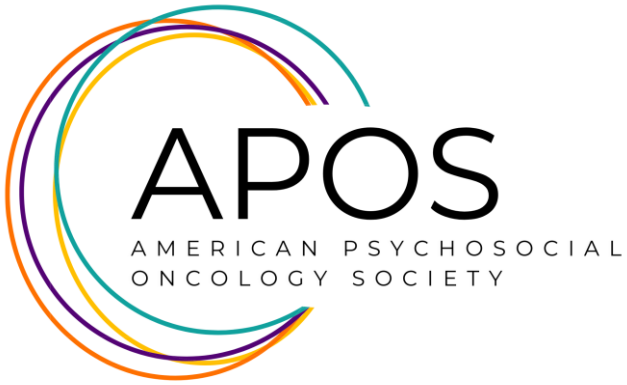
APOS PSYCHOSOCIAL POCKET GUIDE APPENDIX OF TABLES



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Standards & Best Practices

Table 1. Key Requirements for Distress Management

Organization	Screening construct	Requirement	Timing	Follow up
NCCN Guidelines® (2024 version)[3]	Broad conceptualization of distress (physical, psychological, social, spiritual)	Assessment, documentation, and treatment – at all stages of disease and in all settings	Regular screening, at minimum at "pivotal visits"	Clinical assessment to determine nature of distress and appropriate follow-up
ASCO (2020 version)[4]	Mental health, social status, functional capacity	Assessment and documentation of psychosocial concerns and need for support	Each chemotherapy cycle	Information about and/or referral to psychosocial services provided
CoC (2020 version)[5]	Broad conceptualization of distress (physical, psychological, social, spiritual, financial)	Assessment, documentation, and triage to needed services (in house or by referral)	At least once and before the first course of any treatment	Clinical assessment for moderate or severe distress; Resources and/or referral for psychosocial needs

Standards & Best Practices

Table 2. Candidate Screening Measures

Screening Measure	Constructs assessed	Clinical Utility			# items	Unique Attributes
		Severity score	Diagnostic case finding	Content validity*		
Patient-Reported Outcomes Measurement Information System (PROMIS)[8]	Depression, anxiety, physical function, fatigue, pain, pain interference, ability to participate in social roles and activities, and sleep disturbance. Many more constructs available.	x	x	x	4-8 items per construct Reduced item, ultra-short versions available	Rigorous validity and reliability High sensitivity and specificity EPIC integration available CAT** available to reduce patient response burden (lower content validity)
Edmonton Symptom Assessment System (ESAS)[9]	Depression, anxiety, pain, tiredness, drowsiness, nausea, lack of appetite, shortness of breath, overall well-being (and a fill in the blank item)	x	x		10 total, 1 item per construct	Single item per construct — relies on individual patient definition of construct Includes nausea and appetite Includes fill in the blank item for patient identified symptom Includes bodily location
Patient Health Questionnaire (PHQ-9), General Anxiety Disorder scale (GAD-7)[10]	Depression, Anxiety	x	x	x	9, 7 Reduced item, ultra-short versions available	Suicide item included in PHQ-9
Hospital Anxiety and Depression Scale (HADS)[11]	Depression, Anxiety	x	x	x	14 (7 items for each)	
NCCN Distress Thermometer (DT)[3,12]	General distress + problem checklist	x			1 + multi-item	Low specificity, positive screens require further assessment due to low case-finding utility.

					problem checklist	
Religious and Spiritual Struggles Scale (RSS)[13]	Religious and spiritual distress			x	26	Comprehensive assessment of 6 sub-domains of religious and spiritual distress

*Content validity requires several items to fully assess the "symptom content" of a single construct. As the number of items for each construct decreases, core symptoms are left out and content validity and specificity naturally decrease. As a consequence of low content validity, the need for downstream clinician time and effort increases in the form of assessment and interview. Thus, ultra-short measures (<=5 items) tend to have lower content validity and specificity than short measures (<15 items).[14]

**CAT- Computerized Adaptive Testing

Model Pathways for Distress Management

Table 3. Models for Addressing the Components of Distress Management

Component of DM	Model 1 (least involved/integrated)	Model 2	Model 3 (most involved/integrated)
Timing	A. Start of care B. Pivotal points in care • Remission • Recurrence • Progression • New treatment modality • Completion of treatment	• Timed • Initial Visit • Timed intervals	• Every visit • Exceptions for particular settings, e.g.: • Weekly in radiation oncology • Start of new treatments in infusion
Method of screening	Clinician administered screening	Patient administered screening	Electronic administration
Assessment	Unidimensional distress screening instrument	Emphasis on select patient-centered needs (e.g., depression, physical symptoms)	Multidimensional screening measure or combination of measures, e.g., general multidimensional screening followed by additional assessment tailored to identified needs
Referral	Oncologist manages all aspects of screening and referral	Identified non-mental health staff support oncologist in reviewing screening and triaging to needed services	Specified staff follow-up on screening, perform further assessment, and triage to needed services
Integration/ Collaboration	Coordinated: C. Basic collaboration at a distance, e.g., supportive services and medical services operate in separate systems	Co-located: D. Collaboration on-site, at least some system sharing, in-person communication possible	Integrated: E. Shared concept of team care F. Shared culture G. System and facility sharing, consistent communication
Staffing	H. Physician champions I. Nurses/medical assistants J. Administrative leadership K. (all supportive services external)	L. Physician champions M. Nurses/medical assistants N. Administrative leadership O. Information technology experts P. Social workers Q. (some supportive services internal)	R. Physician champions S. Nurses/medical assistants T. Psychologist/Psychiatrist U. Information technology experts V. Administrative leadership W. Social workers X. Chaplains Y. (most or all supportive services internal)

Assessment & Equity Variables in Unique, High Risk Populations

Table 4. PRAPARE Questions for Assessing SDOH

Personal Characteristics	
1	Are you Hispanic or Latino?
2	Which race(s) are you? Check all that apply.
3	At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?
4	Have you been discharged from the armed forces of the United States?
5	What language are you most comfortable speaking?
Family and Home	
6	How many family members, including yourself, do you currently live with?
7	What is your housing situation today?
8	Are you worried about losing your housing?
9	What address do you live at?
Money and Resources	
10	What is the highest level of school that you have finished?
11	What is your current work situation?
12	What is your main insurance?
13	During the past year, what was the total combined income for you and your family members you live with?
14	In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.
15	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.
Social and Emotional Health	
16	How often do you see or talk to people that you care about and feel close to?
17	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
Optional Additional Questions	
18	In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?
19	Are you a refugee?
20	Do you feel physically and emotionally safe where you currently live?
21	In the past year, have you been afraid of your partner or ex-partner?

PRAPARE Electronic Health Record (EHR) templates are freely available for Cerner, eClinicalWorks, Epic, GE Centricity, Greenway Intergy, and NextGen. Users must first sign an "End User License Agreement," which can be completed online at https://prapare.org/license-agreements/eula/. An Excel file template is also available for standardized PRAPARE data collection without EHR integration (http://www.nachc.org/wp-content/uploads/2019/01/Excel-version-of-PRAPARE_Tool_Mass-League.xlsm).

Assessment & Equity Variables in Unique, High Risk Populations

Table 5. Questions to Ask Patients About Their Understanding of Their Health Condition:

1. What do you call your health condition?

2. Why do you think it started --when it did and what caused it?
3. How has the sickness affected you? your body/ mind / family/ finances/day to day life and social activities/ faith/spirituality/ purpose/priorities/ feelings about you and life?
4. How severe is the sickness? Will it have a long or a short course?
5. What kind of treatment do you think you should receive?
6. What do you need to make you better or heal?
7. What are the chief challenges/problems the sickness has caused?
8. What do you fear most about the sickness?

^ adapted from Kleinman's 8 questions to elicit patient's understanding of their health condition [19]

Assessment & Equity Variables in Unique, High Risk Populations

Table 6. Specific Recommendations for Integrating Culture into Clinical Practice

	Five Recommendations
1	Structure information elicited for the Social History using the 7 cultural components of culture (i.e., environment, economy, technology, religion/world view, language and health literacy, social structure, and beliefs and values)
	Be aware of cultural and individual variations
	Apply information to provide patient- and family-centered care
2	Integrate culturally-based knowledge and communication styles for culturally responsive patient-centered care
	Know your own personal biases
	Use culturally appropriate communication etiquette
	Include use of trained medical interpreters
3	Assess your practice and hospital structures that hinder/support culturally competent practice (e.g., federal standards for Culturally and Linguistically Appropriate Services in Healthcare [CLAS])
4	Integrate recommendations of the Institute of Medicine 2009 Report "*Toward Health Equity and Patient Centeredness: Integrating Health Literacy, Disparities Reductions and Quality Improvement*"
5	Incorporate community resources for ethnic-specific support of cancer patients and their families
	Community organizations that provide bilingual and bicultural services; Culturally competent agencies, such as American Cancer Society (1-800-ACS-2345)

^ adapted from Kagawa-Singer et al, 2010, Cancer*, culture, and health disparities: Time to chart a new course?*[18]

Medical Conditions Presenting as Psychiatric Symptoms

Table 1: Selected Etiologies of Neuropsychiatric Symptoms in Oncology

Brain cancer	Primary brain cancers (e.g., glioblastoma multiforme; CNS lymphoma) Metastatic brain cancer: Most prevalent in primary cancer of lung, breast, melanoma, colorectal, and renal cell Presenting symptoms vary depending on location: headaches (40-50%), focal neurological deficits (30-40%), cognitive impairment (30-35%), seizures (15-20%), stroke (5-10%) Diagnosed via brain MRI, ring-enhancing with surrounding edema
Leptomeningeal disease	Dissemination of malignant cells through subarachnoid space Most prevalent in primary cancer of breast, lung, melanoma, GI malignancies, leukemia, lymphoma Most commonly involves base of the brain, Sylvian fissure, and cauda equina Presenting symptoms vary depending on location, related to increased intracranial pressure, meningeal irritation, and/or nerve disruption: headaches (30-50%), nausea/vomiting (25%), seizures (25%), leg weakness (21%), cerebellar dysfunction (17%), altered mental status (16%), cranial nerve involvement Diagnosed via brain MRI (sensitive), cerebrospinal fluid cytology (specific)
Paraneoplastic syndromes	Immunologic factors directed toward antigens (either intracellular or cell surface/synaptic) that are expressed by tumor and healthy cells, leads to remote neurological effects Some clinical syndromes are well-documented (Lambert-Eaton Myasthenic Syndrome in 3% of small cell lung cancer Myasthenia gravis in 15% of thymomas, Limbic Encephalitis, Paraneoplastic Cerebellar Degeneration, Anti-NMDA Receptor Encephalitis) Diagnosed primarily by clinical syndrome, CSF and/or serum cytology (specific) 80% are diagnosed in people without a known cancer diagnosis
Tumor Lysis Syndrome	Caused by cancer cell death leading to the release of intracellular contents Hyperuricemia and hyperphosphatemia lead to acute kidney injury High rates of delirium
Thiamine deficiency	Wernicke encephalopathy describe the acute process and is a medical emergency Prevalence in oncology is unknown but suspected to be underdiagnosed: gastrointestinal cancers > hematologic cancers > gynecologic cancers > CNS cancers Classic triad of symptoms: encephalopathy, oculomotor abnormalities, and gait disturbance; most patients do not have all 3 Caine criteria for diagnosis in alcohol use disorder (not specifically studied in oncology): ≥2 of the following symptoms: dietary deficiency, oculomotor abnormalities, cerebellar dysfunction, AMS Rule of thumb: if there's concern, treat it Use of 500 mg IV thiamine preferred over 100 mg PO during acute phase
	Korsakoff syndrome describes chronic amnestic syndrome
Hypothyroidism	Can occur regardless of cancer status Potential side effect of immunotherapy agents and radiation; check thyroid function tests and collaborate with endocrinology for management
Adrenal insufficiency	Can occur due to cancer or withdrawal of steroids Non-specificity of symptoms make it difficult to diagnose: weakness, nausea, vomiting, anorexia, dehydration Diagnosed by lab abnormalities in electrolytes (sodium, potassium, kidney function)

