Management of Anxiety and Depression in Adult Survivors of Cancer: ASCO Guideline Update Q&A

William Pirl, MD, MPH[1]; Larissa Nekhlyudov, MD, MPH[2]; Julia H. Rowland, PhD[3]; Christina Lacchetti, MHSc[4]; and Barbara L. Andersen, PhD[5]

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The psychological symptoms of individuals living with and beyond cancer are underrecognized and undertreated throughout the survivorship trajectory.[1-4] To address these symptoms and ensure that cancer survivors have an optimal health span, along with a longer lifespan, the multidisciplinary ASCO guideline panel for the management of anxiety and depression in cancer survivors reviewed the literature and updated the 2014 guideline (Fig 1).[5,6]

QUESTION: WHAT ARE THE KEY TAKEAWAYS FROM THE GUIDELINES?

The panel endorsed ASCO's 2014 recommendations[5] on screening and assessment, reaffirming the validity and reliability of the Patient Health Questionnaire-9[7] for assessment of depression and the Generalized Anxiety Disorder-7[8] for assessment of anxiety. The panel recommended that all patients with cancer are screened for both anxiety and depression at their initial oncology visit, and thereafter, at appropriate intervals, and as clinically indicated, especially with changes in disease status (ie, in treatment, post-treatment, recurrence, and progression) and during transition to palliative/end-of-life care. During the screening process, all patients with cancer and their caregiver, family member, or trusted confidant should be offered information regarding anxiety and depression (eg, materials on Cancer.Net).

If significant anxiety or depression is identified, clinicians should select the most effective and least resource-intensive intervention on the basis of symptom-level severity. Psychological interventions are recommended as the first-line treatment for anxiety and depression for all individuals with cancer, and these should be evidence-based, empirically supported treatments, such as cognitive-behavioral therapy. Psychologists, licensed mental health counselors, and other specially trained clinicians can deliver these psychosocial interventions, in groups or individually. If available, psychiatrists may also deliver some psychosocial interventions. During treatment, mental health professionals should regularly assess (eg, pretreatment, 4 weeks, 8 weeks, and end of treatment) patients' symptoms to determine treatment efficacy and any need for change. Similarly, if pharmacologic treatment is used, the treating clinician should regularly (eg, 4 and 8 weeks) assess, using standardized validated instruments, the extent of symptom relief, side effect(s), and satisfaction with treatment. If there is little improvement in symptoms despite good adherence at 8 weeks, the treating clinician should adjust the regimen.

QUESTION: WHAT IF PSYCHOSOCIAL INTERVENTIONS, SUCH AS INDIVIDUAL AND GROUP THERAPIES, ARE NOT READILY AVAILABLE TO A CANCER PRACTICE?

The majority of US cancer centers have psychosocial services,[9] but the level of such services varies. Accreditation by the American College of Surgeon's Commission on Cancer requires screening,[10] with the expectation that a follow-up for referrals exists. However, data show that centers often struggle to meet these criteria.[11-13] Some centers may use nurses or social workers to manage screening and triage care within or outside the facility. If no services exist within a center or practice, patients will need to be referred to psychosocial clinicians in the community. This may also be preferred by those living further from their treating cancer center or practice.

Investing time and effort in developing relationships with both hospital- and community-based mental health service providers will facilitate referrals. If an oncology practice is part of a general hospital or a medical system, affiliated mental health services may exist, for example

Recommendation	Type	Evidence Quality	Strength
Treatment and Care Options for Depressive Symptoms			
2.1. For patients with moderate to severe depressive symptoms, culturally informed and linguistically appropriate information should be provided to patients and patient-identified caregivers, family members, or trusted confidants. Information might include the following: the commonality (frequency) of depression, common psychological, behavioral, and vegetative symptoms, signs of symptom worsening, and indications to contact the medical team (with provision of contact information)	EB	I	S
2.2. For a patient with moderate symptoms of depression, clinicians should offer individual or group therapy with any one of the following treatment options: Cognitive therapy or cognitive behavior therapy Behavioral activation Structured physical activity and exercise Mindfulness based stress reduction Psychosocial interventions using empirically supported components (eg, relaxation, problem solving)	EB	I	S
2.3. For a patient with severe symptoms of depression, clinicians should offer individual therapy with any one of the following treatment options: Cognitive therapy or cognitive behavior therapy Behavioral activation Mindfulness-based stress reduction Interpersonal therapy	EB	I	S
2.4. Treating clinicians may offer a pharmacologic regimen for depression in patients without access to first-line treatment, those expressing a preference for pharmacotherapy, or those who do not improve after first-line psychological or behavioral management. Pharmacotherapy should also be considered for patients with a history of treatment response to medications, severe symptoms, or accompanying psychotic features	EB	L	W
Qualifying Statement: *Despite the limitations and weak evidence for pharmacologic management, empirically there is some evidence of benefit to warrant their inclusion as an alternative option*			
Treatment and Care Options for Anxiety Symptoms			
3.1. For patients with moderate to severe anxiety symptoms, culturally informed and linguistically appropriate information should be provided to patients and patient-identified caregivers, family members, or trusted confidants. Information might include the following: commonality (frequency) of stress and anxiety, psychological, behavioral, and cognitive symptoms, indications of symptom worsening, and medical team contact information	EB	I	S
3.2. For a patient with moderate symptoms of anxiety, clinicians should offer individual or group therapy with any one of the following treatment options: Cognitive behavior therapy Behavioral activation Structured physical activity and exercise Psychosocial interventions with empirically supported components (eg, relaxation, problem solving)	EB	I	S
3.3. For a patient with severe symptoms of anxiety, clinicians should offer individual therapy with any one of the following treatment options: Cognitive behavior therapy Behavioral activation Mindfulness-based stress reduction Interpersonal therapy	EB	I	S
3.4. Treating clinicians may offer a pharmacologic regimen for anxiety in patients without access to first-line treatment, those expressing a preference for pharmacotherapy, or those who do not improve after first-line psychological or behavioral management	EB	L	W

