Community resource mobilization  
- Problem-solving teaching  
- Advocacy and family/patient education  
- Education/support group sessions  
- Protective services  
- Consider referral for psychosocial/psychiatric treatment  
- Consider referral for chaplaincy counseling |

**Severe/moderate**

<table>
<thead>
<tr>
<th><strong>Follow-up and communication with primary oncology team and family/caregivers</strong></th>
</tr>
</thead>
</table>
| \*Patient/family education*  
\*Education/support group sessions*  
\*Resource lists*  
\*Sex counseling*  
\*Grief counseling* |

**Mild**

<table>
<thead>
<tr>
<th><strong>Interactions</strong></th>
</tr>
</thead>
</table>
| \*Patient and family counseling/psychotherapy, sex counseling, or grief counseling*  
\*Community resource mobilization*  
\*Problem-solving teaching*  
\*Advocacy and family/patient education*  
\*Education/support group sessions*  
\*Protective services*  
\*Consider referral for psychosocial/psychiatric treatment*  
\*Consider referral for chaplaincy counseling* |

\*Social work and counseling services include mental health services using psychological/psychiatric treatment guidelines.\*

**Note:** All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
CHAPLAINCY CARE

Referral by oncology team to chaplaincy care

Follow-up and communication with primary oncology team and family/caregivers

Chaplaincy assessment

Grief (DIS-27)
Concerns about death and afterlife (DIS-27)
Conflicted or challenged belief systems (DIS-27)
Loss of faith (DIS-27)
Concerns with meaning/purpose of life (DIS-27)
Concerns about relationship with deity (DIS-27)
Isolation from religious community (DIS-28)
Guilt (DIS-29)
Hopelessness (DIS-30)
Conflict between religious beliefs and recommended treatments (DIS-31)
Ritual needs (DIS-32)

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Evidence of:
- Grief
- Concerns about death and afterlife
- Conflicted or challenged belief systems
- Loss of faith
- Concerns with meaning/purpose of life
- Concerns about relationship with deity

- Spiritual counseling
- Reading materials (spiritual, philosophical)
- Prayer
- Rituals

Concerns relieved

Yes → Continued support

No → Consider referral to mental health professional

Refer to mental health professional (DIS-4)

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
CHAPLAINCY CARE: ISOLATION FROM RELIGIOUS COMMUNITY

Current member of religious community
• Spiritual assessment/counseling
• Serve as liaison between patient and religious community

Not current member of religious community
Spiritual assessment
Assist patient to access spiritual resources

Participation in religious community resumed
Refer to local congregation
Refer to local congregation or certified chaplain
Refer to mental health professional
Continuing support

Evidence of isolation

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

1Consider referral to community religious resource.
CHAPLAINCY CARE: GUILT

Severe depressive symptoms and/or suicidal ideation present

- Refer to mental health professional for further assessment, intervention, and follow-up
- Spiritual counseling

Guilt expressed

No severe depressive symptoms and/or suicidal ideation present

- Spiritual counseling

Reconciliation ritual desired

Reconciliation ritual not desired

Reconciliation ritual performed

Guilt not relieved

Guilt relieved

Continuing support

Spiritual counseling

Refer to mental health professional

Consider referral to community religious resource.

Note: All recommendations are category 2A unless otherwise indicated. Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.


**CHAPLAINCY CARE: HOPELESSNESS**

<table>
<thead>
<tr>
<th>Hopelessness expressed</th>
<th>Severe depressive symptoms and/or suicidal ideation present</th>
<th>No severe depressive symptoms and/or suicidal ideation not present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Refer to mental health professional for further assessment, intervention, and follow-up</td>
<td>• Spiritual counseling(^1) Palliative/supportive care consultation</td>
</tr>
<tr>
<td></td>
<td>• Spiritual counseling(^1) Palliative/supportive care consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms relieved</td>
<td>Symptoms not relieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continuing support</td>
<td>Continuing support</td>
</tr>
</tbody>
</table>

\(^1\)Consider referral to community religious resource.

---

**Note:** All recommendations are category 2A unless otherwise indicated.

**Clinical Trials:** NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Evidence of conflict between religious beliefs and recommended treatment

Physician consultation to clarify treatment options and goals of care

Assess decision-making capacity
Mental health consult if indicated

Decision-making capacity present
Spiritual counseling

Decision-making capacity absent
Refer to mental health professional

Conflict resolved
continuing support

Conflict not resolved
Ethics/palliative care consultation

Conflict not resolved
Spiritual counseling

Conflict resolved

Consider referral to community religious resource.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Evidence of ritual needs

Refer to clergy of person’s faith or Chaplain provides ritual if appropriate

Ritual needs met

Continuing support

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
RECOMMENDATIONS FOR IMPLEMENTATION OF STANDARDS AND GUIDELINES

- Encourage establishment of institutional interdisciplinary committees for implementation of standards and guidelines.
- Conduct multicenter trials that explore brief screening instruments and pilot treatment guidelines.
- Encourage institutional CQI (continuous quality improvement) projects in quality of distress management.
- Develop educational approaches to distress management for staff, patients, and family.

RECOMMENDED READINGS FOR IMPLEMENTATION OF PSYCHOSOCIAL CARE INTO THE ROUTINE CARE OF PATIENTS WITH CANCER

RECOMMENDED READINGS FOR IMPLEMENTATION OF
PSYCHOSOCIAL CARE INTO THE ROUTINE CARE OF PATIENTS WITH CANCER (continued)

### INSTITUTIONAL EVALUATION OF STANDARDS OF CARE

#### INTERVENTIONS
- Interdisciplinary committee tailors standards to institutional setting
- Screening tool (0–10) in clinics and inpatient setting
- Problem list
- Education of primary oncology teams via rounds and liaison with nurses and social workers
- Clarification of resources access (psychological, social, religious)
- CQI studies

#### OUTCOMES
- Surveys
- Professional Attitudes
- Knowledge Assessment
- Patient Satisfaction
  - (CQI survey of impact)

**DIS-35**

---

1Based on implementation/evaluation of pain management guidelines.

**Note:** All recommendations are category 2A unless otherwise indicated. Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.
Discussion

NCCN Categories of Evidence and Consensus

Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise noted.

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Overview

In the United States, it is estimated that a total of 1,658,370 new cancer cases and 589,430 deaths from cancer will occur in 2015. All patients experience some level of distress associated with the cancer diagnosis and the effects of the disease and its treatment regardless of the stage of disease. Distress can result from the reaction to the cancer diagnosis and to the various transitions throughout the trajectory of the disease, including during survivorship. Clinically significant levels of distress occur in a subset of patients, and identification and treatment of distress are of the utmost importance.

These NCCN Guidelines for Distress Management discuss the identification and treatment of psychosocial problems in patients with cancer. They are intended to assist oncology teams to identify patients who require referral to psychosocial resources and to give oncology teams guidance on interventions for patients with mild distress. These guidelines also provide guidance for social workers, certified chaplains, and mental health professionals by describing treatments and interventions for various psychosocial problems as they relate to patients with cancer.

Literature Search Criteria and Guidelines Update Methodology

Prior to the update of this version of the NCCN Guidelines for Distress Management, an electronic search of the PubMed database was performed to obtain key literature published between October 16, 2014 and December 2, 2015, using the following search terms: (cancer distress) or (cancer depression) or (cancer anxiety) or (cancer dementia) or (cancer delirium) or (cancer mood disorder) or (cancer adjustment disorder) or (cancer cognitive) or (cancer schizophrenia) or (cancer psychotic disorder) or (cancer substance abuse) or (cancer alcohol abuse) or (cancer personality disorder) or (cancer social work) or (cancer spiritual) or (cancer religion) or (cancer chaplain). The PubMed database was chosen because it remains the most widely used resource for medical literature and indexes only peer-reviewed biomedical literature.

The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase II; Clinical Trial, Phase III; Clinical Trial, Phase IV; Guideline; Practice Guidelines; Randomized Controlled Trials; Meta-Analysis; Systematic Reviews; and Validation Studies. The PubMed search resulted in 235 citations, and their potential relevance was examined. The data from key PubMed articles and articles from additional sources deemed as relevant to these guidelines and discussed by the panel have been included in this version of the Discussion section (eg, e-publications ahead of print, meeting abstracts). Recommendations for which high-level evidence is lacking are based on the panel’s review of lower-level evidence and expert opinion.

The complete details of the Development and Update of the NCCN Guidelines are available on the NCCN website (available at www.NCCN.org).