Medical Conditions Presenting as Psychiatric Symptoms

Table 2: Neuroleptic Malignant Syndrome (NMS) and Serotonin Toxicity (ST)

Diagnosis	**NMS**	**ST**
Cause	Dopamine antagonists Examples: antipsychotics, antiemetics	Serotonergic agents: most cases are a result of two or more serotonergic agents used in combination Examples: antidepressants, buspirone, triptans, tramadol, St. John's wort, cocaine, methylenedioxymethamphetamine (MDMA) , some antibiotics
Management	Stop offending agents	
	Supportive care to manage hyperthermia, agitation, hydration, etc.	
	Benzodiazepines if sedation is necessary	
	Consider cyproheptadine	Consider dantrolene, bromocriptine

Medical Conditions Presenting as Psychiatric Symptoms

Table 3: Common Toxic Syndromes

Toxidrome	Vital Signs	Pupils	Other	Example Causes
Cholinergic	↓HR, ↑/↓BP	Miosis	AMS, lacrimation, salivation, urinary incontinence, vomiting, diarrhea, muscle fasciculations, seizures	Organophosphates, pilocarpine, physostigmine, nicotine poisoning, Abrupt discontinuation of high dose anticholinergic agents
Anticholinergic	↑HR, ↑BP, ↑T	Mydriasis	AMS, dry skin, urinary retention, decreased bowel wounds, myoclonus, seizures	Antihistamines, atropine, scopolamine, tricylic antidepressants
Hallucinogenic	↑HR, ↑BP, ↑T	Mydriasis	AMS, hallucinations and illusions, depersonalization, nystagmus	LSD, mescaline, psilocybin
Sedative-hypnotic	N or ↓HR, ↓BP	Variable	AMS, hyporeflexia	Benzodiazepines, barbiturates, alcohol
Opioid	↓HR, ↓BP, ↓RR	Miosis	AMS, hyporeflexia	Opioids

HR, heart rate. BP, blood pressure. T, temperature.

Medical Conditions Presenting as Psychiatric Symptoms

Table 4: Medications Commonly Used in Oncology and Neuropsychiatric Adverse Effects

Medication	Side effects	Management Strategies
Corticosteroids	Anxiety, restlessness, insomnia	Dose reduction if possible Benzodiazepines
	Most common cause of hypomania/mania in cancer	Low dose atypical antipsychotics
Antiemetics	Akathisia (psychomotor restlessness experienced internally in the legs)	Minimize dopaminergic agents β-blockers, benzodiazepines
Cephalosporins	Delirium	Supportive care and symptom management; consideration of another antibiotic as per oncology team's decision making
Opioids	Toxicity-confusion, small pupils, slow breaths, cool skin, seizure Long-term use-bowel dysfunction, sleep disorders, hormonal disruptions, fractures	Supportive care and symptom management Direct to emergency department if necessary Refer to pain specialist
Tamoxifen	Irritability, depression, insomnia	Use of antidepressants; caution with strong CYP2D6 inhibitors serotonin norepinephrine reuptake inhibitors often used to target comorbid hot flashes and neuropathy; evidence based use of gabapentin is suggested
Interferon-alpha	Depression Rare cases of mania	Use of antidepressants Limited evidence for prophylactic use of antidepressants, presentation dependent
Chimeric antigen receptor t-cell therapy	Neurotoxicity related delirium (hypoactive or hyperactive)	Presentation dependent, often in hospital; no guidelines for treatment available at this time

Medical Conditions Presenting as Psychiatric Symptoms

Table 5: Catatonia

Definition	Neuropsychiatric syndrome with motor, vocal, affective, and behavioral changes
Signs	Can include mutism, impoverished speech, stupor, increased motor tone, grimacing, muscle rigidity, autonomic instability
Causes	Cancer illness, medications (tacrolimus, cyclosporine, antibiotics), co-morbid mental illness, psychiatric medication or substance withdrawal
Diagnosis	Clinical exam and Bush-Francis Catatonia Rating Scale
Management	Supportive care, lorazepam, N-methyl-D-aspartate receptor antagonist, electroconvulsive therapy

Delirium

Table 1. The Confusion Assessment Method for the Intensive Care Unit (CAM-ICU)		
	No	**Yes**
Feature 1: Acute onset or fluctuating course A. Is there evidence of an acute change in mental status from baseline? B. Or, did the behavior fluctuate during the past 24 hours?		
Feature 2: Inattention Ask the patient to squeeze the provider's hand when the provider says the letter A in a sequence of letters. Did the patient have difficulty focusing attention?		
Feature 3: Disorganized thinking A. Did they answer 3 or more of the following 4 questions incorrectly? 1. Will a stone float on water? 2. Are there fish in the sea? 3. Does 1 pound weigh more than 2 pounds? 4. Can you use a hammer to pound a nail? B. Or, did they demonstrate unclear thinking when asked to follow a command? Hold up 2 fingers and ask the patient to hold up the same number of fingers. Then ask them to do the same with the other hand without demonstrating it.		
Feature 4: Altered level of consciousness Is the patient's level of consciousness anything other than alert?		
Are Features 1 and 2 and either 3 or 4 present?		

Delirium

Table 2. Pharmacological Strategies for Managing Agitation in Delirium		
Medication Class	**Reasons to Consider**	**Cautions**
Typical antipsychotics	Available IV	Level of sedation varies Risk for EPS Risk for QT prolongation
Atypical antipsychotics	Available IM, dissolvable pills Lower risk for EPS Drug-specific impacts on appetite, nausea, sleep might be of benefit	Higher risk for metabolic side effects in long-term risk Risk for QT prolongation
Benzodiazepines	Class of choice for withdrawal from alcohol or benzodiazepines Class of choice for intoxication on stimulants or anticholinergic toxicity Useful in catatonia	Can exacerbate delirium when it is from other etiologies
Valproic acid	Available IV and in sprinkles Does not prolong QT Option for loading dose	Highly protein-bound. Risk of thrombocytopenia, hepatotoxicity.
Alpha adrenergic agonists	Dexmedetomidine is fast acting and highly effective for severe agitation in the ICU setting	Requires close monitoring
Melatonin	Reinforcement of proper day-night diurnal variation	Limited evidence for PRN use, favor scheduled use

Extrapyramidal symptoms, EPS. Pro re nata (as needed), PRN.

Acute Psychological Disorders

Common Acute Psychological Disorders	Clinical Presentation
Anxiety Disorder	Chronic, preexisting anxiety that is exacerbated by a cancer diagnosis and/or treatment. Common symptoms include irritability/anger, anxious mood, worry, and fear that is excessive and difficult to control.
Panic Attacks	Brief episode (i.e., several minutes) of severe anxiety and physiological arousal. Often comorbid with chronic or adjustment-related anxiety and depression. May be associated with claustrophobia/medical phobia (e.g., medical imaging, needles).
Depressive Disorder	Chronic, recurrent, or single episode of severe depressive symptoms exacerbated by a cancer diagnosis and/or treatment. Common symptoms include depressed mood, withdrawal from hobbies/interests, isolation, frequent crying, fatigue, appetite disturbance, sleep difficulties, fatigue, low self-worth, guilt, helplessness, hopelessness, and suicidal ideation.
Adjustment Disorder	Significant and short-term anxious and/or depressive symptoms in response to a stressful life event (e.g., cancer) that notably interfere with functioning.
Posttraumatic Stress Disorder (PTSD)	Intense, disturbing emotions following traumatic experiences that persist over time and emerge with exposure to triggers related to the original trauma, typically with threats to a person's safety or life. May manifest with intense anger/irritability, tearfulness, flashbacks, nightmares, or avoidance of triggering stimuli.
Substance Use Disorders	Uncontrolled use of a substance despite harmful consequences. May manifest as chronic escalation in use of prescribed controlled substances, inability to reduce use over time, or interference in ability to function due to impairment from effects of substances.
Bipolar Disorder	Episodes of intensely elevated or depressed mood lasting days or weeks. Elevated mood, termed mania, is characterized by decreased need for sleep, excessive energy and/or irritability. Psychotic symptoms may be present including auditory hallucinations, paranoia, or bizarre behavior.
Chronic Psychotic Disorders (Schizophrenia, Schizoaffective Disorder)	Chronic or episodic psychotic symptoms which can include disorganized thinking, bizarre behavior, paranoid or delusional thought content, or auditory hallucinations. Early cognitive decline and globally impaired functioning is common.

Acute Psychological Disorders
Brief Psychosocial Interventions:
Regardless of presenting concern, education, emotional support, and validation are integral elements of all psychosocial interventions. Below are brief, evidence-based interventions that can be tailored to a cancer patient's unique needs.

