

## SCREENING, ASSESSMENT, AND CARE OF ANXIETY AND DEPRESSIVE SYMPTOMS IN ADULTS WITH CANCER\*

**Clinical Question: What are the optimum screening, assessment and psychosocial-supportive care interventions for adults with cancer who are identified as experiencing symptoms of depression and/or anxiety?**

### *Recommendations: Screening for Depressive Symptoms*

All patients should be screened for depressive symptoms at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease or treatment status (i.e., post-treatment, recurrence, progression) and transition to palliative and end-of-life care.

Screening suggested at initial diagnosis, start of treatment, regular intervals during treatment, end of treatment, post-treatment or at transition to survivorship, at recurrence or progression, advanced disease, when dying, and during times of personal transition or re-appraisal such as family crisis, during post-treatment survivorship and when approaching death.

Screening should be done using a valid and reliable measure that features reportable scores (dimensions) that are clinically meaningful (established cut-offs).

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When assessing a person who may have depressive symptoms, a phased screening and assessment is recommended that does not rely simply on a symptom count.

- As a first step for all patients, identification of the presence or absence of pertinent history or risk factors (See Depression Algorithm.) is important for subsequent assessment and treatment decision making.
- As a second step, two items from the PHQ-9 can be used to assess for the classic depressive symptoms of low mood and anhedonia. For individuals endorsing either item (or both) as occurring for more than half of the time or nearly every day within the last two weeks (i.e., a score of  $\geq 2$ ), a third step is suggested in which the patient completes the remaining items of the PHQ-9. It is estimated that 25-30% of patients would need to complete the remaining items.
- The traditional cutoff for the PHQ-9 is  $> 10$ . The Panel's recommended cutoff score of  $> 8$  is based on a study of the diagnostic accuracy of the PHQ-9 with cancer outpatients. A meta-analysis by Manea et al also supports the  $> 8$  cutoff score.
- For patients completing the latter step it is important to determine the associated sociodemographic, psychiatric or health comorbidities, or social impairments, if any, and the duration that depressive symptoms have been present.
- Of special note, one of remaining seven items of the PHQ-9 assesses thoughts of self harm, i.e., "Thoughts that you would be better off dead or hurting yourself in some way." Among patients with moderate to severe or severe depression, such thoughts are not rare. Having noted that, it is the frequency and/or specificity of the thoughts that are most important vis-a-vis risk. Some clinicians/practices may choose to omit the item from the PHQ-9 and administer 8-items. It should be noted, however, that doing may artificially lower the score, with the risk of some patients appearing to have fewer symptoms than they actually do. Such changes also weaken the predictive validity of the score and the clarity of the cutoff scores. It is important to note that individuals do not typically endorse a self-harm item exclusively or independent of other symptom; rather, it occurs with several other symptom endorsements. Thus, it is the patient's endorsement of multiple symptoms that will define the need for services for moderate/severe to severe symptomatology.

Consider special circumstances in the assessment of depressive symptoms. These include but are not limited to the following: (a) use culturally sensitive assessments and treatments as is possible, (b) tailor assessment or treatment for those with learning disabilities or cognitive impairments, (c) be aware of the difficulty of detecting depression in the older adult.

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### *Recommendations: Assessment of Depressive Symptoms*

Specific concerns such as risk of harm to self and/or others, severe depression or agitation, or the presence of psychosis or confusion (delirium) require immediate referral to a psychiatrist, psychologist, physician, or equivalently trained professional.

Assessments should be a shared responsibility of the clinical team, with designation of those who are expected to conduct assessments as per scope of practice.

The assessment should identify signs and symptoms of depression, the severity of cancer symptoms (e.g., fatigue), possible stressors, risk factors, and times of vulnerability. A range of problem checklists is available to guide the assessment of possible stressors. Examples of these are accessible at [www.asco.org/adaptations/depression](http://www.asco.org/adaptations/depression). Clinicians can amend checklists to include areas not represented or ones unique to their patient populations.