Psycosocial Problems in Patients with Cancer

In recent decades, dramatic advances in early detection and treatment options have increased the overall survival rates in patients of all ages with cancer. At the same time, these improved treatment options are also associated with substantial long-term side effects that interfere with patients’ ability to perform daily activities, such as fatigue, pain, anxiety, and depression. In addition, the physiologic effects of cancer itself and
certain anti-cancer drugs can also be non-psychological contributors to distress symptoms.\(^3\)\(^6\) Furthermore, patients with cancer may have pre-existing psychological or psychiatric conditions that impact their ability to cope with cancer.

The prevalence of psychological distress in individuals varies by the type and stage of cancer as well as by patient age, gender, and race.\(^7\) In a study of 4496 patients with cancer, Zabora and colleagues reported that the overall prevalence of distress was 35.1%, which varied from 29.6% for patients with gynecologic cancers to 43.4% for patients with lung cancer.\(^8\) The prevalence of distress, depression, and psychiatric disorders has been studied in many sites and stages of cancer.\(^9\)-\(^15\) Overall, surveys have found that 20% to 47% of patients show a significant level of distress.\(^16\),\(^17\) A meta-analysis reported that 30% to 40% of patients with various types of cancer have some combination of mood disorders.\(^18\)

Patients at increased risk for moderate or severe distress are those with a history of psychiatric disorder, depression, or substance abuse and those with cognitive impairment, severe comorbid illnesses, uncontrolled symptoms, communication barriers, or social issues. Social issues/risk factors include younger age, being female, living alone, having young children, and prior physical or sexual abuse.

Distress is a risk factor for non-adherence to treatment, especially with oral medications. In women with primary breast cancer, Partridge and colleagues observed that the overall adherence to tamoxifen decreased to 50% in the fourth year of therapy and nearly one fourth of patients may be at risk of inadequate clinical response due to poor adherence.\(^19\) In a meta-analysis, DiMatteo and colleagues found that noncompliance was 3 times greater in depressed patients compared to non-depressed patients.\(^20\) In addition to decreased adherence to treatment, failure to recognize and treat distress may lead to several problems: patients may have trouble making decisions about treatment and may make extra visits to the physician's office and emergency room, which takes more time and causes greater stress to the oncology team.\(^21\),\(^22\) Distress in patients with cancer also leads to poorer quality of life and may even negatively impact survival.\(^15\),\(^23\)-\(^25\) Furthermore, survivors with untreated distress have poorer compliance with surveillance screenings and are less likely to exercise and quit smoking.\(^26\)

Early evaluation and screening for distress leads to early and timely management of psychological distress, which in turn improves medical management.\(^27\),\(^28\) A randomized study showed that routine screening for distress, with referral to psychosocial resources as needed, led to lower levels of distress at 3 months than did screening without personalized triage for referrals.\(^29\) Those with the highest level of initial distress benefitted the most. In addition, there is evidence from randomized trials that psychologically effective interventions may lead to a survival advantage in patients with cancer.\(^30\)-\(^32\) Overall, early detection and treatment of distress lead to:

- better adherence to treatment,
- better communication,
- fewer calls and visits to the oncologist's office, and
- avoidance of patients' anger and development of severe anxiety or depression.

Barriers to Distress Management in Cancer

Less than half of distressed patients with cancer are actually identified and referred for psychosocial help.\(^33\),\(^34\) Many patients with cancer who are in need of psychosocial care are not able to get the help they need because of the under-recognition of patients' psychological needs by the primary oncology team and lack of knowledge of community...
The need is particularly acute in community oncologists’ practices where there are few to no psychosocial resources and cancer care is often provided by short visits.

An additional barrier to patients receiving the psychosocial care they require is the stigma associated with psychological problems. For many centuries, patients were not told their diagnosis of cancer due to the stigma attached to the disease. Since the 1970s, this situation has changed and patients are well aware of their diagnosis and treatment options. However, patients are reluctant to reveal emotional problems to the oncologist. The words “psychological,” “psychiatric,” and “emotional” are as stigmatizing as the word “cancer.” The word “distress” is less stigmatizing and more acceptable to patients and oncologists than these terms, but psychological issues remain stigmatized even in the context of coping with cancer. Consequently, patients often do not tell their physicians about their distress and physicians do not inquire about the psychological concerns of their patients. The recognition of patients’ distress has become more difficult as cancer care has shifted to the ambulatory setting, where visits are often short and rushed. These barriers prevent distress from receiving the attention it deserves, despite the fact that distress management is a critical component of the total care of the person with cancer.

The first step was to understand why this area has been so difficult to develop. The panel members decided that words like “psychiatric” or “psychological” are stigmatizing; patients and oncologists were reluctant to label any symptoms or patients as such. The way around this barrier was developed by using a term that would feel “normal” and non-stigmatizing. This led to the first published guidelines in 1999 for the management of distress in patients with cancer. This accomplishment provided a benchmark, which has been used as a framework in the handbook for oncology clinicians published by the IPOS press (International Psycho-Oncology Society).

The panel defines distress as a multifactorial, unpleasant, emotional experience of a psychological (ie, cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common, normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.

Recommendations in the guidelines are based on evidence and on consensus among panel members. In addition to the guidelines for oncologists, the panel established guidelines for social workers, certified chaplains, and mental health professionals (psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses).
The New Standard of Care for Distress Management in Cancer

Psychosocial care had not been considered as an aspect of quality cancer care until the publication of a 2007 Institute of Medicine (IOM) report, *Cancer Care for the Whole Patient*.[39] The IOM report is based on the pioneering work of the NCCN Panel, which recommends screening for distress and the development of a treatment plan with referrals as needed to psychosocial resources. Psychosocial care is now a part of the new standard for quality cancer care and should be integrated into routine care.[39-41] The IOM report supported the work of the NCCN Guidelines for Distress Management by proposing a model for the effective delivery of psychosocial health services that could be implemented in any community oncology practice:

- Screening for distress and psychosocial needs,
- Making and implementing a treatment plan to address these needs,
- Referring to services as needed for psychosocial care, and
- Reevaluating, with plan adjustment as appropriate.

In Canada, routine psychosocial care is part of the standard of care for patients with cancer; emotional distress is considered the sixth vital sign that is checked routinely along with pulse, respiration, blood pressure, temperature, and pain.[21,42]

In August 2012, the Commission on Cancer (CoC) of the American College of Surgeons (ACS) released new accreditation standards for hospital cancer programs ([http://www.facs.org/cancer/coc/programstandards2012.html](http://www.facs.org/cancer/coc/programstandards2012.html)). Their patient-centered focus now includes screening all patients with cancer for psychosocial distress. These standards are required for accreditation, to be phased in by 2015. The American Psychosocial Oncology Society (APOS), the Association of Oncology Social Work (AOSW), and the Oncology Nursing Society (ONS) published a report and a joint statement endorsing the new CoC accreditation standards.[43,44] This task force provided recommendations to help facilitate cancer centers adopting procedures for distress screening.[44] Recommendations included: soliciting the input of individuals with psychosocial expertise, appropriate timing, mode, and tools for screening, proper referral to mental health professionals, and documentation of screening.

The standards of care for managing distress proposed by the NCCN Distress Management Panel are broad in nature and should be tailored to the particular needs of each institution and group of patients. The overriding goal of these standards is to ensure that no patient with distress goes unrecognized and untreated. The panel based these standards of care on quality improvement guidelines for the treatment of pain.[45] The standards of care developed by the NCCN Distress Management Panel, which can also be found in the guidelines, are:

- Distress should be recognized, monitored, documented, and treated promptly at all stages of disease and in all settings.
- Screening should identify the level and nature of the distress.
- Ideally, patients should be screened for distress at every medical visit as a hallmark of patient-centered care. At a minimum, patients should be screened to ascertain their level of distress at the initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status (eg, remission, recurrence, or progression; treatment-related complications).
- Distress should be assessed and managed according to clinical practice guidelines.
- Interdisciplinary institutional committees should be formed to implement standards for distress management.
• Educational and training programs should be developed to ensure that health care professionals and certified chaplains have knowledge and skills in the assessment and management of distress.

• Licensed mental health professionals and certified chaplains experienced in the psychosocial aspects of cancer should be readily available as staff members or by referral.

• Medical care contracts should include adequate reimbursement for services provided by mental health professionals.

• Clinical health outcomes measurements should include assessment of the psychosocial domain (eg, quality of life; patient and family satisfaction).

• Patients, families, and treatment teams should be informed that distress management is an integral part of total medical care and is provided with appropriate information about psychosocial services in the treatment center and in the community.

• Finally, the quality of distress management programs/services should be included in institutional continuous quality improvement (CQI) projects.

Patients and families should be made aware that this new standard exists and that they should expect it in their oncologist’s practice. The Alliance for Quality Psychosocial Cancer Care is a coalition of professional and advocacy organizations whose goal is to advance the recommendations from the IOM report. In addition, the Alliance advocates for policies promoting access to quality psychosocial care for all patients with cancer and helps to advance research in psychosocial oncology. Its website (http://www.wholecancerpatient.org/) has hundreds of psychosocial resources for health care professionals, patients, and caregivers, searchable by state.