Positive events scheduling	What to do: 1) Find out what activities promote relaxation/positive mood 2) Encourage the patient to schedule at least 1 activity per day or 3) Plan an activity for the future (e.g., vacation) What it can help: Depression, Anxiety, Adjustment Disorders, Substance Use Disorders
Deep breathing	What to do: 1) Prompt the patient to place their hand on their stomach, inhale slowly, and feel their stomach rise and fall with their breath 2) Instruct the patient to hold the breath for a few seconds and to exhale slowly 3) Encourage the patient to practice several times daily for maximum benefit 4) If a heart rate monitor is available, it may be used to demonstrate how deep breathing lowers heart rate and blood pressure What it can help: Anxiety, Panic Attacks, Depression, Adjustment Disorders, PTSD, Bipolar Disorder, Chronic Psychotic Disorders
Promote support	What to do: 1) Ask who are the people in their life they go to when times are tough 2) Encourage reaching out to these supports during this time 3) Provide resources on relevant support groups What it can help: Depression, Anxiety, Panic Attacks, Adjustment Disorders, Substance Use Disorders, PTSD, Chronic Psychotic Disorders
Positive imagery	What to do: 1) Instruct the patient to close their eyes and imagine a place that makes them feel calm and relaxed 2) Immerse the patient in the imaginal experience by asking sensory-related questions (e.g., "What do you see?" "What can you smell?" "What do you hear?" etc.) What it can help: Anxiety, Panic Attacks, Depression, Adjustment Disorders
Positive distraction	What to do: 1) Identify activities the patient can easily engage in to distract from troublesome worries/thoughts (e.g., television, puzzles, coloring, reading, listening to music) 2) Engage in conversation about pleasant topics (e.g., hobbies, interests, family) What it can help: Anxiety, Panic Attacks, Depression, Adjustment Disorders, Substance Use Disorders, Bipolar Disorder, Chronic Psychotic Disorders
Rehearsal of feared procedures	What to do:

	1) Teach the patient relaxation techniques (i.e., deep breathing, positive imagery) to use throughout the procedure 2) Show the patient pertinent medical equipment and demonstrate how they work (e.g., MRI machine, immobilization device) 3) Educate the patient on what they can expect throughout the procedure and answer any questions What it can help: Anxiety, Panic Attacks, PTSD
Progressive muscle relaxation	What to do: 1) Instruct the patient to patient to take slow, deep breaths 2) During inhalation, prompt the patient to tense a muscle group (e.g., arms) and to hold the breath/tension for five seconds 3) Instruct the patient to release the tension during exhalation 4) Repeat with all major muscle groups (i.e., legs, torso, head and neck) What it can help: Anxiety, Panic Attacks, Depression, Adjustment Disorders, PTSD, Bipolar Disorder, Chronic Psychotic Disorders
Grounding techniques	What to do: 1) Instruct the patient to take slow, deep breaths 2) Orient the patient to their surroundings by having them engage their senses (e.g., playing soothing music, rubbing something soft, naming things they can see) What it can help: Anxiety, Panic Attacks, PTSD, Bipolar Disorder, Chronic Psychotic Disorders

Suicidal (Assessment, Risk, & Prevention)

Table 1: Suicide screening tools
Patient Health Questionnaire (PHQ-9) Beck Hopelessness Scale (BHS) SAD PERSONS Scale Manchester Self-Harm Rule (MSHR) Columbia Suicide Risk Assessment (C-SSRS) Ask Suicide-Screening Questions (ASQ)

Suicidal (Assessment, Risk, & Prevention)

Table 2: Emergent safety measures for acutely suicidal oncology patients	
Outpatients	● Emergent risk assessment and psychiatric evaluation ○ If immediately available, this can be done by outpatient psychiatry. ○ If not, ensure the patient or the patient's family brings the patient to the nearest emergency department. ○ A member of the medical team may need to escort the patient to the emergency department if in a connected facility. ○ If this is not feasible, call 911/emergency medical services to have the patient evaluated at the nearest emergency department. ○ For patients at home, a safety check facilitated by law enforcement may be necessary in the event the patient is unwilling to seek care voluntarily.
In ED Triage	● If suicidal thoughts occur in the context of an acute medical condition or related to a medication adverse effect, the patient will likely require a medical admission with constant 1:1 observation. ● If the suicidal crisis is not due to medical condition or medication, the patient will likely require inpatient psychiatric hospitalization.
Inpatients	● Constant 1:1 observation from the time suicidal thoughts are expressed. ● Follow hospital suicide safety protocols, including room searches for available means for self-harming behavior. ● Urgent psychiatric evaluation.

Psychological Disorders: *Anxiety*

Table 1. Most common anxiety disorders in cancer, ICD-10 codes, prevalence in cancer and the general population, and criteria for diagnosis

Anxiety Diagnosis	Prevalence in Cancer[1]	Prevalence in General Population	DSM-5 Criteria/Symptoms
Adjustment disorder with anxiety or with mixed anxiety and depressed mood (F43.22, F43.23)	15.4%-19.4%	2.94%-11.5% (varies substantially by population & stressors)	• Emotional or behavioral symptoms within three months of a specific stressor • Experiencing more stress than would normally be expected or stress causes significant problems in relationships, work, or school • Symptoms are not the result of another disorder or part of normal grieving
Generalized anxiety disorder (F41.1)	3.39%	2.57%	• Excessive worry about a variety of topics for a period of at least six months; may spend a lot of time each day worrying • Worry is difficult to control • Worry is accompanied by **at least three of the following symptoms:** ▪ Restlessness or edginess ▪ Tiring easily or more fatigued than usual ▪ Impaired concentration ▪ Irritability ▪ Increased muscle tension or soreness ▪ Sleep difficulties (often related to worry)
Panic disorder (F41.0)	2.22%	2.79%	• Panic attacks can occur in the absence of panic disorder. To meet criteria for panic disorder, patients must have **recurrent and unexpected attacks** with attacks followed by persistent concern about future attacks, worry about the implications of the attack, and a significant change in behavior related to the attacks. The attacks are not due to medication or a medical condition and are not accounted for by another disorder. • Presence of **four or more of the following symptoms:** ▪ Chest pain or discomfort, like an elephant sitting on patient's chest ▪ Sensations of shortness of breath or smothering ▪ Trembling or shaking ▪ Fear of dying ▪ Feeling dizzy, unsteady, lightheaded, or faint ▪ Chills or heat sensations ▪ Sweating ▪ Palpitations, pounding heart, or accelerated heart rate ▪ Feeling of choking ▪ Nausea or abdominal distress ▪ Numbness or tingling sensations ▪ Fear of losing control or going crazy ▪ Feelings of unreality or being detached from oneself

			• **Agoraphobia** is a fear of entering open or crowded spaces, leaving home, using public transportation, or being somewhere where escape is difficult. Less than 1% of patients experience this as part of panic disorder and often describe this as a fear of having a panic attack in public.
Specific phobia (F40.9)	10.97%	9.08%	• Unreasonable, excessive fear that is persistent and intense triggered by a specific object or situation • Immediate fear/anxiety when in presence of the object or situation • Person goes out of their way to avoid the object or situation or endures with extreme distress • **Fear significantly impacts person's school, work, or personal life** • Duration must be for six months and not caused by another disorder

Psychological Disorders: *Anxiety*

Table 2. Risk factors for cancer-related anxiety

• Shorter time since diagnosis • Previous history of anxiety or depression • Family history of anxiety or depression • Female gender • Younger age • Less education • Rural place of residence	• Financial distress • Other non-cancer stressful experiences • Limited support • Poorly controlled symptoms • Comorbid illness • Advanced disease and poorer prognosis

Psychological Disorders: *Anxiety*

Table 3. Self-report measures to assess and monitor anxiety symptoms in oncology populations

Problem	Measure	Items/Subscales	Scoring
Anxiety	Beck Anxiety Inventory (BAI)	• 21 items	0-7 minimal 8-15 mild 16-25 moderate 26-63 severe Scores > 7 identify 89% of individuals with panic disorder
	Depression, Anxiety, Stress Scale-21 (DASS-21)	21 items; 3 subscales: • Depression (DASS-D) • Anxiety (DASS-A) Stress (DASS-S)	4-5 minimal 6-7 moderate 8-9 severe 10+ extremely severe
	Hospital Anxiety and Depression Scale (HADS)	14 items; 2 subscales: • Anxiety (HADS-A) • Depression (HADS-D)	HADS-A scores > 6 may warrant clinical attention Scores > 8 associated with GAD
GAD	Generalized Anxiety Disorder Assessment (GAD-7)	• 7 items	5-9 mild 10-14 moderate 15+ severe Scores > 7 associated with GAD
	Penn State Worry Questionnaire (PSWQ)	16 items	Scores > 62 associated with GAD
	Intolerance of Uncertainty Scale (IUS)	12 items	Scores > 28 associated with GAD
Panic Disorder	Panic Disorder Severity Scale (PDSS)	7 items	Scores > 10 associated with panic disorder
	Agoraphobic Cognitions Questionnaire (ACQ)	14 items	Item mean > 3 associated with panic disorder/agoraphobia
Specific Phobias	Blood–Injection Symptom Scale (BISS)	14 items	
	Medical Fear Survey (MFS)	25 items	
	Claustrophobia General Cognitions Questionnaire (CGCQ)	26 items	
Cancer-Related Distress	Assessment of Survivor Concerns Scale (ASC)	5 items	
	Fear of Progression Questionnaire-Short Form (FoP-Q-SF)	12 items	Scores > 34 may warrant clinical attention
	Fear of Relapse/Recurrence Scale (FRRS)	5 items	

Psychological Disorders: *Anxiety*

Table 4. Evidence-based psychological treatments for anxiety disorders

Problem	Intervention	Techniques	Resources
Adjustment to cancer	Supportive psychotherapy CBT	• Reflective listening • Normalizing cancer-related fear thoughts and beliefs and challenging/reframing unhelpful thoughts • Identifying values/goals and re-establishing meaning/purpose • Enhancing support systems • Establishing healthy boundaries and self-care	American Cancer Society https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/emotional-mood-changes.html National Cancer Institute https://www.cancer.gov/about-cancer/coping
GAD (worry)	CBT ACT MBCT	• Psychoeducation • Worry awareness and monitoring • Decentering/defusing from worry thoughts • Challenging positive (e.g., "If I worry about it, it won't happen.") and negative (e.g., "This worry is making me sick.") beliefs about worry • Worry postponement (i.e., creation of a "designated worry period") • Mindfulness practices • Relaxation techniques (e.g., diaphragmatic breathing; progressive muscle relaxation)	Society of Clinical Psychology https://div12.org/treatment/cognitive-and-behavioral-therapies-for-generalized-anxiety-disorder/ HelpGuide https://www.helpguide.org/articles/anxiety/therapy-for-anxiety-disorders.htm
Panic/ agoraphobia	CBT ACT	• Psychoeducation • Interoceptive exposure (e.g., experiencing increased heart rate) • Graduated exposure to feared situations • Challenging/disconfirming fears, thoughts, and beliefs • Decentering/defusing from fear thoughts • Identifying values/goals	Oxford Series: Treatments That Work https://www.oxfordclinicalpsych.com/view/10.1093/med:psych/9780195311358.001.0001/med-9780195311358 American Psychological Association https://www.apa.org/topics/anxiety/panic-disorder
Blood-injection-injury phobia; Claustrophobia	Behavior therapy CBT	• Psychoeducation • Identifying values and goals (i.e., motivation for facing feared stimulus) • Applied muscle tension (blood-injection-injury) • Graduated exposure to feared stimulus • Relaxation techniques	Society of Clinical Psychology https://div12.org/treatment/exposure-therapies-for-specific-phobias/ Centre for Clinical Interventions https://www.cci.health.wa.gov.au/~/media/CCI/Mental-Health-Professionals/Anxiety/Anxiety---Information-

		• Challenging/disconfirming fear thoughts and beliefs • Decentering/defusing from fear thoughts	Sheets/Anxiety-Information-Sheet---13---What-is-needle-phobia.pdf https://www.cci.health.wa.gov.au/~/media/CCI/Mental-Health-Professionals/Anxiety/Anxiety---Information-Sheets/Anxiety-Information-Sheet---14---Overcoming-needle-phobia.pdf