Patients should first be assessed for depressive symptoms using the Patient Health Questionnaire 9 (PHQ-9). Table 2 in the guideline adaptation publication provides a list of other depressive symptom assessment measures, which can be used in follow up to the PHQ-98 or as alternatives.

If moderate to severe or severe symptomatology is detected through screening, individuals should have further diagnostic assessment to identify the nature and extent of the depressive symptoms and the presence or absence of a mood disorder.

Medical or substance-induced causes of significant depressive symptoms (e.g., Interferon administration) should be determined and treated.

As a shared responsibility, the clinical team must decide when referral to a psychiatrist, psychologist, or equivalently trained professional is needed. This includes, for example, all patients with a PHQ-9 score in the severe range or patients in moderate range but with pertinent history/risk factors. Such would be determined using measures with established reliability, validity, and utility (e.g., cut-off or normative data available) or standardized diagnostic interviews for assessment and diagnosis of depression.

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For any patient who is identified as at risk of harm to self and/or others, refer to appropriate services for emergency evaluation. Facilitate a safe environment and one-to-one observation, and initiate appropriate harm-reduction interventions to reduce risk of harm to self and/or others.

First treat medical causes of depressive symptoms (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte imbalance).

For optimal management of depressive symptoms or diagnosed mood disorder use pharmacological and/or non-pharmacological interventions (e.g., psychotherapy, psycho-educational therapy, cognitive-behavioral therapy, and exercise) delivered by appropriately trained individuals.

These guidelines make no recommendations about specific antidepressant pharmacological regimens being better than another. The choice of an antidepressant should be informed by the side effect profiles of the medications, tolerability of treatment, including the potential for interaction with other current medications, response to prior treatment, and patient preference. Patients should be warned of any potential harm or adverse effects.

Offer support and provide education and information about depression and its management to all patients and their families, including what specific symptoms and what degree of symptom worsening warrants a call to the physician or nurse.

Special characteristics of depressive disorders are relevant for diagnosis and treatment, including the following:

- Many individuals (50-60%) with a diagnosed depressive disorder will have a comorbid anxiety disorder, with generalized anxiety being the most prevalent.
- If an individual has comorbid anxiety symptoms or disorder(s), the route is usually to treat the depression first.
- Some people have depression that does not respond to an initial course of treatment.

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## SCREENING, ASSESSMENT, AND CARE OF ANXIETY AND DEPRESSIVE SYMPTOMS IN ADULTS WITH CANCER\*

It is recommended to use a stepped care model and tailor intervention recommendations based on variables such as the following:

- Current symptomatology level and presence/absence of DSM-V diagnosis
- Level of functional impairment in major life areas
- Presence/absence of risk factors
- History of and response to previous treatments for depression
- Patient preference
- Persistence of symptoms following receipt of an initial course of depression treatment

Psychological and psychosocial interventions should derive from relevant treatment manuals for empirically supported treatments specifying the content and guiding the structure, delivery mode, and duration of the intervention.

Use of outcome measures should be routine (minimally pre and post treatment) to a) gauge the efficacy of treatment for the individual patient; b) monitor treatment adherence; and, c) evaluate practitioner competence.

### ***Recommendations: Treatment and Care Options for Depressive Symptoms***

It is common for persons with depressive symptoms to lack the motivation necessary to follow through on referrals and/or to comply with treatment recommendations. With this in mind, on a bi-weekly or monthly basis, until symptoms have remitted:

- Assess follow-through and compliance with individual or group psychological/psychosocial referrals, as well as satisfaction with these services.
- Assess compliance with pharmacologic treatment, patient's concerns about side effects, and satisfaction with the symptom relief provided by the treatment.
- If compliance is poor, assess and construct a plan to circumvent obstacles to compliance, or discuss alternative interventions that present fewer obstacles.
- After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are poor, despite good compliance, alter the treatment course (e.g., add a psychological or pharmacological intervention; change the specific medication; refer to individual psychotherapy if group therapy has not proved helpful).