FIG 1. Summary of guideline recommendations. EB, evidence-based; I, intermediate; L, low; S, strong; W, weak.

through primary care,[14] but special arrangements might need to be made for timely evaluations. Other resources should be explored including listings of therapists (eg, Psychology Today[15] or similar services), or considering therapy provision through commercial telehealth providers. However, some communities might lack sufficient mental health resources, and oncology practices may need to consider increasing the number of their psychosocial clinicians.

QUESTION: IS THERE A ROLE FOR MEDICATIONS IN THE MANAGEMENT OF DEPRESSION AND ANXIETY IN INDIVIDUALS WITH CANCER?

The panel concluded that there are no data that psychiatric medications are superior to psychosocial interventions for mild-to-moderate depression and anxiety in individuals with cancer. There is stronger evidence for the efficacy of psychosocial interventions than medications. Although psychiatric medications should not be avoided, psychosocial interventions should be first-line treatments. The stepped-care approach, with first-line psychosocial interventions and medications as additive treatments, is supported by randomized clinical trials of the collaborative care model in individuals with cancer.[16] However, some circumstances may warrant consideration of medications over or in addition to psychological or behavioral interventions. These include a patient preference for medications; severe depression and anxiety, especially if the symptoms impair the ability to engage in treatment; subtypes of depression (eg, major depressive disorder with psychotic features); and for individuals with a history of depression and anxiety who previously responded to a particular medication. Additionally, medications can act more quickly for immediate and short-term management of severe anxiety.[17]

QUESTION: WHAT IS THE ROLE OF CANCER CENTERS IN MANAGING THE MENTAL HEALTH NEEDS OF THEIR PATIENTS?

Patients with depression and/or anxiety are not emotionally stable, are not able to maintain their quality of life, and are at risk for symptom exacerbation and premature death regardless of treatment receipt.[18,19] Screening is essential but only when uncovering symptoms results in appropriate management.[20,21] Unfortunately, this cannot occur in the context of an underfunded and overwhelmed system of mental health care in the United States. Depression and anxiety rose significantly during the COVID-19 pandemic, making insufficient numbers of providers, inefficiencies in care provision, inequities in care delivery, and other problems abundantly clear.[22-26] Cancer centers struggled with timely access to mental health services, particularly psychiatry,[9] before the pandemic,[27] and are now confronted with an increased pressure to manage additional mental health needs of their patients.

Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs[28] listed three primary sources of care delivery: (1) major cancer centers serving as full-service providers, (2) community-based centers providing some of this care and also partnering with community organizations to fill the complementary gaps in coverage, and (3) a telemedicine model of care provision for those centers remotely based and/or with limited internal and local resources. One source is not superior to any other, rather, key is access to care.

Cancer centers urgently need to develop solutions to increase and expand access. These could include investing in more psychosocial clinicians to provide care in-house or reorganizing existing services into population health-based models better suited to high volumes, such as the collaborative care model or other integrated behavioral health models.[27] As enormous resources are spent on high-cost cancer treatments, lack of access to mental health care could be considered an ethical challenge, akin to rationing that was recognized as a potential path related to medical resource scarcity during the COVID-19 pandemic.[29] Although most cancer centers in the United States did not need to ration cancer treatment, mental health services, by contrast, have been rationed because of insufficient financial resources and omission of psychosocial care in institutional missions. To effectively treat patients with cancer, cancer centers need to address the holistic health-related needs of their patients that jeopardize cancer outcomes, including mortality. If mental health services are not available in the community for patients in the most need, cancer centers need to re-evaluate their responsibility to their patients and ensure availability within their facilities.

AFFILIATIONS

[1]Dana-Farber Cancer Institute, Boston, MA
[2]Brigham and Women's Hospital and Dana-Farber Cancer Institute, Boston, MA
[3]Smith Center for Healing and the Arts, Washington, DC
[4]American Society of Clinical Oncology, Alexandria, VA
[5]The Ohio State University, Columbus, OH

CORRESPONDING AUTHOR

American Society of Clinical Oncology, 2318 Mill Rd, Ste 800, Alexandria, VA 22314; e-mail: guidelines@asco.org.

DISCLAIMER

This Q&A is derived from recommendations in Management of Anxiety and Depression in Adult Survivors of Cancer: ASCO Guideline Update. This document is based on an ASCO Guideline and is not intended to substitute for the independent professional judgment of the treating physician. Practice guidelines do not account for individual variation among patients. This Q&A does not purport to suggest any particular course of medical treatment. Use of the guideline and this Q&A are voluntary. Please refer to the complete guideline to understand the full recommendations.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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AUTHOR CONTRIBUTIONS

Conception and design: All authors
Administrative support: Christina Lacchetti
Collection and assembly of data: All authors
Data analysis and interpretation: All authors
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Final approval of manuscript: All authors
Accountable for all aspects of the work: All authors

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William Pirl
Honoraria: Wiley

Larissa Nekhlyudov
Honoraria: UpToDate

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