Psychological Disorders: *Cognitive Dysfunction*

Table 1. Risk Factors Associated with CRCI Evaluation & Diagnosis

Demographic variables	• Older age • Lower cognitive reserve • Lower premorbid intellectual ability • Cultural consideration: non-Caucasian race and ethnicity categories could be under-represented in the CRCI literature
Genetic predispositions	• APOE4 • COMT Val+ allele • BDNF val66met polymorphism
Medical comorbidities	• Cardiovascular disease • Diabetes • Chronic inflammatory diseases
Cancer Treatments	• Chemotherapies (e.g., alkylating agents, taxanes, antimetabolites and anthracyclines • Regional radiation therapy in non-CNS cancers • Endocrine therapies • Androgen depression therapies • Vascular endothelial growth factor receptor tyrosine kinase inhibitors (VEGF) such as sunitinib
Cancer-related Symptoms	• Fatigue • Depressive symptoms (or major depressive disorder) • Anxiety symptoms (or an anxiety disorder) • Insomnia

Psychological Disorders: *Cognitive Dysfunction*

Table 2. Non-Pharmacologic Management of CRCI

Treatment Type	Brief Description	Evidence	Pros/Cons
Mindfulness Stress Reduction See Example: https://doi.org/10.1007/s11764-015-0494-3	8 weekly 2-hour classes of meditation and mindfulness practices taught by certified instructors	Improved attention, accuracy in discrimination task in early research	**Pro:** Likely helpful for cognitive performance; can be done in groups; possible adaptation to telehealth; affordable, possibly reimbursed by some insurance plans **Con:** Requires trained instructors, space for groups
Computerized Cognitive Training See Example: Brain HQ (Posit Science) http://www.brainhq.com/	Computerized repetitive practice of performance-adjusted exercises; based on brain plasticity theory; 1hr per day, 5 days per week practice for 8 weeks	Evidence of improved processing speed in prostate and breast cancer survivors	**Pro:** Commercially available; self-administered, little to no professional guidance, highly scalable, can be done from home; **Con:** Requires computer access; motivation for time commitment to daily practice for good "dosing"; no third-party payment but affordable
Exercise See Review: https://doi.org/10.1093/ptj/pzz090	May include, resistive and aerobic exercise; during active cancer treatment or post-treatment	Can be helpful for CRCI, with one review showing 45% of studies with positive results; however, cognition was a secondary outcome in most studies; more direct research needed	**Pro:** Exercise benefits are numerous for cancer survivors (fatigue, weight reduction); Low cost; group, in-person or telehealth delivery **Con:** more specific research on cognition needed or underway
Cognitive Behavioral Therapy See Example: https://doi.org/10.1093/med/9780197521571.001.0001	One example (see DOI) consists of education, cognitive modification of CRCI distress,	CBT is generally effective for CRCI with some evidence of improved neurocognitive	**Pro:** Generally effective for CRCI and has a developing evidence base; CBT is reimbursed by

	stress management, compensatory strategy use in daily life; 8 visits (45 min) designed for telehealth delivery	outcomes in processing speed, verbal memory; stronger results in self-reported cognition and QOL	insurance; can be delivered via telehealth improving care access, or in individual or group formats; published clinician manual & survivor workbook **Con:** Requires professional administration (psychologist, counselor or rehabilitation/nurse specialist)
Cognitive Training See Example: https://doi.org/10.1007/s00520-021-06453-w	One example (see DOI) consists of 7 weekly cognitive skills training workshops in-	Generally helpful for CRCI coping and cog function and self-reported outcomes.	**Pro**: Generally helpful and can be done in groups; likely adaptable to telehealth groups; **Con:** May or may not be reimbursed by insurance

Symptom Management: *Fatigue*

Model	Description	Example characteristics
Predisposing factors	Characteristics that increase an individual's vulnerability to developing fatigue	female gender; younger age; unemployed work status
Precipitating factors	Triggers leading to the onset of clinically significant fatigue episodes	disease processes or tumor progression; cancer treatment; comorbid medical or psychological conditions or states; pain; stress; metabolic or hormonal issues; medications
Perpetuating factors	Characteristics that contribute to the maintenance or exacerbation of fatigue symptoms over time	circadian rhythm dysregulation; overactive or sedentary activity profiles; social withdrawal; maladaptive thinking styles; emotional and cognitive load

Psychological Disorders: *Depressive Disorders*

Table 1. Depressive disorder categories, ICD-10 codes, prevalence, and diagnostic criteria. (* not cited in the literature)

Depressive Disorder Diagnosis	Prevalence in General Population / Cancer Population	DSM-5 Criteria/Symptoms
Adjustment disorder with depressed mood (F.43.1)	5-20% / 24.7%	• Emotional or behavioral symptoms within three months of the onset of a specific stressor • Experiencing distress out of proportion to the stressor which causes impairment in social, occupational, and other areas of functioning • Symptoms do not represent another disorder or part of normal bereavement
Major depressive disorder (F32.0 – F33.9)	7% / 16.5%	• Low mood and/or decreased interest in activities for most of the day and at least 4 of the following: • Significant weight loss or weight gain • Insomnia or hypersomnia • Psychomotor agitation or feelings of being slowed down • Fatigue • Excessive feelings of worthlessness or guilt • Difficulties with concentration or indecisiveness • Reoccurring thoughts of death or suicide • Symptoms cannot be explained by the physiological effects of a substance or to a medical condition • Symptoms cause significant distress or impairment in social, occupational, and other areas of functioning
Substance/ Medication-Induced Depressive Disorder (F10.14 - F19.94)	0.26% / *	• Significant disturbance in mood evidenced by depressed mood or decreased interest in activities • Findings from history, physical examinations, or laboratory results indicate that the symptoms developed following the intoxication of a substance, withdrawal from a substance, or exposure to medication • Symptoms are not better explained by an independent depressive disorder • The disturbance does not solely occur during the presence of delirium • Symptoms cause significant distress or impairment in social, occupational, and other areas of functioning
Depressive Disorder due to Another Medical Condition (F06.31 - 34)	* / *	• Persistent depressed mood or decreased interest in activities • Findings from history, physical examinations, or laboratory results indicate that the disturbance is the direct pathophysiological consequence of another medical condition. The disturbance does not solely occur during the presence of delirium. • Symptoms cause significant distress or impairment in social, occupational, and other areas of functioning

Persistent Depressive Disorder (F43.1)	1.5% / *	• Depressed mood for most of the time for at least two years (one year in children and adolescents) with at least two other symptoms. • Low appetite or increased appetite • Insomnia or hypersomnia • Low self-esteem • Fatigue • Difficulties with concentration or decisiveness • Feelings of hopelessness • An absence of symptoms does not occur for more than two months • There is no presence of a manic or hypomanic episode. Cyclothymic disorder criteria have not been met • The disturbance is not better explained by schizophrenia spectrum disorders and is not explained by the physiological effects of a substance or medication condition • Symptoms cause significant distress or impairment in social, occupational, and other areas of functioning

Psychological Disorders: *Depressive Disorders*

Table 2. Validated measures for depression screening for cancer patients.

Measure	Public Domain	Items/Subscales and Scoring
Center for Epidemiological Studies Depression Scale (CES-D) https://cesd-r.com/	Y	20 items; Ranges from 0-60 Scores < 16 non-depressed; 16-19 mild; 20-30 moderate; > 30 severe in the general population. Scores tend to run slightly higher in advanced cancer population.
Edmonton Symptom Assessment System-revised (ESAS-r) Depression items https://www.albertahealthservices.ca/assets/info/peolc/if-peolc-ed-esasr-admin-manual.pdf	Y	10 items; Each time is rated on a 0-10 numerical rating scale. While not widely studied, a difference of 1 points is recognized as being a minimum clinically important difference in one international multicenter study
Hospital Anxiety and Depression Scale (HADS) https://eprovide.mapi-trust.org/instruments/hospital-anxiety-and-depression-scale	N	14 items/2 subscales of anxiety and depression Depression subscale cutoff scores: 0-7 normal; 8-10 mild; 11-14 moderate; 15-21 severe
Patient Health Questionnaire-2 (PHQ-2) https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf	Y	2 items; Total score ranges from 0-6; Endorsing either item as occurring for more than half of the time or nearly every day (score of $\geq$ 2) prompts recommendation for PHQ-9.
Patient Health Questionnaire-9 (PHQ-9)* https://www.phqscreeners.com/ *contain somatic items resembling cancer symptoms/treatment side effects	Y	9 items and 1 additional unscored question; Depression cutoff: Score of 3 or more on first 2 items and total score of >8 (lower threshold reflects ASCO Guideline Adaptation recommendation) Can result in false positives for advanced cancer patients or those in active treatment with neurovegetative symptoms.
Profile of Mood States (POMS-37/POMS-SF) https://doi.org/10.1207/s15327752jpa4703_14	N	37 items/6 subscales: tension, depression, anger, vigor, fatigue, and confusion; Depression subscale ranges from 0-32, with lower scores indicating more stable mood
Brief Edinburgh Depression Scale BEDS https://www.midss.org/content/brief-edinburgh-depression-scale-beds/	Y	6 Items; Each item is rated on a 4-point Likert scale; Depression subscale cutoff scores: 4-6 mild; 7-8 moderate; 9-11 moderately severe; 12+ severe

Psychological Disorders: *Depressive Disorders*

Table 3. Risk and resilience factors influence the development, course, and recovery from depression

Risk Factors		
Disease-related Factors	Sociodemographic Factors	Individual Factors
• Cancer Type Brain Pancreas Lung Head and Neck • Advanced/Late Stage • Poorer prognosis • Physical burden • Fatigue • Pain • Disfigurement • Disability	• Younger age • Inadequate social support • Social Isolation • Socioeconomic status	• Personal and/or family history of depression • History of substance use disorder • Maladaptive coping–such as substance use, treatment nonadherence • Prior trauma
Resilience Factors		
• Strong social support • Mental/psychological flexibility	• Supportive care team • Faith/spiritual support	• Adaptive coping approaches, such a problem-solving, seeking social support

Evaluation & Diagnosis

Clinicians evaluate and diagnose depression by conducting a clinical interview that incorporates diagnostic criteria, symptom measures, clinical history, and clinical observations. Areas assessed in an interview typically include:

• Presenting symptoms, history of onset, and severity • Level of functional impairment • Presence or absence of risk factors • Predisposing, precipitating, and perpetuating factors	• Personal and family history of psychiatric disorder • Presence of comorbid mental disorders, such as anxiety • Psychosocial factors that may influence health outcomes • Symptoms, side effects, and medications which can mimic mood disorders

Psychological Disorders: *Depressive Disorders*

Table 4. Low- and high-intensity psychological interventions have been developed for individuals with cancer:[8]

Low Intensity	High Intensity
• Psychoeducation • Mindfulness Based Stress Reduction • Behavioral Activation Treatment • Problem Solving Therapy • Self-guided cognitive behavioral interventions • Structured group physical activity	• Cognitive Behavioral Therapy • Mindfulness Based Cognitive Therapy • Interpersonal Therapy • Supportive-Expressive Therapy • Acceptance and Commitment Therapy • Behavioral Couple Therapy • Core Conflictual Relationship Theme

Psychological Disorders: *Substance Use*
Treatment

Treatment Modality or Technique	Pros and Cons	Patient Selection Issues
Motivational Interviewing (MI)	Pros: • Ascertain patient motivation to control level of substance use, • Encourage patient to discuss reasons for seeking change and downside of status quo. • "Meet them where they are" with interventions. • Focuses on strengths of patient rather than weaknesses Cons: - N/A	A basic approach suitable for initiation of discussion with all patients
Twelve-Step Programs	Pros: • Long-standing source of support for patients highly necessary during cancer treatment. • Now offer programs with non-religious alternatives to Higher Power. • Incorporation of patient's sponsor into treatment decision-making and monitoring may be beneficial Cons: • Discomfort with patients receiving controlled substances for pain and symptom management	Meeting attendance may be challenging for those with advanced disease or who are not ambulatory
Recovery Support Techniques for Management of Pain 1. Frequent visits 2. Limited medication supply per prescription 3. Drug testing 4. Pill counts 5. prescription drug monitoring 6. Program checks	Pros: • Provides limits to help patient to adhere to treatment and manage their medication supply Cons: • Risk of infantilizing or inconveniencing patients • Can be perceived as punitive by patients, family, and staff	Essential for patients who are actively or have recently been using. Clinician should be prepared to ease restrictions as patient demonstrates adherence
Cognitive Behavioral Therapy (CBT)	Pros: • Demonstrated efficacy for substance use disorders in healthy individuals • Focuses on strengths of patient rather than weaknesses Cons:	Best suited for patients with adequate levels of comfort with therapy and willing/able to complete home practice.