Recommendations for Implementation of Standards and Guidelines

Implementation of the IOM standards for integration of psychosocial care into the routine care of patients with cancer can be improved by providing feedback to oncology practices on the quality of their psychosocial care. Quality indicators thus have been developed by Jacobsen and colleagues. They have developed a patient chart audit that permits an oncologist’s office or clinic to evaluate the quality of their psychosocial care. The survey queries whether there is documentation that the patient’s current emotional wellbeing has been assessed and if there is documentation that any action has been taken if the patient has been identified as having a problem. These quality indicators can be widely used to determine the quality of psychosocial care given by a clinic or office.

The Quality Oncology Practice Initiative (QOPI) was started in 2002 by ASCO as a pilot project (http://qopi.asco.org/program.html). This program became available to all ASCO member medical oncologists in 2006. Jacobsen’s psychosocial quality indicators were added as part of the core measures in the QOPI quality measures in 2008. A 2008 manuscript showed that practices participating in QOPI demonstrated improved performance, with initially low-performing practices showing the greatest improvement. Blayney and colleagues from the University of Michigan Comprehensive Cancer Center reported that QOPI can be adapted for use in practice improvement at an academic medical center. APOS has also adopted these quality indicators.

The panel also encourages the establishment of institutional interdisciplinary committees to implement and monitor distress management. The interdisciplinary committee should be responsible for evaluation of standard care in distress management with CQI studies. The panel encourages interdisciplinary CQI studies to assess the
quality of distress management programs as well as the efficacy of standards of care, implementation of these NCCN Guidelines for Distress Management, and the quality standard established by the IOM report. The panel also emphasizes that multicenter randomized trials and pilot testing are needed to compare the efficacy of brief screening instruments. Educational approaches should be developed for medical staff, patients, and caregivers to increase their awareness of the prevalence of distress and of psychological interventions.

Jacobsen and colleagues conducted a study in 2005 evaluating the implementation of NCCN Guidelines for Distress Management by 15 NCCN Member Institutions. Eight institutions (53%) conducted routine distress screening of some patient populations, and an additional 4 institutions (27%) also performed pilot testing of screening strategies. However, concordance to NCCN Guidelines (defined as screening all outpatients) was observed in only 20% of the NCCN Member Institutions at that time. A follow-up survey was conducted 7 years later that found increased levels of screening. As of 2012, 14 of 20 responding NCCN Member Institutions (70%) performed routine screening for distress in at least some patient populations. Half of responding centers reported screening all outpatients for distress. Another survey of 233 APOS members and attendees at the APOS 2008 and 2009 annual meetings, representing 146 U.S. institutions, found that routine distress screening was not performed at a majority of cancer centers. In this survey, 51% of cancer care organizations performed routine screening for distress in newly diagnosed patients with cancer.

As part of the Florida Initiative for Quality Cancer Care, medical records were reviewed to determine if clinicians from 10 oncology practices in Florida were complying with IOM standards regarding psychosocial care. When controlling for practice location and payer status, the number of patients for whom an emotional well-being problem was identified increased from 13% in 2006 to 16% in 2009 (P = .026). However, the percentage of patients for whom emotional well-being was assessed did not significantly increase from 2006 to 2009 (P = .661). Further, among those for whom an emotional well-being problem was identified, the percentage of patients for whom action was taken decreased from 2006 to 2009 (57.4%–45.3%), though this decrease did not reach statistical significance (P = .098).

A recently published survey of oncology nurses identified barriers to adoption of distress screening and found that time, staff uncertainties, and ambiguous accountability were the biggest barriers. The survey also found that nurses who were familiar with these NCCN Guidelines for Distress Management were more comfortable discussing distress.

A 2013–2014 survey of applicants for a distress screening cancer education program, spanning 70 institutions, showed that fewer than half of these institutions had not yet begun distress screening. The MD Anderson Cancer Center published a 2010 report on its efforts to implement the integration of psychosocial care into clinical cancer care. The authors outline strategies they used to accomplish the required cultural shift and describe the results of their efforts. Other groups have also described their efforts toward implementing psychosocial screening in various outpatient settings. Wagner and colleagues, for example, described efforts at oncology locations in the Chicago area to implement an electronic system that was tested between 2011 and 2012. About one third of patients requested assistance with a psychosocial problem, including stress management and coping with a cancer diagnosis, and the authors deemed the system feasible.
Institutions should have a framework in place to address psychosocial care in patients who need it, in order to effectively manage distress. A 2012 survey completed by 20 NCCN Member Institutions showed most institutions do not formally keep track of the number of patients who utilize psychosocial care and/or services, which limits the ability to ensure that centers are adequately implementing standards of psychosocial care. A 2014 survey of 2,134 members of the Association of Oncology Social Work who were also employees of a CoC-accredited cancer program showed that most programs have procedures in place to address psychosocial care and are successful in identifying psychosocial needs in patients and addressing these needs appropriately. However, programs tend to be less successful with follow-up of psychosocial care and training of providers regarding psychosocial care.

Additional guidance for the implementation and dissemination of the new IOM standards has been published. For example, Lazenby recommends applying the “evidence integration triangle” to facilitate widespread incorporation of distress screening into cancer care. In Canada, a national approach has been used to implement screening for distress. Its strategies have been described. Groups in Italy and France have also described results of their preliminary efforts toward the implementation of psychosocial distress screening. A reading list for implementation of programs that integrate psychosocial care into the routine care of patients with cancer is provided in the guidelines above.

To implement the new standard of integrating psychosocial care into the routine care of all patients with cancer, it is critical to have a fast and simple screening method that can be used to identify patients who require psychosocial care and/or referral to psychosocial resources. The NCCN Distress Management Panel developed such a rapid screening tool, as discussed below.

Screening Tools for Distress and Meeting Psychosocial Needs

Identification of a patient's psychological needs is essential to develop a plan to manage those needs. Ideally, patients tell their oncologists about their problems or they respond to the oncologist's query about them. In routine clinical practice, time constraints and the stigma related to psychiatric and psychological needs often leads to no discussion of these issues. Screening tools have been found to be effective and feasible in reliably identifying distress and the psychosocial needs of patients. Completion of a psychosocial screening instrument may lead to earlier referral to social work services. A routine distress screening program implemented at cancer care sites in Canada reduced endorsement of problems related to emotional, practical, informational, spiritual, social, and physical well-being.

Mitchell and colleagues reported that ultra-short screening methods (Patient Health Questionnaire-2 [PHQ-2] or the Distress Thermometer [DT]) were acceptable to about three quarters of clinicians. Automated touch-screen technologies, interactive voice response, and web-based assessments have also been used for psychosocial and symptom screening of patients with cancer. Recently, an internet-based program that includes distress screening, reporting, referrals, and follow-up components has been developed. The screening component was validated in a trial of 319 community-based cancer survivors and showed good psychometric properties.

A meta-analysis compared 8 tools designed to screen for depression in the cancer setting that had been validated by at least 2 separate studies. This analysis included the Hospital Anxiety and Depression Scale (HADS), the Beck Depression Inventory-II (BDI-II), and the DT (discussed below). Other tools have also been described.
Some recent results have caused doubts in the minds of some regarding the efficacy of distress screening for improving patient outcomes. For instance, a recent systematic review failed to find evidence that screening improved distress levels over usual care in patients with cancer.\(^93\) Criticisms of this review include the inappropriately narrow inclusion criteria and the focus on only distress as an outcome.\(^94\) A recent, unblinded, two-arm, parallel randomized controlled trial (RCT) that used the DT and Problem List (see below) as a screening tool versus usual care found no differences in psychological distress at 12 months between the arms.\(^95\) However, no specific triage algorithms were followed, and inadequate staff training may have prevented effective referral and treatment.\(^96\) Another randomized trial found that distress screening followed by personalized triage in patients with lung cancer led to improvements in pain, breathlessness, coping, and family relationships compared to patients who were merely screened.\(^97\) Furthermore, a recent systematic review found that trials reporting a lack of benefit to distress screening in patients with cancer lacked appropriate follow-up care of distressed patients, while trials that linked screening with mandatory referral or intervention showed improvements in patient outcomes.\(^98\) Overall, results of these studies show that screening, while a critical component of psychosocial care, is not sufficient to impact patient outcomes without adequate follow-up referrals and treatment. Indeed, an RCT examining the effects of screening on 568 patients with cancer receiving radiotherapy showed that screening alone does not significantly impact distress and quality of life, but earlier referral to mental health professionals was associated with better outcomes (ie, greater health-related quality of life, less anxiety).\(^99\) As proposed by Lazenby, the concept of “comprehensive distress screening” includes screening plus triage of patients to appropriate referral sources.\(^73\)

### The Distress Thermometer

The NCCN Distress Management Panel developed the DT, a now well-known tool for initial screening, which is similar to the successful rating scale used to measure pain: 0 (no distress) to 10 (extreme distress). The DT serves as a rough initial single-item question screen, which identifies distress coming from any source, even if unrelated to cancer. The receptionist can give it to the patient in the waiting room.

