ASCO® Guidelines

Management of Anxiety and Depression in Adult Survivors of Cancer: ASCO Guideline Update				
Category	**Recommendation**	**Type**	**Evidence Quality**	**Strength**
General Management Principles	**1.1.** All patients with cancer and any patient-identified caregiver, family member, or trusted confidant should be offered information* regarding depression and anxiety. They should also be offered resources, such as the providers' contact information for further evaluation and treatment within or external to the facility whenever available.	EB	I	S
	Qualifying Statement: **Information should be culturally informed and linguistically appropriate and can include a conversation between clinician and patient, and/or electronic or written material on depression and anxiety. Examples of materials can be found at Cancer.Net, such as ASCO Answers Anxiety and Depression.*			
	1.2. Clinicians should use a stepped-care model, i.e., selecting the most effective and least resource intensive intervention based on symptom severity when selecting treatment for anxiety and/or depression. Other variables which may inform the choice of treatment approach include the following: • Psychiatric history, i.e., prior diagnoses, with or without treatment • History of substance use • Prior mental health treatment response • Functional abilities and/or limitations related to self-care, usual activities, and/or mobility • Recurrent or advanced cancer • Presence of other chronic disease(s) (e.g., cardiac disease) • Member of socially and/or economically marginalized group (e.g., Black race, low SES)	EB	I	S
	1.3. Psychological and psychosocial interventions provided by mental health practitioners should derive from manualized, empirically supported treatments. Manuals for evidence-based treatments specify content, structure, delivery mode, session number, treatment duration, and related topics. Linguistic, cultural, and socioecological contexts need to guide any treatment tailoring.	EB	I	M

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	1.4. When making a referral for further evaluation or psychological care, clinicians should make every effort to reduce barriers and facilitate patient follow-through. Determining follow through to the first appointment is essential as is discovering any barriers that may have arisen for the patient. Thereafter, determining patient satisfaction and assisting with any new and/or continuing barriers would also be helpful.	IC	Ins	M
	1.5. For patients who have symptoms of both depression and anxiety, treatment of depressive symptoms should be prioritized. Alternatively, treatment with a unified protocol (i.e., combining CBT treatments for depression and anxiety) may be used.	EB	H	S
	1.6. For patients referred to and receiving psychological treatment, mental health professionals should regularly assess treatment response (e.g., pre-treatment, 4-weeks, 8-weeks, and end of treatment).	EB	I	S
	1.7. If pharmacologic treatment is used, the treating clinician should regularly (e.g., 4 and 8- weeks) assess using standardized validated instruments, the extent of a patient's symptom relief, side effect and adverse event occurrence, and satisfaction. If symptoms are stable or worsening, the treating clinician should re-evaluate the plan and revise.	IC	Ins	S
	1.8. After 8 weeks of treatment for depression and/or anxiety, if there is little improvement in symptoms despite good adherence, the treating clinician should adjust the regimen (e.g., add a psychological or pharmacological intervention to a single treatment; if pharmacologic, change the medication; and if group therapy, refer to individual therapy). The same considerations may apply if patient satisfaction with treatment is low and/or barriers to treatment exist.	IC	Ins	M
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

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	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 (e.g., 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 following 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

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	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 (e.g., 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 following first-line psychological or behavioral management.	EB	L	W

Abbreviations. CBT, cognitive behavior therapy; EB, evidence based; H, high; I, intermediate; IC, informal consensus; Ins, insufficient; L, low; M, moderate; S, strong; SES, socioeconomic status; W, weak

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