	• Difficult for patients with advanced disease or uncontrolled pain and other symptoms to fully engage at times	
Medication Management: Opioids (buprenorphine, methadone)	Pros: • Relieves craving • Prevents withdrawal • With modifications to dosing regimens, can treat pain Cons: • Buprenorphine is a partial agonist that may not be effective for progressively worsening pain • Methadone has a long half-life and can accumulate in patients with poor clearance/metabolism/elimination due to medical problems such as liver disease and concurrent medications	Patients with recent or active abuse and/or experience with MAT Patients with stable disease or survivors Naltrexone is an opioid antagonist which, is unsuited for patients who are likely to have pain. May be useful in some long-term survivors.
Medication Management: Alcohol (disulfiram, acamprosate, long-acting benzodiazepines)	Pros: • Relieves craving • Prevents withdrawal symptoms and delirium tremens Cons: • Drug effects may complicate or exacerbate side effects of cancer treatments (e.g., additive sedation) • Can be mistaken for or worsen cancer-related symptoms (e.g., nausea/vomiting)	Best suited for highly-motivated patients with good social support and engaged family members who can assist with adherence Naltrexone is an opioid antagonist sometimes prescribed for alcohol use. It is unsuited for patients who are likely to have pain. May be useful in some long-term survivors.

Psychological Disorders: *Body Image*

Table 1 provides suggestions for fundamental elements of conducting a more thorough clinical assessment of body image concerns[4]. This assessment strategy is based on obtaining an understanding of the patient's perception and description of the manner in which body image changes are affecting his or her daily functioning.

Table 1. Content Areas for Clinical Assessment of Body Image Concerns
· Importance/meaning of affected body part(s)
· Description of body part affected
· Description of how body has changed
· Concerns about future changes to body
· Expected/unexpected nature of body changes
· Difficulties with viewing the affected body part
· Preoccupation with body image changes
· Distress related to body image changes
· Avoidance of activities due to body image changes
· Grooming behaviors/rituals (avoidance or excessive)
· Reassurance seeking behaviors related to body image
· Concerns about sexuality/intimacy

Symptom Management: *Fatigue*

Commonly used standardized assessments

Assessment tool	**Number of items**	**Fatigue dimensions**
EORTC QLQ-C30 and EORTC QLQ-FA12	3 and 12	severity, physical, emotional, cognitive
Fatigue Symptom Inventory (FSI)	14	severity, frequency, interference
Functional Assessment of Cancer Therapy-Fatigue (FACIT-F)	41/13	physical, social/family, emotional, functional, fatigue
Multidimensional Fatigue Inventory (MFI)	20	general, physical, reduced motivation, reduced activity, mental
Multidimensional Fatigue Symptom Inventory-Short Form (MFSI-SF)	30	general, physical, mental, emotional, vigor
Piper Fatigue Scale-12 (PFS-12)	12	behavior, affect, sensory, cognition
PROMIS CAT (Computer Adaptive Testing)	Up to 20	fatigue, sleep disturbance, sleep impairment

Symptom Management: *Fatigue*

Treatment

- Ongoing monitoring and follow-up are required for successful treatment

Treatment	Treatment options/modalities	Specialty Referrals
General Management/Education	Encourage ongoing physical activity Energy conservation (e.g., pacing, prioritization, delegation) Common patterns of fatigue during/after treatment and end-of-life.	See below.
Physical activity	Continuing or initiating physical activity at optimal levels	Physical medicine, physical and/or occupational therapy, exercise physiologist
Psychosocial Interventions	Cognitive Behavioral Therapy (CBT)/Behavioral Therapy; CBT for Sleep/Insomnia; Supportive expressive therapies; psycho-education therapies	Service providers (e.g., psychology, social work) specifically trained in psychosocial oncology whenever possible
Mind-body interventions	Mindfulness, Yoga, Acupuncture, Massage	Integrative oncology providers
Nutrition Consultation	Dietary changes or supplementation	Registered Dietician
Pharmacologic	Review of medications for potential contributions or treatment of pain, distress, and anemia	Appropriate professionals include physicians and advanced practice (NP/PA) include oncology, psychiatry, palliative care, and physical medicine as well as oncology-specific pharmacists for medication review

Symptom Management: *Fatigue*

Risk Factors

A biopsychosocial model of predisposing, precipitating, and perpetuating factors involved in the onset and maintenance of CRF is useful in the evaluation of fatigue.

Model	Description	Example characteristics
Predisposing factors	Characteristics that increase an individual's vulnerability to developing fatigue	female gender; younger age; unemployed work status
Precipitating factors	Triggers leading to the onset of clinically significant fatigue episodes	disease processes or tumor progression; cancer treatment; comorbid medical or psychological conditions or states; pain; stress; metabolic or hormonal issues; medications
Perpetuating factors	Characteristics that contribute to the maintenance or exacerbation of fatigue symptoms over time	circadian rhythm dysregulation; overactive or sedentary activity profiles; social withdrawal; maladaptive thinking styles; emotional and cognitive load

Symptom Management: *Fatigue*
Treatment

- Ongoing monitoring and follow-up are required for successful treatment

Treatment	Treatment options/modalities	Specialty Referrals
General Management/Education	Encourage ongoing physical activity Energy conservation (e.g., pacing, prioritization, delegation) Common patterns of fatigue during/after treatment and end-of-life.	See below.
Physical activity	Continuing or initiating physical activity at optimal levels	Physical medicine, physical and/or occupational therapy, exercise physiologist
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Nutrition Consultation	Dietary changes or supplementation	Registered Dietician
Pharmacologic	Review of medications for potential contributions or treatment of pain, distress, and anemia	Appropriate professionals include physicians and advanced practice (NP/PA) include oncology, psychiatry, palliative care, and physical medicine as well as oncology-specific pharmacists for medication review

Symptom Management: ***Pain & Discomfort***

Treatment

Table 1. Non-Pharmacological Pain Management Strategies

Pain Education	Providing information about the biopsychological model of pain shifts one's conceptualization away from viewing pain purely as a marker of tissue damage. **Pros:** Pain education can enhance patients' motivation to utilize non-pharmacological coping skills. **Cons:** If not explained clearly, pain education may be misinterpreted by patients as the pain being "all in their head." **How to choose:** Should be standard for all patients. The amount and complexity of information presented can be tailored to the patient's level of understanding.
Relaxation Training	Relaxation exercises, such as progressive muscle relaxation, requires individuals to tense and then relax muscle groups throughout the body one by one. This skill promotes relaxation and increases one's awareness of muscle tension which can exacerbate pain. **Pros:** Pain relaxation can decrease stress and muscle tension. **Cons**: Pain relaxation training, such as progressive muscle relaxation, can take up to 20 minutes and should be practiced regularly for optimal effects. **How to choose:** Helpful for most patients. Some patients respond positively to this on the first try while others will need repeated practice to derive benefits. Brief relaxation exercises can be demonstrated in the medical setting, with encouragement to practice regularly.
Imagery	Relaxation focused on a pleasant image. Individuals are encouraged to incorporate all five senses to make the image as vivid and relaxing as possible. Imagery redirects one's attention away from pain while improving mood. **Pros:** Imagery is one of the few coping skills that is not focused on the breath or body. **Cons:** Imagery may be more challenging for patients who do not enjoy visualization. **How to choose:** Most patients find this enjoyable and helpful. Patients who are unable or dislike to visualize images will typically state this upfront and should be encouraged to use alternative strategies.
Mindfulness Meditation	Mindfulness encourages individuals to bring their awareness to their present moment experiences in non-judgmental way. Mindfulness meditations vary in length and style with individuals being asked to focus on either their breath, emotional experience, or physical sensations. **Pros:** Mindfulness mediation can change patients' relationship to their pain and decrease pain catastrophizing. Even 5-10 minutes per day of meditation can be helpful. **Cons:** Mindfulness meditation may not be suitable for some patients with trauma histories. It also should be practiced regularly for optimal effects.

	How to choose: Suitable for most patients except those with trauma histories and those who tend to dissociate**.**
Distraction	Focusing one's attention away from pain and towards other activities, such as reading or listening to music, can improve mood and promote adaptive coping. **Pros:** Distraction is a simple strategy that can be effective for coping with acute pain flare-ups. **Cons:** Distraction is primarily effective in the short-term. **How to choose:** Most effective in coping with acute pain (e.g., procedural) or with pain flares.
Cognitive Restructuring / Coping Thoughts	Identifying negative automatic thoughts related to pain (e.g., "there is nothing I can do to manage my pain") and replacing them with thoughts that promote coping (e.g., "my pain may be high now but there are things I can do to manage my pain"). **Pros:** Cognitive restructuring can decrease pain catastrophizing. **Cons:** Cognitive restructuring can be challenging for patients who have difficulty differentiating thoughts from emotions. **How to choose:** Most helpful for patients who are high in pain catastrophizing, or are experiencing significant levels of pain-related depression and/or anxiety.
Pleasant Activity Scheduling	Scheduling pleasant or meaningful activities redirects one's attention away from pain while enhancing one's mood. **Pros:** Pleasant activity scheduling can promote movement and provide structure to one's day. **Cons:** Pleasant activity scheduling may be impeded by environmental or financial barriers. **How to choose:** All patients can benefit from this.
Activity Pacing	Alternating between brief periods of activity and brief periods of rest promotes movement which can improve physical functioning while limiting overactivity or underactivity. **Pros:** Activity pacing can assist patients in maintaining some activities which they previously enjoyed by modifying them to incorporate rest. **Cons:** Activity pacing may need to be used several times before the optimal activity and rest periods are identified. **How to choose:** Most helpful for patients who are very inactive, or who are overdoing activities which leads to pain flares

Managing Depression and Anxiety	Unmanaged depression and anxiety can increase pain. Adaptive coping skills such as relaxation exercises, cognitive restructuring, and pleasant activity scheduling can improve mood symptoms and enhance one's ability to cope with pain. **Pros:** Improved mood may increase overall quality of life. **Cons:** Pharmacological treatments may be needed to supplement behavioral strategies for depression or anxiety. **How to choose:** Any patient who is experiencing clinically significant psychological distress.
Managing Sleep Disturbance	A poor night's sleep can exacerbate next-day pain. Making the environment conducive to sleep and avoiding non-sleep activities in the bed/bedroom, including limiting the amount of time spent awake in bed, can promote better sleep. **Pros:** Improved sleep can lead to secondary improvements in both pain and mood. **Cons:** Behavioral strategies to improve sleep can temporarily cause sleep to worsen before sleep improves long-term. **How to choose:** Any patient who is experiencing sleep disturbance (whether or not it is related to pain).
Involving Caregivers	Providing feedback to caregivers about ways in which they can assist with pain management (e.g., setting reminders to take medicine, encouraging appropriate activity), as well as feedback about what is not helpful (e.g., over-focusing on pain, solicitous responses, minimizing pain experiences). **Pros:** Involving caregivers can decrease interpersonal stress contributing to pain and muscle tension and provide reinforcement for positive pain coping behaviors. **Cons:** Some caregivers may be less amenable to feedback. **How to choose:** Any patient who has a family caregiver involved in their care.