The word “distress” was chosen as described above, because it is less stigmatizing and more acceptable to patients and oncologists than other terms such as psychiatric, psychosocial, or emotional. Using this non-stigmatizing word diminishes clinicians’ concerns that the patient will be embarrassed or offended by these questions. Asking an objective question such as, “How is your pain today on a scale of 0 to 10?” makes it easier and more comfortable for caregivers to learn about patients’ pain. Similarly, asking patients, “How is your distress today on a scale of 0 to 10?” opens a dialogue with the oncologist or nurse for a discussion about emotions that is more acceptable.

The patient in the waiting room places a mark on the DT scale answering: “How distressed have you been during the past week on a scale of 0 to 10?” Scores of 4 or higher suggest a level of distress that has clinical significance. If the patient’s distress level is mild (score is <4 on the DT), the primary oncology team may choose to manage the concerns by usual clinical supportive care management. If the patient’s distress level is 4 or higher, a member of the oncology team looks at the Problem List (see below) to identify key issues of concern and asks further questions to determine to which resources (mental health, social work and counseling, or chaplaincy professionals) the patient should be referred.
The DT has been validated by many studies in patients with different types of cancer, in different settings, and in different languages, cultures, and countries and has revealed concordance with the HADS. The DT has shown good sensitivity and specificity. The needs assessment surveys performed in ambulatory clinics using these screens show that 20% to 40% of patients have significant levels of distress. Two studies validated a version of the DT with an expanded problems list. Tuinman and colleagues validated the DT with the 46-item Problem List in a cross-sectional group of 227 patients with cancer. Graves and colleagues validated the DT with an adapted problems list with two new problem categories (information concerns and cognitive problems) in patients with lung cancer. The DT is also a useful tool for screening distress among bone marrow transplant recipients. The DT had acceptable overall accuracy and greater sensitivity and specificity when compared to the Center for Epidemiologic Studies Depression Scale (CES-D) in the assessment of depression in patients undergoing bone marrow transplants. A meta-analysis of 42 studies with greater than 14,000 patients with cancer found the pooled sensitivity of the DT to be 81% (95% CI, 0.79−0.82) and the pooled specificity to be 72% (95% CI, 0.71−0.72) at a cut-off score of 4.

The NCCN DT and Problem List (discussed below) are freely available for non-commercial use. In addition, the NCCN patient website includes a patient-friendly description of distress with a copy of the tool. NCCN also has verified translations of the DT and Problem List in various languages that are freely available online.

The Problem List

The screening tool developed by the NCCN Distress Management Panel includes a 39-item Problem List, which is on the same page as the DT. The Problem List asks patients to identify their problems in five different categories: practical, family, emotional, spiritual/religious, and physical. The panel notes that the Problem List may be modified to fit the needs of the local population.

Cognitive Impairment

“Memory/concentration problems” is one item on the Problem List. Cognitive impairment is common in patients with primary central nervous system (CNS) cancers, due to the effects of brain tumors themselves and the effects of treatment targeted to the brain. Recent evidence has shown that chemotherapy-related cognitive dysfunction is also prevalent in patients with non-CNS cancers and without brain metastases. Chemotherapy can cause subtle cognitive changes, studied primarily in patients with breast cancer or lymphoma. It can continue over years and at times, when more severe, can impact quality of life and function. A recent study, however, showed that patients with breast cancer who received systemic adjuvant therapy did not report significantly greater cognitive impairment 7 to 9 years after treatment, compared to patients with breast cancer who did not receive systemic adjuvant therapy (N = 1,889), when statistically controlling for menopausal status and sociodemographic and clinical covariates. The underlying mechanisms for chemotherapy-induced cognitive changes are not known. Studies have reported elevated levels of cytokines or DNA damage as some of the possible mechanisms. Furthermore, changes in brain activity have been observed in patients following chemotherapy, suggesting that direct damage to the brain may contribute to chemotherapy-induced cognitive decline.
Evidence suggests that cancer itself and therapies other than chemotherapy, such as hormone therapy, can cause cognitive impairments in patients with cancer.\textsuperscript{130-133} A meta-analysis including 14 studies with 417 prostate cancer patients showed that androgen deprivation therapy negatively impacts performance of visuomotor tasks.\textsuperscript{134} A national cross-sectional study found that a history of cancer is independently associated with a 40% increase in the likelihood of self-reported memory problems.\textsuperscript{135} A case-control study (\textit{N} = 226) showed that patients with breast cancer may experience some cognitive impairment prior to beginning treatment, and this impairment may be due to post-traumatic stress symptoms.\textsuperscript{136} A better understanding of the mechanisms that cause cancer-related cognitive impairment is essential for the development of treatments to improve cognitive function and quality of life in patients with cancer.\textsuperscript{121,122,137}

There is no standard treatment for the management of cognitive changes in patients with cancer, and intervention studies to date have been limited by methodologic flaws such as a small sample size, poor generalizability, and lack of a proper control group.\textsuperscript{125} Cognitive behavioral therapy (CBT), cognitive rehabilitation programs, and exercise may be effective interventions to improve cognitive function in patients with cancer.\textsuperscript{125,138-140} In addition, some studies have shown that the use of psychostimulants such as methylphenidate and modafinil improved cognitive function in patients with cancer.\textsuperscript{141-146} Donepezil, a reversible acetylcholinesterase inhibitor (approved to treat mild to moderate dementia in patients with Alzheimer’s disease) also improved cognitive function, mood, and health-related quality of life in patients with primary low-grade glioma.\textsuperscript{147} Further placebo-controlled trials are needed to confirm these preliminary findings.\textsuperscript{125,142}

In October 2006 the International Cognition and Cancer Task Force (ICCTF), comprised of a multidisciplinary group of health professionals and health advocates, was formed. The mission of ICCTF is to advance understanding of the impact of treatment-related cognitive and behavioral functioning in patients with non-CNS cancers.\textsuperscript{148} ICCTF also has a website (www.icctf.com) to provide up-to-date information to both physicians and patients seeking assistance in the management of cognitive symptoms associated with cancer treatment.

The NCCN Guidelines for Survivorship (available at www.NCCN.org) contain more information on this topic, with recommendations for the management of cognitive dysfunction in survivors.

\textbf{Fertility}

Another item on the Problem List is the “ability to have children.” Chemotherapy and radiation therapy also have an impact on the fertility of patients, especially in those who are of child-bearing age.\textsuperscript{149} Therefore, the panel has included “ability to have children” as one of the items listed under the family problems category. The Oncofertility Consortium is a useful patient education resource for those who are concerned about the possible effect of cancer treatment on their fertility (www.MyOncofertility.org). Additionally, the NCCN Guidelines for Adolescent and Young Adult (AYA) Oncology (available at www.NCCN.org) have information on fertility preservation.

\textbf{Substance Abuse}

For the 2013 version of these guidelines, the panel added substance abuse to the list of possible physical problems. Substance abuse in patients with cancer who do not have a history of abuse or addiction is rare and is usually caused by insufficient symptom control. Improving symptom control often alleviates the substance dependence. This problem is discussed in more detail below in \textit{Substance-Related and Addictive Disorders}. 
Initial Evaluation and Treatment by Oncology Team

The panel recommends that all patients be assessed in the waiting room using a simple screening tool. While there are several types of screening tools, the DT and the accompanying Problem List are recommended to assess the level of distress and to identify causes of distress. If the patient's distress is moderate or severe (thermometer score ≥4), the oncology team must recognize that score as a trigger to a second level of questions, including clinical interviews and/or validated scales/screeners for anxiety and depression, should prompt referral to a mental health professional, social worker, or spiritual counselor, depending on the problems identified in the Problem List. Common symptoms that require further evaluation are: excessive worries and fears, excessive sadness, unclear thinking, despair and hopelessness, severe family problems, social problems, and spiritual or religious concerns. Any unrelieved physical symptoms should be treated based on NCCN’s disease-specific guidelines, and referral for palliative care management may also be considered (see the NCCN Guidelines for Palliative Care, available at http://www.nccn.org/).