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## SCREENING, ASSESSMENT, AND CARE OF ANXIETY AND DEPRESSIVE SYMPTOMS IN ADULTS WITH CANCER\*

### *Recommendations: Screening for Anxiety*

All health care providers should routinely screen for the presence of emotional distress and specifically symptoms of anxiety from the point of diagnosis onward.

All patients should be screened for distress at their initial visit, at appropriate intervals and as clinically indicated, especially with changes in disease status (i.e., post-treatment, recurrence, progression) and when there is a transition to palliative and end-of-life care.

Screening is suggested at initial diagnosis, start of treatment, regular intervals during treatment, end of treatment, post-treatment or at transition to survivorship, at recurrence or progression, advanced disease, when dying, and during times of personal transition or re-appraisal such as family crisis, during post-treatment survivorship and when approaching death.

Screening should identify the level and nature (problems and concerns) of the distress as a red flag indicator.

Screening should be done using a valid and reliable tool that features reportable scores (dimensions) that are clinically meaningful (established cut-offs).

Anxiety disorders include specific phobias and social phobia, panic and agoraphobia, generalized anxiety disorder (GAD), obsessive compulsive disorder, and post-traumatic stress disorder (PTSD).

It is recommended that patients be assessed for generalized anxiety disorder, as it is the most prevalent of all anxiety disorders and it is commonly comorbid with others, primarily mood disorders or other anxiety disorders (e.g., social anxiety disorder).

Use of the Generalized Anxiety Disorder (GAD)-7 scale (Table 1 in manuscript) is recommended. Table 2 (in the manuscript) provides a list of other assessment measures for symptoms of anxiety, nervousness, and GAD.

Patients with GAD do not necessarily present with symptoms of anxiety, per se. The pathognomic GAD symptom, i.e., multiple excessive worries, may present as 'concerns' or 'fears.' Whereas cancer worries may be common for many, GAD worry or fear may be disproportionate to actual cancer-related risk (e.g., excessive fear of recurrence, worry about multiple symptoms or symptoms not associated with current disease or treatments). Importantly, an individual with GAD has worries about a range of other, non-cancer topics and areas of his/her life.

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It is important to determine the associated home, relationship, social, or occupational impairments, if any, and the duration that anxiety related symptoms. As noted above, problem checklists can be used. Examples of these are accessible at [www.asco.org/adaptations/depression](http://www.asco.org/adaptations/depression). Clinicians can amend the checklists to include additional key problem areas or ones unique to their patient populations.

As with depressive symptoms, consider special circumstances in screening/assessment of anxiety including using culturally sensitive assessments and treatments and tailoring assessment or treatment for those with learning disabilities or cognitive impairments.

### ***Recommendations: Assessment of Anxiety***

Specific concerns such as risk of harm to self and/or others, severe anxiety or agitation, or the presence of psychosis or confusion (delirium) requires referral to a psychiatrist, psychologist, physician, or equivalently trained professional.

When moderate to severe or severe symptomatology is detected through screening, individuals should have a diagnostic assessment to identify the nature and extent of the anxiety symptoms and the presence or absence of an anxiety disorder or disorders.

Medical and substance-induced causes of anxiety should be diagnosed and treated.

As a shared responsibility, the clinical team must decide when referral to a psychiatrist, psychologist or equivalently trained professional is needed (i.e., all patients with a score in the moderate to severe or severe range, with certain accompanying factors and/or symptoms, identified using valid and reliable measures for assessment of symptoms of anxiety).

Assessments should be a shared responsibility of the clinical team, with designation of those who are expected to conduct assessments as per scope of practice.