Symptom Management: *Sexual Health*

Table 1 Annon's PLISSIT Model [7]

Permission	Give permission to talk and think about sexuality and cancer at the same time: "What sexual changes have you noticed?" "Sexually, how are things going?" "Tell me about any sexual changes." "How has this affected you sexually?"
Limited Information	Tell the patient about sexual side effects: Lower libido, Erectile dysfunction, alopecia, vaginal dryness, menopausal symptoms, change in orgasm.
Specific **S**uggestions	Make suggestions to help with sexual dysfunction i.e., personal lubricants and moisturizers; medications, position changes, sensate focusing, safer sex.
Intensive **T**herapy	Refer to pelvic floor physiotherapist, marital therapist, sexual therapist or psychotherapist.

Table 2: Treatment side effects on sexuality (1, 6, 7, 12, 13,

Side effects	Sexual effect
Alopecia/ change in body image	One of the most devastating events, often resulting in feeling unattractive, less "sexy"; May lower libido and can affect arousal.
Altered cognition	May be disinhibited; hard to remember last sexual encounter; may be hard to focus on partner's pleasure. Affects libido.
Changed orgasms	Frustration, not as powerful and takes longer. Loss of ejaculate Affects libido, orgasms
Change in vaginal elasticity	Can cause dyspareunia, makes insertive sex painful. May not be able to accommodate male partner. Affects libido, arousal, and orgasm.
Depression	Decreased sexual interest and initiation of sexual activity; May have poor social interaction. Affects libido and arousal.
Diarrhea	Perineum tender, hard to receive anal intercourse or be stimulated anally. If colostomy present may be hard to control flow of stool. May affect libido, arousal and orgasm.
Dyspnea	Doesn't have enough breath to complete sexual activity. Affects arousal and orgasm.
Erectile dysfunction (less firm erections)	Makes penetrative sexual activity impossible in men who have sex with men (MSM). Change in sexual roles and practices. Changes to prostate and rectal sensation. Spontaneous sexuality activity no longer possible if using erectile functioning aids. Affects arousal, libido, and orgasm
Fatigue	Not enough energy to perform; worried about enough stamina to complete sexual activity. Affects libido, arousal, and orgasm.
Fibrosis	Impairs movement if in arm; if lung, hard to breathe; if vagina, may cause dyspareunia. Affects libido, arousal, and orgasm.
Hot flashes	Impairs physical closeness, sleep. Affects libido, arousal, and orgasm.
Immunosuppression	Afraid to kiss, perform oral sex, feels social isolation, HPV may be activated after being dormant for years which can cause suspicion of the partner. Affects libido and arousal.
Incontinence	Embarrassment, afraid to initiate sexual activity. Affects libido, arousal and orgasm
Infertility	May feel sexual activity is selfish, only for fun and not to procreate; feels like "used goods", disappointed, grieving. Affects libido.
Insomnia	Can cause fatigue, affects mood and energy level. May affect libido and arousal.
Low libido	Doesn't have sexual dreams, fantasies, want to initiate sex or engage in sexual activities. May go through the motions to please partner.
Lower testosterone	Doesn't initiate sexual activity, no sexual dreams or fantasies. erectile dysfunction; smaller penis, small testes. Elevated body mass index (embarrassment); high blood pressure; Low libido.
Malnutrition/cachexia	Too weak to initiate or engage in sexual activities. Affects libido, arousal, and orgasm.
Menopausal symptoms	Vaginal dryness, lower libido, dyspareunia, delayed orgasm.
Musculoskeletal symptoms	Focused on pain control which makes it hard to perform sexually. Affects libido, arousal, and orgasm.
Mucositis	Hard to kiss or engage in penetrative sexual activity: mouth, vagina & anus may be tender. Affects libido and arousal.
Nausea/vomiting	Hard to kiss, perform oral sex. Affects libido and arousal.
Osteoporosis	Less agile, more pain, risk of fracture. Less options with sexual positions.

	Affects arousal and orgasm.
Ovarian failure	Infertility, early menopause. Affects libido, arousal, and orgasm.
Pain (phantom, neuropathic, poorly controlled)	May have side effects from medication (sedation, dry mouth, constipation) Affects libido, arousal, orgasm
Peripheral neuropathies	Can affect clitoris and the glans causing numbness. Hard to use hands and may make masturbating and foreplay difficult. Hard to feel partner's body, skin and may be painful. More falls. Affects arousal.
Poor body image (discolored skin, rashes, scars, lymphedema, ostomy, skin thickening)	Feels unattractive, unwanted, not "sexy". Feels embarrassed by body changes. Affects libido and arousal.
Taste changes and dry mouth	Hard to kiss, difficult to perform oral sex. Affects libido and arousal.
Vaginal dryness	Painful sex discourages further sexual activities. Affects libido, arousal, and orgasms.
Weight distribution changes	Doesn't feel attractive, may affect breathing during sexual activity. Affects libido, arousal, and orgasms.

Psychological Disorders: *Sexual Health*

Treatment

Interventions are aimed at preservation or recovery of sexual intimacy after treatment (13).

Table 3 Treatment of Sexual Dysfunction 4

Alibido (hypoactive sexual desire)	• Medicate physical symptoms (pain, nausea, fatigue, etc.) • Treat anxiety and depression or change antidepressants (from SSRI), • Refer to sexual therapist • Regular exercise • Shower together	• Testosterone supplement or refer to endocrinologist • Estrogen supplements • L-arginine for women who can't take estrogen (anecdotal) • Schedule sexual encounters • Erotica- books, movies
Dyspareunia	• Use lubricants on both partners • Use vaginal moisturizers	• Refer to pelvic floor physiotherapist
Female sexual arousal disorder	• Water soluble/silicone vaginal lubricants • Vaginal moisturizers • Natural oils (coconut, almond, olive) • EROS-CTD®- a vacuum device for females • Vibrators	• Vaginal dilators • Spacer rings on long penis • Positional change • Treat depression and anxiety • Sensate focus exercises • Masturbate
Male erectile disorder	• Oral medications (PDE5 inhibitors), • Vacuum constriction device • Penile injections • Penile implant	• Penile band • Vibrator • Positional change • Masturbate
Orgasmic disorder	• Change antidepressants (SSRIs can delay orgasm) • Vibrators • Masturbate	• Positional change • Refer to sexual therapist. • Psychostimulants • Sensate focus exercises

Psychological Disorders: *Sleep Disruption*
Treatment
Pharmacological treatment

Medication Classes	Indications
Benzodiazepine receptor agonists ("Z drugs")	See ASSM guidelines for drugs that can be used for sleep onset and/or sleep maintenance difficulties: https://jcsm.aasm.org/doi/10.5664/jcsm.6470
Benzodiazepines	
Orexin receptor agonists	
Melatonin agonists	
Antidepressants	
Over-the-counter preparations	Not recommended for sleep onset and sleep maintenance difficulties

Adapted from Sateia et al., 2017

Sleep Hygiene

Sleep Hygiene Education
• Avoid consuming coffee 4 to 6 hours before bedtime • Avoid smoking at bedtime and during nighttime awakenings • Avoid alcohol before going to bed • Avoid heavy meals/snacks late in the evening • Exercise regularly but avoid strenuous physical exercise close to bedtime • Arrange your bedroom comfortably • Keep your bedroom cool, control the amount of noise and reduce exposure to artificial light (e.g., LED, screens lights) before bedtime and during nocturnal awakenings

Cognitive-Behavioral Therapy

Stimulus Control and Sleep Restriction Instructions

Stimulus Control
• Set aside at least an hour for yourself to unwind before going to bed
• Only go to the bed when you feel sleepy
• If you are unable to fall asleep or get back to sleep within 20-30 minutes, get out of bed and go to another room
• Use an alarm clock to get out of bed at the same time every morning, no matter how much sleep you got
• Use your bed and bedroom only for sleeping and sexual activity
• Avoid napping during the day. If you need to, nap before 3 pm and no longer than one hour
 	
Sleep Restriction
• Limit the time you spend in bed to the actual duration of your sleep
  ○ Calculate the average time spent asleep over the past week of the past 2 weeks (ideally with a sleep diary). This is the duration of time that should be spent in bed for the next week. Example: if sleep duration is of 6 hours, then the time spend in bed should be 6 hours.
  ○ Decide bedtime and arising time based on this duration. Example: from 11:00 pm to 5:00 am; from 12:00 am to 6:00 am.
  ○ If sleep improves (sleep efficiency [total sleep time/time spent in bed] of 85% or greater), the time spent in bed can be increased by 20 to 30 minutes the following week. If sleep is unimproved, keep the same sleep schedule.
  ○ This is repeated until satisfactory sleep is achieved.