Mild distress (DT score <4) is routinely managed by the primary oncology team and represents what the panel terms "expected distress" symptoms. The symptoms that the team manages are fear, worry, and uncertainty about the future; concerns about the illness; sadness about loss of good health; anger and the feeling that life is out of control; poor sleep, poor appetite, and poor concentration; preoccupation with thoughts of illness, death, treatment, and side effects; and concerns about social roles (eg, mother, father). Most patients experience these symptoms at the time of diagnosis and during arduous treatment cycles. They might persist long after the completion of treatment. For instance, minor symptoms are often misinterpreted by survivors as a sign of recurrence, which causes fear and anxiety until they are reassured.

The primary oncology team is the first to deal with these painful problems. The oncologist, nurse, and social worker each have a critical role. First and foremost is the quality of the physician’s communication with the patient, which should occur in the context of a mutually respectful relationship so that the patient can learn the diagnosis and understand the treatment options and side effects. Adequate time should be provided for the patient to ask questions and for the physician to put the patient at ease. When communication is done well at diagnosis, the stage is set for future positive trusting encounters. It is important to ensure that the patient mentally grasps what has been said. Information may be reinforced with drawings or by recording the session and giving the recording to the patient. Communication skills training programs that teach oncology professionals, for example, how to discuss prognosis and unanticipated adverse events and how to reach a shared treatment decision may be very helpful. In fact, in an RCT, it was found that patients of oncologists who had communication skills training were less depressed at follow-up than patients of oncologists from the control group (P = .027). Communication skills training was reviewed by Kissane, et al.

It is important for the oncology team to acknowledge and validate that this is a difficult experience for the patient and that distress is normal and expected. Being able to express distress to the staff helps provide relief to the patient and builds trust. The team needs to ensure that social supports are in place for the patient and that he or she knows about community resources such as support groups, teleconferences, and help lines. The IOM report contains a list of national organizations and their toll-free numbers. Some selected organizations that provide free information services to patients with cancer are:

- American Cancer Society: www.cancer.org
- American Institute for Cancer Research: www.aicr.org

(APOS provides a toll-free Help Line [866.276.7443] to which patients and their caregivers can be referred to help them find psychological resources in their community. This help line is now available through the Cancer Support Community [see below].) [154]

Cancer Support Community: [http://www.cancersupportcommunity.org](http://www.cancersupportcommunity.org)

(Cancer Support Community provides the Cancer Support Helpline at 888.793.9355)

CancerCare: [www.cancercare.org](http://www.cancercare.org)

National Cancer Institute: [www.cancer.gov](http://www.cancer.gov)

Cancer.net, sponsored by ASCO: [www.cancer.net](http://www.cancer.net)

Clinicians should be aware of the evidence-supported interventions available for the management of distress. In addition to these NCCN Guidelines for Distress Management, the following clinical practice guidelines will be useful to clinicians, including the oncology team:

- National Cancer Institute and several partners have developed a website that provides information about research-tested intervention programs ([http://rtips.cancer.gov/rtips/index.do](http://rtips.cancer.gov/rtips/index.do)).
- Screening, Assessment, and Care of Anxiety and Depressive Symptoms in Adults With Cancer: An American Society of Clinical Oncology Guideline Adaptation ([http://www.asco.org/](http://www.asco.org/))

Follow-up at regular intervals or at transition points in illness is an essential part of the NCCN Guidelines for Distress Management and the IOM model for care of the whole patient. This reassessment is particularly important in elderly patients with cancer. [155]

Psychological/Psychiatric Treatment by Mental Health Professionals

Psychosocial Interventions

Psychosocial interventions have been effective in reducing distress and improving overall quality of life among patients with cancer. [39,40] The 2007 IOM report noted that a strong evidence base supports the value of psychosocial interventions in cancer care. [39] The review examined the range of interventions (psychological, social, and pharmacologic) and their impact on any aspect of quality of life, symptoms, or survival. The extensive review found randomized clinical trials, systematic reviews, and meta-analyses supporting the conclusion that psychosocial aspects must be integrated into routine cancer care in order to give quality cancer care. More recent meta-analyses have come to similar conclusions, although more research is clearly needed. [156-158]

Systematic reviews examining psychosocial interventions for patients with prostate cancer showed that these interventions may yield at least short-term effects on quality of life. [159,160] A meta-analysis including 53 studies of psychosocial interventions for patients with cancer (N = 12,323) showed that patients were more willing to participate in interventions delivered over the telephone versus in-person (P = .031) and when intervention is offered shortly after diagnosis versus later (P = .018). [161] CBT, supportive psychotherapy, and family and couples therapy are three key types of psychotherapies discussed in the IOM report. [39]

Cognitive Behavioral Therapy

CBT involves relaxing, enhancing problem-solving skills, and identifying and correcting inaccurate thoughts associated with feelings. In randomized clinical trials, CBT and cognitive-behavioral stress management have been shown to effectively reduce psychological symptoms (anxiety and depression) as well as physical symptoms (pain and fatigue) in patients with cancer. [162-166] A recent Cochrane systematic
review including 28 RCTs (N = 3,940) showed that CBT interventions favorably impact anxiety, depression, and mood disturbance in patients with non-metastatic breast cancer. The quality of the evidence was low for anxiety and depression and moderate for mood disturbance, however, indicating the need for studies to use higher quality intervention methods and validated instruments for measuring outcomes.

Ferguson and colleagues have developed a brief CBT intervention (Memory and Attention Adaptation Training [MAAT]) aimed at helping breast cancer survivors manage cognitive dysfunction associated with adjuvant chemotherapy. In this single-arm pilot study, improvements in self-reporting of cognitive function, quality of life, and standard neuropsychological test performance were observed in all patients (29 women at an average of 8 years after adjuvant chemotherapy for stage I–II breast cancer). The authors have since performed a randomized study to evaluate the efficacy of MAAT. They found that patients in the intervention arm had improved verbal memory performance and spiritual well-being.

Supportive Psychotherapy
Supportive psychotherapy, aimed at flexibly meeting patients’ changing needs, is widely used. Different types of group psychotherapy have been evaluated in clinical trials among patients with cancer. Supportive-expressive group therapy has been shown to improve quality of life and psychological symptoms, especially improvements in mood and pain control in patients with metastatic breast cancer. Hematopoietic stem cell transplant survivors (n = 264) who were experiencing survivorship problems and were randomized to an expressive helping intervention reported less distress, compared to survivors randomized to receive peer helping and neutral writing interventions (P < .05). Cognitive-existential group therapy has been found to be useful in women with early-stage breast cancer receiving adjuvant chemotherapy. Meaning-centered group psychotherapy, designed to help patients with advanced cancer sustain or enhance a sense of meaning, peace, and purpose in their lives (even as they approach the end of life), has also been shown to reduce psychological distress among patients with advanced cancer. Dignity therapy has been assessed in an RCT of patients with a terminal diagnosis (not limited to cancer). Although there was no significant improvement in levels of distress in patients receiving dignity therapy as measured by several scales, significant improvements, specifically for depression and self-reported aspects of quality of life, were seen. An RCT for patients with renal cell carcinoma (N = 277) showed that expressive writing reduces self-reported cancer-related symptoms (eg, pain, nausea, fatigue) and improves physical functioning. An individually delivered intervention targeting patients with advanced cancer includes components of manualized, supportive, expressive, cognitive, existential, and meaning-centered group psychotherapy approaches. A feasibility study (N = 39) showed reduced depressive symptoms and death-related anxiety, and improved spiritual well-being. A larger RCT is currently being conducted. Interventions incorporating internet support groups have become popular, but the results of a recent RCT that included an internet support group with a prosocial component showed that this intervention did not reduce depression and anxiety in women with nonmetastatic breast cancer (N = 184).

Psychoeducation
Psychoeducational interventions are those that offer education to those with specific psychological disorders or physical conditions. Psychoeducational interventions for patients with cancer may be general, such as providing information regarding stress management and healthy living (eg, nutrition, exercise), while other interventions...
may be more specific to the cancer type. For example, an intervention for patients with melanoma was developed by Fawzy and Fawzy that provided information regarding sun protection, as well as stress management and coping strategies.\textsuperscript{183} An RCT in which the effects of this intervention were tested on 262 patients with melanoma showed improvements in fatigue, vigor, mood disturbance, and coping strategies, though improvements did not persist past 6 months.\textsuperscript{184} In an RCT examining the effects of a group-based psychoeducational intervention for 312 women with early-stage breast cancer, improved adjustment was demonstrated up to six months after the intervention.\textsuperscript{185} A year-long nurse-led intervention for patients with head and neck cancer ($N = 205$) that included education regarding problems related to head and neck cancer and, if indicated, CBT and referral for further psychological treatment positively impacted emotional and physical functioning, social contact, and depressive symptoms.\textsuperscript{186} At 12-month follow-up (ie, one year after the end of the year-long intervention), effects persisted for emotional functioning only. A meta-analysis examining 19 psychoeducational interventions with 3,857 cancer patients showed small post-treatment effects overall for emotional distress, anxiety, depression, and quality of life.\textsuperscript{156} The only significant effects at long-term follow-up were for quality of life. Psychoeducation interventions that offer education regarding symptom management may also be effective when delivered via the internet.\textsuperscript{187}

**Exercise**

Exercise during and after cancer treatment can improve cardiovascular fitness and strength and can have positive effects on balance, body composition, and quality of life.\textsuperscript{188-190} Small RCTs have shown that exercise may also impact mental health outcomes in patients with cancer.\textsuperscript{191,192} A Cochrane systematic review including nine RCTs ($N = 818$) showed that aerobic exercise for patients with hematologic malignancies may impact depression (SMD, 0.25; 95% CI, 0.00–0.50, $P = .05$) but not anxiety ($P = .45$).\textsuperscript{193} However, the quality of the evidence in this area is low, as larger RCTs and longer follow-up periods are needed.