The assessment should identify signs and symptoms of anxiety (e.g., panic attacks, trembling, sweating, tachypnea, tachycardia, palpitations, and sweaty palms), severity of symptoms, possible stressors (e.g., impaired daily living), risk factors and times of vulnerability, and should also explore underlying problems/causes.

A patient considered to have severe symptoms of anxiety following the further assessment should, where possible, have confirmation of an anxiety disorder diagnosis before any treatment options are initiated (e.g., DSM-V, which may require making a referral).

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***Recommendations: Treatment and Care Options for Anxiety Symptoms***

For any patient who is identified as at risk of harm to self and/or others, clinicians should refer to appropriately trained professionals for emergency evaluation. Facilitate a safe environment and one-to-one observation, and initiate appropriate harm-reduction interventions to reduce risk of harm to self and/or others.

It is suggested that the clinical team making a patient referral for the treatment of anxiety review with the patient in a shared decision process, the reason(s) for and potential benefits from the referral. Further, it is suggested that the clinical team subsequently assess the patient's compliance with the referral and treatment progress or outcomes.

First treat medical causes of anxiety (e.g., unrelieved symptoms such as pain and fatigue) and delirium (e.g., infection or electrolyte imbalance).

For optimal management of moderate to severe or severe anxiety, consider pharmacological and/or non-pharmacological interventions delivered by appropriately trained individuals. Management must be tailored to individual patients, who should be fully informed of their options.

For a patient with mild to moderate anxiety, the primary oncology team may choose to manage the concerns by usual supportive care management.

The choice of an anxiolytic should be informed by the side effect profiles of the medications, tolerability of treatment, including the potential for interaction with other current medications, response to prior treatment and patient preference. Patients should be warned of any potential harm or adverse effects. Caution is warranted with respect to the use of benzodiazepines in the treatment of anxiety, specifically over the longer term. These medications carry an increased risk of abuse and dependence and are associated with side effects that include cognitive impairment. As a consequence, use of these medications should be time limited in accordance with established psychiatric guidelines.

Offer support and provide education and information about anxiety and its management to all patients and their families and what specific symptoms or symptom worsening warrant a call to the physician or nurse.

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- Current symptomatology level and presence/absence of DSM-V diagnoses
- Level of functional impairment in major life areas
- Presence/absence of risk factors
- Chronicity of GAD and response to previous treatments, if any
- Patient preference
- Persistence of symptoms following receipt of the current anxiety treatment

Psychological and psychosocial interventions should derive from relevant treatment manuals of empirically supported treatments specifying the content and guiding the structure, delivery mode, and duration of the intervention. Use of outcome measures should be routine (minimally pre and post treatment) to a) gauge the efficacy of treatment for the individual patient; b) monitor treatment adherence; and c) evaluate practitioner competence.

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### *Recommendations: Follow-Up and Re-assessment*

As cautiousness and a tendency to avoid threatening stimuli are cardinal features of anxiety pathology, it is common for persons with symptoms of anxiety to not follow through on potentially helpful referrals or treatment recommendations. With this in mind, it is recommended that the mental health professional or other member of the clinical team managing the patient's anxiety, on a monthly basis or until symptoms have subsided:

- Assess follow-through and compliance with individual or group psychological or psychosocial referrals, as well as satisfaction with the treatment.
- Assess compliance with pharmacologic treatment, patient's concerns about side effects, and satisfaction with the symptom relief provided by the treatment.
- Consider tapering the patient from medications prescribed for anxiety if symptoms are under control and if the primary environmental sources of anxiety are no longer present. . Longer periods of tapering are often necessary with benzodiazepines, particularly with potent or rapidly eliminated medications.
- If compliance is poor, assess and construct a plan to circumvent obstacles to compliance, or discuss alternative interventions that present fewer obstacles.
- After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are poor, despite good compliance, alter the treatment course (e.g., add a psychological or pharmacological intervention; change the specific medication; refer to individual psychotherapy if group therapy has not proved helpful).

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