Psychosocial Concerns: *Financial Distress*

Patient Risk Factors	
Younger age	• More likely to not have completed education, have active student loans • More likely to have jobs based on hourly wages and less likely to have adequate insurance coverage or paid sick leave • Less likely to have significant savings • Dependence on parental caregivers
Lower SES	• More likely to have lower healthy literacy • More likely to have difficulty with transportation and lodging • Less likely to have adequate insurance coverage or paid sick leave • Less likely to able to participate in clinical trials • More likely to be living paycheck to paycheck (limited savings or financial cushion for time away from work)
Underinsured or uninsured	• More likely to be paying OOP for visits, treatment, and supportive medications • Limited access to specialty cancer care or supportive services • Limited ability to get medications
Unemployment	• Less likely to have adequate insurance coverage (due to high-cost COBRA plans, or limited coverage via short-term, limited-duration insurance) • More likely to be dependent on charity care and financial support • Limited income from disability or unemployment benefits
Racial/ethnic minorities	• More likely to be denied insurance secondary to structural racism • More likely face work related barriers (no sick time, limited work allowances) • More likely to have transportation barriers • Less likely to have access to cancer screening and thus present at more advanced stages requiring more intense treatment
Rural residence	• Increased barriers to care include increased transportation and lodging costs • Limited access to specialty cancer care, supportive services; more difficulties coordinating care
Disease Risk Factors	
Cancer Type	• Cancer types which require multimodality treatment, i.e. surgery, chemotherapy, and radiation • Cancer or cancer treatment which causes significant symptom burden which requires time off work and a caregiver • Cancer treatments which require prolonged hospitalizations i.e. induction chemotherapy and transplant
Cancer Stage	• Advanced disease requiring intense treatment and potentially durable side effects causing debility • Metastatic disease which may require life-long treatment

Psychosocial Concerns: *Financial Distress*
Negative Effects of Financial Toxicity

Coping Behavior	Behavioral changes due to increased expenses	Potential negative personal, financial, or family outcomes
Altering care plan	• Skipping or delaying treatment • Unfilled prescriptions • Rationing medication • Declined recommended supportive services • Delayed or missed appointments • Avoidance of recommended procedure/tests	• Suboptimal treatment leading to treatment gaps, disease recurrence/progression, death • Higher physical symptom burden, decreased quality of life • Lower quality survivorship care, decreased recovery and poorer long term functioning
Altering lifestyle	• Decrease in recreational activities • Decrease spending on food and other essentials	• Decreased quality of life • Decreased nutrition, increased food insecurity • Decreased in overall wellness of the patient and family/caregivers
Altering school/work	• Dropping out of school/training • Early return to work (including during active treatment) • Early retirement • Decrease to part time work/decreased responsibilities	• Decreased earning potential and/or limited career growth • Decreased ability to recover from treatment if returning too soon, increased exposure to pathogens, delayed recovery • Possible loss of employee-based insurance coverage • Loss of income/decreased financial stability
Support seeking from others	• Dependence on family, friends, and community for caregiving, loans, supportive care	• Caregiver financial, emotional, and physical fatigue

Psychosocial Concerns: *Financial Distress*

Potential Interventions

Level of Intervention		**Recommendations**	
Primary Prevention	Health Policy	Value based care	• Advocate for alternative payment models that incorporate both quality care delivery metrics and patient affordability concerns • Increased price transparency
	Clinical Infrastructure	Financial navigation	• Formal training of financial navigators • Patient training for communicating with insurance companies • Patient paperwork assistance • Partnering with community resources to address social influencers of health, support groups, financial tools
		Clinical-financial pathways	• Institutionalize multi-disciplinary clinical roadmaps that include financial responsibilities prior to, during and after primary cancer management
		Limit indirect costs	• Parking vouchers for patients • Offer telehealth and bundled appointments to limit time away from work and need for childcare • Improve facilities to allow for work conducive areas (Wi-Fi in waiting areas and infusion centers; quiet rooms) • Expand hours of care • Offer on-site childcare services • Expand food, transportation, lodging services
	Healthcare Provider	Provider education	• Decrease low value care via national guidelines like Choosing Wisely[6] • Train care team members to collaborate with financial navigators and utilize lower cost sites of care and/or lower OOP cost services; promote conversations about expected and potential unexpected costs • "Financial Rounding": include representatives from billing in patient rounds to increase understanding of unique patient financial situations • Enhanced infrastructure to obtain outside records to avoid duplication of diagnostic evaluations that can increase costs for patients
	Patient	Patient education	• Catalogue and distribute financial support resources • Encourage visit companions (engage family/friends) • Provide accessible personnel to answer questions • Create survivorship plans that acknowledge financial concerns
Secondary Prevention	Clinical Infrastructure	Financial toxicity screening	• Financial harm screening (via validated COST score or single question screening), reassess along cancer treatment path given cumulative burdens

			• Support shared-decision making for financial friction point decisions
		Financial toxicity "tumor boards"	• Engage all members of the clinical care team (MDs, PharmDs, RNs, LCSWs, financial navigators, medical billing) to meet regularly to conduct holistic needs assessments and review all patients to mitigate financial toxicity
Tertiary Prevention	Healthcare Provider	Encourage cost conversations when appropriate	• Discuss financial cost-benefit of medications and potential alternatives with a focus on patient priorities via shared-decision making • Provide reassurance that care teams and the health system will remain present for patient even in difficult times (e.g. loss of job, loss of insurance) and connect patients to appropriate resources • Provide information on alternative pharmacy cost containment mechanisms (GoodRx, Cost Plus Drugs)
	Pharmacy	Proactive pharmacy assistance	• Start pharmacy assistance for expensive medications at the time of prescription • Alert cancer team to prescribe less costly alternatives via EMR programs sharing patient-specific formulary and out of pocket cost estimates • Provide estimates of medication regimen over time for chronic conditions

Psychosocial Concerns: *Caregiver Distress*

Who are cancer caregivers?

• Women (58%)	• Working at least part time
• 53.1 years old	• Median household income is $55,500
• Approximately 65% report non-Hispanic White ethnicity, followed by Hispanic (16%), non-Hispanic Black (11%), and Asian (8%).	• 40% have a college or graduate degree
• Majority provide care for a relative (88%), largely parents or parents-in-law (44%) and including spouses and partners (16%). Around 10% care for friends or community members.	• Provide care, on average, 32.9 hours a week

What do cancer caregivers do?

Activities	**Examples**
Assist with activities of daily living (ADLs; activities that allow an individual to live independently in a community)	Toileting, dressing, personal care, transferring, eating
Assist with instrumental activities of daily living (IADLs; complex skills needed to maintain one's home and life)	Driving, managing medications, paying bills, housekeeping, home repairs
Nursing tasks	Administering injectable medications, taking vital signs, changing catheter bags, cleaning and dressing skin wounds
Emotional Support	Coping with depression, anxiety, fears of recurrence and dying, coping with functional changes
Decisional Support	Helping to make decisions about treatment and advance care plans

Psychosocial Concerns: *Caregiver Distress*

What are empirically supported approaches to addressing caregiver distress?

Intervention	Goal	Techniques
Psychoeducation	Helps caregivers to gain in-depth knowledge and fact-based understanding of caregiving responsibilities to self-reflect on its impact on their overall wellbeing and day-to-day life.	• Therapeutic alliance building • Educating about fact-based and "how to" topical content • Facilitating self-reflection and adaptive coping
Cognitive Behavioral Therapy for Caregivers (CBT)	Focuses on altering caregivers' interpretation of a stressor to influence the emotional response in the presence of that stressor, thus promoting problem-solving skills.	• Psychoeducation about the association between thoughts, feelings and behaviors • Cognitive restructuring • Behavioral activation
Dyadic Interventions	These approaches help patients and caregivers work together to manage the demands of illness, problem-solve important treatment decisions, and support one another as they cope with the stress of illness.	• Communication skills training • Discussion of role changes • Facilitation of dyadic coping and stress management
Meaning-Centered Psychotherapy for Caregivers (MCP-C)	Assists caregivers in connecting to a sense of meaning and purpose despite the challenges and suffering endemic in caregiving.	• Psychoeducation about four key sources of meaning (i.e., historical, attitudinal, creative, experiential) in life and caregiving • Reflection on experiential exercise questions to facilitate connectedness to meaning

Psychosocial Concerns: *Caregiver Distress*

General Intervention Guidelines

• Care should be delivered as early in the caregiving trajectory as possible	• Care should be delivered individually to caregivers, when possible
• In-person caregiver support should be delivered concurrent with patient care to limit additional burden on caregivers	• While telehealth is powerful, a digital divide remains, and caregiver preferences should be accounted for
• Interventions delivered in real time are more powerful than those that are self-guided, though some care is better than no care	• Distress increases for caregivers as patients enter survivorship, so this is a period when caregivers need support
• Group support is beneficial for caregivers who are isolated, but groups that are structured with weekly topics are strongly preferred to those that are open to all comers each week and lack a target focus of discussion.	• Distress increases for caregivers of patients whose disease has recurred and/or is advanced, so this is a group in need of support.
• Caregivers should be screened for distress and referred to appropriate levels of care and intervention that target specific unmet needs.	• Continuity of support into bereavement is necessary for caregivers and protective against feelings of abandonment

Psychosocial Concerns: *Grief & Bereavement*

Table 1: Guidelines to Support Family Members Before and After the Death of a Loved One

Before a Patient's Death
Help family members prepare for their loved one's death, psychologically and practically.
Involve palliative care early in the disease trajectory as part of usual care.
Provide clear and accurate information about the dying process to aid decision-making.
Recommend an early hospice referral.
Assess the coping skills of family members, screening for known risk factors of complex grief reactions where possible.
Make a referral to an appropriate community based clinician prior to the patient's death for individuals who present with risk factors for complex grief reactions.
After a Patient's Death
Family members who were not present at the patient's death should be contacted by the physician as soon as possible to inform them of the death, express condolences, answer any immediate questions and offer the family the opportunity to view the body.
Express condolences – an essential component of quality end-of-life care. Make a bereavement telephone call or send a letter of condolence or card from either the individual clinician or the team – see Table 2 for Condolence Guidelines.
Provide psycho-educational information about grief and expectations of progress e.g., grief comes in waves; grief is both emotionally and physically stressful; significant dates can result in larger waves; routine, self-care and social connections are important in the initial weeks and months to facilitate adjustment. Provide age-appropriate information about supporting grieving children. It's recommended that children be told the truth about the death in terms they can understand and be included in the funeral or memorial events. Provide opportunities for children to say goodbye to their loved one, such as writing a card to be placed in the coffin. For age-appropriate information see www.dougy.org
Offer opportunities for family members to return to the hospital at a later date to meet with the team to address any lingering questions.
Recommend that all individuals see their family doctor early in their bereavement and not ignore their own health care, given how stressful grief can be.
Refer individuals considered to be at risk of a poor bereavement outcome, including those who are dealing with intense emotions, such as guilt or anger, to counseling.
Consider offering annual memorial events for staff and bereaved families to come together to remember patients who have died within the previous year.
Offer hospital-based bereavement support groups specific to the type of loss, e.g., spouse/partner groups, to promote a sense of connection and reduce feelings of isolation.
Suggest community-based group support as appropriate e.g., local hospice bereavement programs or faith-based groups, including recommendations for children and teenagers to organizations specializing in child bereavement, such as grief camps.

Psychosocial Concerns: *Grief & Bereavement*

Table 2: Condolence Guidelines: Components of a Condolence Call Using the TEARS Acronym.