**Family and Couples Therapy**

A cancer diagnosis causes distress in partners and family as well as the patient. Psychosocial interventions aimed at patients and their families together might lessen distress more effectively than individual interventions. In a longitudinal study of couples coping with early-stage breast cancer, mutual constructive communication was associated with less distress and more relationship satisfaction for both the patients and partners compared to demand/withdraw communication or mutual avoidance, suggesting that training in constructive communication would be an effective intervention.\textsuperscript{194} Family and couples therapy has not been widely studied in controlled trials. In an RCT in which 62 couples (patients with localized prostate cancer and their partners) were randomly assigned to receive cognitive existential couple therapy or usual care, adaptive and problem-focused coping was improved in couples receiving the therapy sessions, which in turn improved relationship cohesion, as well as relationship function in younger patients.\textsuperscript{195} A small randomized trial was reported in which patients and their caregivers received eight emotionally focused therapy sessions or standard care.\textsuperscript{196} Significant improvements in marital functioning and patient experience of empathetic care by the caregiver were seen. These effects were maintained 3 months after the intervention. In a pilot study, a telephone-based dyadic intervention for patients with advanced lung cancer and their families ($N = 39$) improved depression, anxiety, and caregiver burden.\textsuperscript{197} In addition, an RCT showed that family-focused grief therapy can reduce the morbid effects of grief in families with terminally ill patients with cancer.\textsuperscript{198}
Some systematic reviews have been carried out to assess the efficacy of therapy involving patients’ close others. A systematic review of 23 studies that assessed the efficacy of psychosocial interventions for couples affected by cancer found evidence that couples therapy might be at least as effective as individual therapy. Another systematic review examining the effects of 10 interventions for couples coping with breast cancer showed that, though results are mixed, these interventions tend to yield at least some benefit.

**Pharmacologic Interventions**

Research suggests that antidepressants and antianxiety drugs are beneficial in the treatment of depression and anxiety in adult patients with cancer. In RCTs, alprazolam (a benzodiazepine) and fluoxetine (a selective serotonin reuptake inhibitor [SSRI]) are effective in improving depressive symptoms in patients with cancer. SSRIs are widely used for depression and anxiety symptoms.

Psychostimulant drugs help in the management of fatigue. Methylphenidate is likely effective for the treatment of cancer-related fatigue, but additional trials are needed. Wakefulness-promoting agents such as modafinil are also commonly used to treat fatigue in patients with cancer, but their efficacy remains to be shown conclusively.

Withdrawal from pharmacologic agents (eg, benzodiazepines, opioids, antidepressant and antianxiety drugs) should be managed with care and will vary based on the specific agent.

**Complementary and/or Integrative Therapies**

Regarding complementary and/or integrative therapies for patients with cancer, a recent systematic review including 203 RCTs showed that meditation, yoga, relaxation with imagery, massage, and music therapy may be helpful for patients with depressive disorders who have breast cancer. Music therapy, meditation, and yoga may be used to reduce anxiety in patients with breast cancer. The panel recommends relaxation, mediation, and creative therapies such as art and music for patients experiencing distress.

**Psychological/Psychiatric Treatment Guidelines**

Patients scoring 4 or higher on the DT during any visit to the oncologist are referred to the appropriate supportive service (mental health, social work and counseling, or chaplaincy professionals) based on the identified problem.

Mental health professionals are expected to conduct a psychological or psychiatric evaluation that includes an assessment of the nature of the distress, behavior and psychological symptoms, psychiatric history, use of medications, pain, fatigue, sleep disturbances, other physical symptoms, cognitive impairment, body image and sexuality, and capacity for decision making and physical safety. A psychiatrist, psychologist, nurse, advanced practice clinician, or social worker may perform the evaluation. All of these professionals are skilled in mental health assessment and treatment.

The panel has developed evaluation and treatment guidelines for the most commonly encountered psychiatric disorders, consistent with the classification in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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anticancer therapies and cause adverse effects. Howard et al\textsuperscript{217} reviewed some of these interactions and discusses other challenges in treating cancer in patients with severe mental illness.

Patients considered to be a danger to themselves or others should receive a psychiatric consultation. Increased monitoring is also warranted, as well as the removal of dangerous objects. Hospitalization and suicide and homicide risk evaluation may sometimes be necessary. Psychiatric treatment/follow-up of these patients and family education regarding safety is warranted.

Additional information regarding treatment of distress and psychiatric disorders in cancer can be found in the comprehensive handbook, \textit{Psycho-Oncology: A Quick Reference on the Psychosocial Dimensions of Cancer Symptom Management},\textsuperscript{218} and the comprehensive textbook, \textit{Psycho-Oncology}.\textsuperscript{219} Additional resources targeting specific age groups include the comprehensive handbooks, \textit{Geriatric Psycho-Oncology: A Quick Reference on the Psychosocial Dimensions of Cancer Symptom Management},\textsuperscript{220} and \textit{Pediatric Psycho-Oncology: A Quick Reference on the Psychosocial Dimensions of Cancer Symptom Management},\textsuperscript{221} which target management of psychological, cognitive, and social difficulties in older adults and children/adolescents, respectively.

**Neurocognitive Disorders**

Neurocognitive disorders that may affect patients being treated with cancer include dementia and delirium. Dementia and delirium are cognitive impairments that can severely alter the patient’s decision-making capacity. Dementia is a permanent cognitive impairment. It is not a common complication of cancer treatment, but is often present in elderly patients as a comorbid condition.\textsuperscript{222,223} A retrospective chart review of 771 palliative care consultations showed that symptoms of delirium were misinterpreted by the primary oncology team 61\% of the time.\textsuperscript{224} Dementia can be treated with cognitive rehabilitation, with or without medications, though treatment is largely behavior management.

Delirium is a short-term cognitive impairment and has been reported to occur in as many as 43\% of patients with advanced cancer.\textsuperscript{225} It is usually reversible and occurs in cancer treatment related to any toxic state, and it is often related to medication, particularly opioids.\textsuperscript{226} Benzodiazepines should be used with caution, as their use may contribute to delirium.\textsuperscript{227-229} A prospective case-control cohort study (\textit{N} = 245) showed a significant association between benzodiazepine use and development of postoperative delirium (odds ratio \([\text{OR}]\), 3.0; 95\% CI, 1.3–6.8), with stronger associations for long-acting agents (\textit{OR}, 5.4; 95\% CI, 1.0–29.2) and high-dose exposure (\textit{OR}, 3.3; 95\% CI, 1.0–11.0).\textsuperscript{227} Delirium is managed by attention to safety, modification of opioids or other medications, antipsychotics, behavior management, and family support and education.\textsuperscript{230}

The United Kingdom’s National Institute for Health and Care Excellence (NICE) issued detailed guidelines for the diagnosis, prevention, and management of delirium.\textsuperscript{231} In addition, a comprehensive review in \textit{The Journal of Clinical Oncology} Special Series on Psychosocial Care in Cancer by Breitbart and Alici\textsuperscript{232} describes the evidence base for recommended pharmacologic and non-pharmacologic treatments for delirium in patients with cancer.

**Depressive and Bipolar-Related Disorders**

Depressive and bipolar-related disorders are common in patients with cancer and can be debilitating.\textsuperscript{233-235} A cross-sectional analysis of 2,141 patients with cancer showed a 4-week prevalence rate of 6.5\% (95\% CI, 5.5–7.5) for a depressive or bipolar-related disorder.\textsuperscript{236} Depressive symptoms during cancer diagnosis and treatment may persist for as
Depressive and bipolar-related disorders are associated with poorer cancer survival. \(^\text{238,239}\) Patients with uncontrolled depressive and bipolar-related disorders can develop suicidal tendencies. A study of over 5000 patients at one center found that 6% of patients with cancer experienced suicidal ideation. \(^\text{240}\) The incidence of suicide among patients with cancer in the United States is twice that of the general population. \(^\text{241-243}\) Older patients and men with head and neck cancer or myeloma seem to have a higher risk of suicide. \(^\text{244}\) Violence may also be associated with depressive disorders, particularly when there is comorbid substance use. \(^\text{245}\) Therefore, both suicide and homicide risk should be evaluated in patients believed to be a danger to themselves and others.

Depressive and bipolar-related disorders are usually managed with psychotherapy or psychotropic medication (category 1). The evidence for these treatments has been described. \(^\text{40,246-252}\) In particular, a review by Li et al. \(^\text{253}\) in *The Journal of Clinical Oncology* Special Series on Psychosocial Care in Cancer comprehensively describes the evidence for recommended pharmacologic and psychosocial interventions for treating depression in patients with cancer. Referral to social work and counseling and chaplaincy services may also be considered.

ASCO recently released a clinical oncology guideline adaptation of a pan-Canadian practice guideline for the screening, assessment, and treatment of anxiety and depression in patients with cancer. \(^\text{254}\)

**Trauma- and Stressor-Related Disorders**

Trauma and stressor-related disorders that may affect patients with cancer include post-traumatic stress disorder (PTSD), acute stress disorder, and adjustment disorder. PTSD may develop after arduous cancer treatments, during a cancer treatment that triggers a traumatic memory of a past frightening event, or just from the stress of a cancer diagnosis. As many as 12% of patients with stage I–III breast cancer were found to have persistent PTSD. \(^\text{255}\) Survivors of cancer may continue to experience PTSD symptoms. \(^\text{256}\) Acute stress disorder is diagnosed in the first month following a traumatic event, and the criteria contain a greater emphasis on dissociative symptoms. Twenty-three percent to 28% of patients diagnosed with cancer meet criteria for acute stress disorder. \(^\text{257,258}\) Adjustment disorder refers to a cluster of symptoms such as stress, depressive symptoms, and physical symptoms following a stressful life event such as cancer diagnosis and treatment. It may be diagnosed when a patient who experienced a stressful life event does not meet criteria for PTSD or acute stress disorder. Adjustment disorder is prevalent in 15.4% of patients in palliative care settings and in 11% to 19% of patients in oncological and hematologic settings. \(^\text{18,236}\)

Treatment of trauma- and stressor-related disorders in patients with cancer includes psychotherapy with or without an anxiolytic and/or an antidepressant (category 1). If this treatment yields no response or a partial response, then psychotherapy, support, and education should be reevaluated. Choice of medication should also be reconsidered, with a consideration of antipsychotics. For patients diagnosed with adjustment disorder specifically, patients with moderate/severed disorder should receive medication and/or psychotherapy, while patients with mild disorder should receive psychotherapy only. For patients who receive medication, type of medication and the dosage should be adjusted as needed. Patients diagnosed with adjustment disorder who do not respond to treatment should be evaluated for personality disorders.

**Anxiety Disorders and Obsessive Compulsive Disorder**

Anxiety occurs at times in most patients with cancer. \(^\text{233,259}\) A cross-sectional analysis of 2,141 patients with cancer showed a 4-week
The prevalence rate of 11.5% (95% CI, 10.2–12.9) for any anxiety disorder. The diagnosis of cancer and the effects of the disease and its treatment are obvious sources of unease; however, anxiety may also be related to physiological aspects of the medical condition (e.g., hormone-secreting tumors; effects of certain types of medications [bronchodilators]; withdrawal from alcohol or narcotics; pain or some other distressing physical symptom). Anxiety may not be severe or problematic, but needs to be addressed when it becomes disruptive. After ruling out medical causes, the clinician should assess symptoms to determine the particular nature of the anxiety disorder(s).

Generalized anxiety disorder is usually pre-existing and may be exacerbated by illness. Panic disorder may recur during illness in a person with previous panic symptoms. Obsessive-compulsive disorder is a pre-existing disorder that results in difficulty in making decisions, ruminative thoughts about illness, and fearfulness to take medication. Some patients develop phobias of needles, hospitals, and blood or conditioned nausea/vomiting related to chemotherapy. Chemotherapy-induced nausea and vomiting should be managed according to the NCCN Guidelines for Antiemesis (available at www.NCCN.org).

The NCCN Distress Management Panel recommends psychotherapy with or without an anxiolytic and/or an antidepressant for the treatment of anxiety disorders, including obsessive compulsive disorder (category 1), after eliminating medical causes. If the patient responds to initial treatment, follow-up should occur with the primary oncology team and family/caregivers. If no response or a partial response is noted, the patient should be re-evaluated and treated with different medications (an antipsychotic should be considered) with continued psychotherapy, support, and education. If there is still not a complete response, then the patient should be evaluated for depression and other psychiatric comorbidity.

The evidence for the effectiveness of these treatments has been reviewed. In a review in The Journal of Clinical Oncology Special Series on Psychosocial Care in Cancer, Traeger et al give a comprehensive description of the evidence for recommended pharmacologic and non-pharmacologic treatments for anxiety in patients with cancer.

Substance-Related and Addictive Disorders

Substance dependence, abuse, and addiction is rare among patients with cancer who do not have a history of active dependence, abuse, or addiction to opioids, alcohol, or tobacco. Substance abuse or dependence developing during the course of the treatment may be due to insufficient symptom control and can be treated by improving symptom control. Alcohol and recreational drug use should be evaluated in patients with signs and symptoms of depressive disorders, bipolar and related disorders, and anxiety disorders, as substance use may exacerbate symptoms of these disorders.

In patients with a history of substance abuse, its impact on cancer treatment should be assessed and risk-reduction strategies should be discussed. Patients with a history of substance abuse should also be monitored for signs and symptoms of relapse. Referral should be considered for risk reduction, substance abuse management, or specialized treatment programs as needed. For patients with current substance dependence issues, symptoms should be treated and they should enter a substance abuse management program.

Following appropriate detoxification regimens, patients should be provided with psychoeducation with or without psychotherapy and with...
or without medication. CBT may be effective for substance-related abuse and disorders, though a meta-analysis of 53 studies showed only a small effect (Hedges’ g = 0.15, P < .005). Studies evaluating the efficacy of CBT for substance-related abuse and disorders in patients with cancer are lacking. Referral can also be made to specialized maintenance programs, and strategies to prevent future abuse can be discussed.

Personality Disorders

Patients with cancer may have a pre-existing personality disorder, which can be exacerbated by the stress of cancer and its treatment. When a personality disorder is suspected, the patient should be evaluated by a mental health professional, and safety and decision-making capacity should be assessed. If possible, any medication or other factors that could be aggravating the condition should be modified. A coordinated behavioral, psychological, and medical treatment plan, with or without medication, should be developed with the health care team.

Schizophrenia Spectrum and Other Psychotic Disorders

Psychotic disorders include hallucinations, delusions, and/or thought disorders; patients with recurrent psychotic episodes are considered to have a schizophrenia spectrum disorder. Schizophrenia spectrum and other psychotic disorders can exist as comorbidities in patients with cancer and can also be caused or exacerbated by cancer and its associated stress and treatment. In particular, steroids or steroid withdrawal can induce psychosis, which may be relieved by modifying dose or changing steroid choice. When a patient in a long-term psychiatric facility develops cancer, there is a need for coordination of care between the psychiatric facility and the inpatient cancer facility. Special attention should be paid to the transition of a psychiatric patient who needs inpatient oncology care. The issues around continuation of psychotropic medications, when they must be stopped for surgery or chemotherapy and when they should be restarted, are important issues in total care. Evaluation for any active signs of psychosis should be considered when someone with a history of schizophrenia or a psychotic disorder is diagnosed with cancer.

When a psychotic episode occurs in a patient with cancer, differential diagnoses must be ruled out. Delirium is often confused with psychotic disorder and is much more common; dementia, depressive and bipolar-related disorders, and substance abuse/withdrawal should also be considered. When psychotic disorder or schizophrenia spectrum disorder is diagnosed, several interventions can be considered: 1) anti-psychotic medication; 2) medication for mood; 3) transfer to a psychiatric unit/hospital; or 4) electroconvulsive therapy (ECT) for psychotic depression/mania or catatonia. In ECT, electrical currents are passed through the brain in a controlled fashion, inducing a brief seizure. ECT appears to be an effective treatment of psychotic depression, mania, catatonia, and other psychiatric disorders.

Although the use of ECT in cancer has not been well studied, several case studies suggest that it can be safe and effective. Anti-psychotics may need to be urgently administered if there is risk to self, others, or the environment.

Social Work and Counseling Services

Social work and counseling services are recommended when a patient has a psychosocial or practical problem. Practical problems are illness-related concerns; concrete needs (eg, housing, food, financial assistance, help with activities of daily living, transportation); employment, school, or career concerns; cultural or language issues;
and caregiver availability. The guidelines outline interventions that vary according to the severity of the problem.

Psychosocial problems are adjustment to illness; family conflicts and social isolation; difficulties in decision making; quality-of-life issues; concerns about advance directives; domestic abuse and neglect; poor coping or communication skills; concerns about functional changes (eg, body image, sexuality); and issues pertaining to end of life and bereavement (including cultural and caregiver concerns).

Social workers intervene in mild psychosocial problems by using patient and family education, support groups, and/or sex or grief counseling and by suggesting available local resources. For moderate to severe psychosocial problems, counseling and psychotherapy are used (including sex and grief counseling); community resources are mobilized; problem solving is taught; and advocacy, education, and protective services are made available.

**Spiritual and Chaplaincy Care**

Religiousness and spirituality are positively associated with mental health in patients with cancer, and attendance at religious services is associated with lower cancer-related mortality. Many patients use their religious and spiritual resources to cope with illness; many cite prayer as a major help. In addition, the diagnosis of cancer can cause an existential crisis, making spiritual support of critical importance. Balboni et al surveyed 230 patients with advanced cancer treated at multiple institutions who had failed to respond to first-line chemotherapy. The majority of patients (88%) considered religion as somewhat or very important. Nearly half of the patients (47%) reported receiving very minimal or no support at all from their religious community, and 72% reported receiving little or no support from their medical system. Importantly, patients receiving spiritual support reported a higher quality of life. Religiousness and spiritual support have also been associated with improved satisfaction with medical care. Astrow et al found that 73% of patients with cancer had spiritual needs, and that patients whose spiritual needs were not met reported lower quality of care and lower satisfaction with their care. A multi-institution study of 75 patients with cancer and 339 oncologists and nurses (the Religion and Spirituality in Cancer Care Study) found that spiritual care had a positive effect on patient-provider relationships and the emotional well-being of patients. However, a survey conducted in 2006 through 2009 found that most patients with advanced cancer never receive spiritual care from their oncology team.

A short psycho-spiritual curriculum that encourages self-forgiveness, self-acceptance, self-improvement, and commitment through prayer/meditation, reflection, and expressive writing was developed, and effects were assessed in an RCT (N = 83). The intervention impacted self-forgiving feelings and actions, self-acceptance, self-improvement, and pessimism in the expected directions. Another RCT examining the effects of a multidisciplinary intervention including a spiritual module showed that spiritual quality of life was improved at post-intervention, but not at long-term follow-up (N = 131).

The panel has included chaplaincy care as part of psychosocial services. All patients should be referred to a chaplaincy professional when their problems are spiritual or religious in nature or when they request it. The panel identified 11 issues related to illness for which people often seek chaplaincy services. A treatment guideline is available for each of these issues: grief, concerns about death and the afterlife, conflicted or challenged belief systems, loss of faith, concerns with meaning and purpose of life, concerns about relationship with deity, isolation from the religious community, guilt, hopelessness, conflict between beliefs and recommended treatments, and ritual needs.
The certified chaplain evaluates the problem and may offer spiritual or philosophical reading materials, spiritual advice and guidance, prayer, and/or rituals. For patients who are members of a religious community, the certified chaplain could also serve as a liaison between the patient and the religious community or assist the patient to access spiritual resources. Some patients may be referred to a counseling or mental health professional if the problems indicate a need for more than spiritual counseling. In addition, patients whose concerns are not allayed may be referred for mental health evaluation while continuing to receive spiritual counseling if they wish. In particular, patients who experience guilt or hopelessness should also be evaluated by mental health professionals for further assessment since they may also have severe depressive symptoms or suicidal ideations. A palliative/supportive care consultation can also be important for patients who express hopelessness.

A consensus conference on improving the quality of spiritual care as a dimension of palliative care was held in February 2009. The report from this conference provides recommendations for health care professionals on the integration of spiritual care into the patient’s overall treatment plan. The inclusion of a certified chaplain on the interdisciplinary team is critical for the implementation of spiritual care into routine clinical practice.

The following guidelines on religion and spirituality in cancer care may be useful for clinicians and patients:

- National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, Third Edition, 2013. These guidelines provide a framework to acknowledge the patient’s religious and spiritual needs in a clinical setting. Spiritual, religious, and existential aspects of care are included as 1 of the 8 clinical practice domains in these guidelines:


- The National Cancer Institute’s comprehensive cancer information database (PDQ®) has information on “Spirituality in Cancer Care” for patients:
  http://www.cancer.gov/cancertopics/pdq/supportivecare/spirituality/Patient

- and for health care professionals:

Oncologist Burnout

The stress and demands of treating patients with cancer and making life and death decisions daily often cause psychologic distress for oncologists. This distress can in turn cause depression, anxiety, and fatigue. It can also cause moral distress, compassion fatigue, and/or burnout. Burnout, characterized by a lack of enthusiasm for work, feelings of cynicism, and a low sense of personal accomplishment with work, occurs in as many as 28% to 45% of oncologists. Burnout can affect patient care, physician-patient relationships, and personal relationships and can lead to substance abuse and even suicide. Strategies for avoiding and reducing burnout include training in self-care, personal wellness, mindful meditation, and behavioral change by medical schools, residency programs, hospitals, and private practices. Organizational strategies can also create a culture that is less stressful and less conducive to oncologist burnout.

The Journal of Clinical Oncology Special Series on Psychosocial Care in Cancer

In April 2012, the Journal of Clinical Oncology published a Special Series on psychosocial care (http://jco.ascopubs.org/content/30/11.toc), demonstrating that this topic is now getting the attention is has so long
deserved. The Special Series includes a review by Jacobsen and Wagner that describes how the new standard of psychosocial care, the development of clinical practice guidelines for psychosocial care such as these NCCN Guidelines, and the establishment of indicators to measure the quality of psychosocial care can help increase the number of patients with cancer receiving psychosocial care.\textsuperscript{289} Integral to the successful integration of psychosocial care into routine cancer care is a distress screening program. In the Special Series, Carlson et al\textsuperscript{71} present their recommendations for implementing such a program, and Fann et al\textsuperscript{72} discuss the organizational challenges of this new integrated care model, with a focus on the collaborative care service model.

Research on psychosocial care in cancer treatment has expanded greatly in recent years. This fact attests to the growing awareness of the importance of the topic, both by health care professionals and by the public.\textsuperscript{290} The Special Series includes reviews of evidence-based interventions for 3 common psychosocial problems in patients with cancer: depression, anxiety, and delirium.\textsuperscript{232,253,260}

Worries and concerns about cancer do not necessarily end with the end of acute care. The Special Series thus also includes articles addressing the psychosocial needs of AYA and adult cancer survivors.\textsuperscript{291,292} An article on the psychosocial needs of caregivers is also included.\textsuperscript{293}

In addition, an article was included on oncologist burnout.\textsuperscript{285} The Special Series concludes with a review and meta-analysis of studies that provide evidence for the development of an appropriate curriculum for communication skills training of oncologists.\textsuperscript{153} Patient benefit from such training (ex, better adherence to treatment) has yet to be demonstrated.

Summary

Psychosocial care is increasingly being recognized as an integral component of the clinical management of patients with cancer. Treating distress in cancer benefits the patients, their families/caregivers, and the treating staff and helps improve the efficiency of clinic operations. For patients with cancer, integration of mental health and medical services is critically important. Spirituality and religion also play an important role for many patients with cancer in coping with the diagnosis and the illness.

The NCCN Guidelines for Distress Management recommend that each new patient be rapidly assessed in the office or clinic waiting room for evidence of distress using the DT and Problem List as an initial rough screen.\textsuperscript{294} A score of 4 or greater on the DT should trigger further evaluation by the oncologist or nurse and referral to a psychosocial service, if needed. The choice of which psychological service is needed is dependent on the problem areas specified on the Problem List. Patients with practical and psychosocial problems should be referred to social workers; those with emotional or psychological problems should be referred to mental health professionals including social workers; and spiritual concerns should be referred to certified chaplains.

Health care contracts often allow these services to “fall through the cracks” by failing to reimburse for them through either behavioral health or medical insurance. Reimbursement for services to treat psychosocial distress must be included in medical health care contracts to prevent fragmentation of mental health services for the medically ill. Outcomes research studies that include quality-of-life assessment and analysis of cost-effectiveness are needed to help make this a reality.

The primary oncology team members (oncologist, nurse, and social worker) are central to making this model work. It is critical for at least
one team member to be familiar with the mental health, psychosocial, and chaplaincy services available in the institution and the community. A list of the names and phone numbers for these resources should be kept in all oncology clinics and should be updated frequently.

Education of patients and families is equally important to encourage them to recognize that control of distress is an integral part of their total cancer care.
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