Timing Ideally call the bereaved within the first 1-2 weeks Allow enough time to make the call so not to feel pressured or rushed If you don't learn of the death immediately, it's never too late to call or send a card
Express condolences Expect emotion Express condolences: "*I am very sorry to hear of ___'s death"* Share a story about the patient – what you will remember or miss Emphasize the good job the family did in caring for patient, which helps if they are second-guessing their actions or decisions
Ask Ask factual questions, which are usually easier to answer, especially if the bereaved is upset, e.g., *"Have you family staying with you?" "Have the children gone back to school?"* If appropriate, ask about the circumstances of the death: *"Can you tell me about what happened at the end…?"* Inquire about their coping – *"How are you managing at the moment?"*
Recommend Provide psycho-education e.g., grief comes in waves; grief is unique Recommend that they see their family doctor Suggest individual or community based support Offer a team meeting at a later date to answer questions or to say goodbye to the team
Say goodbye Decide ahead of time whether this call/card will be the final contact or whether you will be available for future contact. Examples include: *"It was a privilege to care for _____and to meet you and your family. I wish you all the very best over the coming months."* *"It was an honor to care for _____and to meet you. I am not sure whether our paths will cross again – I wish you all the very best."* *"It was an honor to care for _____and to meet you and your family. You are always welcome to contact me in the future if questions arise."*

Psychosocial Concerns: ***Relationship Issues***

Treatment

Phase in the Cancer Continuum	Dyadic Stressors	Evidence-based Skills and Therapeutic Approaches
At Diagnosis	• Treatment decision making (agree vs disagree) • Loss of sense of control • Fears about mortality • Fears about the quality of the relationship and whether they can truly count on their partner during this time of extreme flux and stress	• Teach couples the importance of seeing cancer as a shared problem and the benefits of joining together against the threat of cancer/mortality • Encourage assurances of commitment and articulation of the view that cancer is a shared problem. • Encourage couples to talk about medical facts, seek out information, and negotiate new roles/responsibilities together as a means of reasserting a sense of control over an otherwise uncontrollable situation and helping couples to accommodate illness into their everyday routines. • Joint problem-solving skills training may assist couples with the process of decision making and role negotiation • Encourage couples who are reluctant or unsure about how to communicate about cancer to shift their focus from cancer to their relationship by talking together about it (e.g., how good it is, relationship memories and how the couple addressed challenges together in the past, and future plans) in an effort to remind them of the strengths and resources that they have to deal with the disease.
During Treatment	• Adjusting to role changes • Coordination of care and symptom management • Balancing treatment, home, family, and work responsibilities	• Encourage couples to talk with one another about managing side-effects and what they are both comfortable doing. This can help improve the coordination of care and prevent

	• Protective buffering about psychological distress • Uncertainty about the future • Differences in coping responses • Sexual functioning issues • Financial burdens • Both partners may not agree about how to feel or are not prepared to validate each other's feelings. There may also be dissimilarity in partners' preferences and patterns of talk, their perceptions of mutuality, and their ability to respond with reciprocal disclosures.	disagreements/conflict. • Couples may benefit from communication skills training to effectively express wants/needs without blame/criticism, engage in reflective listening, validation, and reciprocal disclosures • When communication with a partner is challenging, indirect methods such as showing affection through physical touch, having everyday conversations that are not about cancer, and spending time together engaging in shared activities may provide a more comfortable context for illness-related issues to spontaneously arise. • Encourage couples to maintain physical intimacy and expand their ideas of what sex and intimacy can be.
Post-Treatment Survivorship	• Differences in adjusting to the "new normal" • Coping with late/chronic effects • Differences in the desire to revert to the pre-existing relationship structure or renegotiate roles/responsibilities • Lifestyle changes related to diet and exercise • Fear of cancer recurrence • Change in expected future (vacations; retirement)	• Encourage couples to spend time together engaging in healthy lifestyle behavioral changes • Couples may benefit from scheduling opportunities to have fun and reconnect as partners as opposed to patient and caregiver
Metastatic Cancer/End of Life	• Difficulty communicating about fears, death, physical symptom burden, discontentment • Lack of energy to participate in activities that bring joy • Disconnection from social circle (friends distancing) • Disagreements about end-of-life preferences • Disruption of family functioning	• In this stage there is opportunity for the couple to heal past hurts, commit to focus on what is deeply meaningful, and talk openly and honestly about their concerns whether logical or not. • If couples are reluctant to talk about cancer related fears and concerns, it may be useful to explore how discussing other topics and engaging in indirect or implicit forms of communication can change appraisals, facilitate processing, and provide comfort. • Under conditions where disclosure to a partner becomes

		challenging or problematic, individuals may reap some benefits from disclosing to a neutral third-party. • Encourage couples to express appreciation and to reflect on the quality of their relationship (e.g., how good it is, fond shared memories).

Psychosocial Concerns: *Treatment Adherence*

Table 1. Predictors and Risk Factors for Nonadherence

Broad Category of Predictors	**Examples in Category**
Patient-related	Depression, understanding, health literacy, forgetfulness, beliefs, self-efficacy, social support, resources (time, financial, etc.)
Treatment or regimen-related	Side effects, complexity of regimen, frequency of doses
Disease-related	Severity of disease
Provider-patient interaction/communication-related	Shared decision-making; relationship-centered care; partnership, collaboration, open, and thorough communication
System-related	Cost, access to treatment

Psychosocial Concerns: *Treatment Adherence*

Table 2. Adherence Measurement Tools

Measurement Tool	Description	Strengths	Weaknesses
Patient Self-Report	There are several validated questionnaires designed to measure adherence and interviews or diaries are also self-report measurement options	• Easy to administer • Inexpensive to administer • Require little time to complete	• Potential for memory recall issues • Potential for social desirability biases
Electronic Monitors (e.g., MEMS caps)	The pill bottle has a cap that records date/time of opening	• Can measure adherence behavior over time (provides longitudinal data) and at particular times (e.g., right before medical visit) • Can measure changes in medication taking behaviors	• Expensive • Could lead to patients feeling loss of control of medication taking or interfere with their daily life
Pharmacy Refills Databases	Total days of medication given to a patient is divided by the number of days they should take the medication to calculate the Medication Possession Ratio (MPR)	• Can be used to analyze large amounts of data	• Cannot measure daily variations in medication taking or ingestion of medication • Cannot be measured if medications come from pharmacies with independent databases
Pill Counts	Percent adherence calculated by multiplying the units of medication dispensed by the dosage and divided by the number of tablets that were supposed to be consumed	• Can be used as an overall measure of adherence	• Risk of dumping pills out • Does not show daily variations in adherence or assess ingestion of medication
Blood or Urine Monitoring	Level of medication in plasma, serum, blood, or urine	• Shows that medication was taken	• Cannot be used for all medications • Costly • Invasive

Psychosocial Concerns: *Treatment Adherence*

Table 3. Approaches in the Clinical Setting to Promote Patient Adherence

Tools in the clinical setting to promote adherence	**Example or Technique**
Involve patients in treatment decision process, discuss options, understand patient values, and hear patient concerns. Use decision aids.	"How does this regimen sound to you?" "What is most important to you in making decisions about treatment?"
Ask about nonadherence in a nonjudgmental way	"Many of our patients have difficulty taking this medication every day as prescribed (or forget to take it every day). How often do you think this happens to you?"
Explain the regimen clearly and ensure patients understand (e.g., use teach-back method)	"I want to be sure I have explained this new treatment clearly. Can you tell me how you will take this medication?"
Give written information/checklist/clear instructions/keep health literacy levels in mind	"Here is a checklist that you can use to report symptoms or side effects you are having, and we can discuss ways to address those."
Encourage patients to ask questions	"We covered a lot of information about this new treatment. What questions can I answer?"
Provide follow-up after a new regimen starts	"You started this treatment _____ ago. I wanted to check in to see how it is going."
Explain the risks and benefits of treatment	"As with any treatment, there are some potential risks, but we believe the long-term benefits outweigh the risks. Let's discuss those now."
Recommend or encourage reminder methods to help with forgetfulness	"Many patients forget to take their medications sometimes. Would you like to discuss reminder tools or mobile apps that could help you?"
Assess/be aware of patient mental health	Consider using a depression symptom screening tool to screen for depression.
Consider patient resources, including social support	"How has your family responded to your diagnosis?" "Have you considered joining a support group of other patients with the same illness?"
Use motivational interviewing principles	Understand your patient's current state of mind in regard to their treatment. Determine their barriers to change and understand their motivations.
Use health technologies to improve adherence	Consider tools such as e-prescribing, patient portals, automated reminders from pharmacy, appointment reminders, medication reminders (mobile apps, smart pillboxes, others)

Psychosocial Concerns: ***End of Life Communication & Shared Decision Making***

Table 1. Clinician skills for effective communication:

Domain[2]	**Skill**[2]	**Tips and Examples**
General communication with patients	• Listens to patients • Encourages questions from the patient • Talks with patients in an honest and straight forward way • Gives bad news in a sensitive way • Willing to talk about dying • Sensitive to when patients are ready to talk about death	The patient may ask how many treatment options are left. This is a sign they are seeking a timeline to their death. The patient may be tearful or a family caregiver may start to cry during the appointment, a sign they are aware the illness may be progressing toward death. "You have just asked me how long I think you will live. Sounds like you are interested in discussing issues associated with death. Tell me more about what has been on your mind."
Emotional support	• Shows compassion • Maintains hope and a supportive attitude • Responsive to patient's emotional needs	Lean in, ask them what they are thinking about. What are they most worried about right now? What are they hoping for?
Accessibility and continuity	• Takes as much time as needed with the patient • Avoids keeping the patient waiting without explanation or apology • Minimizes interruptions and focuses on the patient during visits • Ensures that they are accessible to the patient and family in a timely manner • Makes the patient feel confident that they will not be abandoned prior to death • Continues to be involved with the patient after referral to hospice • Has contact with the family after the patient's death	"I'm so sorry to keep you waiting. I know how important your time is. I had an unexpected issue I had to take care of…a call to make…last visit took longer than expected." "My team and I will still be here for you and want to know how you are doing as we make this transition." (with hospice transfer) To the family post-bereavement, "I'm so sad to learn about X's death. I really appreciated the opportunity to serve X and you. We are thinking of you and wishing you peace and comfort."
Competence	• Knowledgeable about medical care • Takes the patient's symptoms seriously • Recommends appropriate treatments for cancer and symptoms • Has good technical skills • Is prepared for appointments • Appropriately refers the patient to specialists	Review all test results. Know which cycle of treatment the patient has recently received. Review notes by other providers since you last met with the patient, especially supportive care notes. Consider referrals to other specialists including palliative care, rehabilitation medicine, chaplains, psychosocial oncology,

	• Knowledgeable about the care needed by patients during the dying process • Knows when to stop treatments that are no longer helpful	social work, and hospice when indicated. Screening and triage can help.
Respect and humility	• Polite and considerate • Treats patients (and families) as their equal • Admits when he/she does not know something • Comfortable with people who are dying • Does not view death as a medical or personal failure	"I'm not certain about that, but I will look into this with my team." "It has been an honor to work with you. Sometimes things do not go the way we had hoped, despite our best efforts."
Patient education	• Gives enough detailed information so that patient understands their illness and treatments • Tells patient how this illness may affect their life • Guides patient and family to helpful resources • Talks with patients about what their dying might be like	"Would you like to learn more about what might happen next or what you can anticipate as death approaches?" (prior to reviewing signs/symptoms of imminent death)
Team communication and coordination	• Teaches the patient who to call for different problems • Makes sure there is someone available to help the patient when the physician is not available • Respects and uses the expertise of nurses, social workers, and other team members • Helps the patient and family get consistent information from the entire health care team • Guides patient or family to hospice in a timely manner	"I'm sorry you have gotten different messages. That sounds challenging. Let me see if I can help clarify to make sure you are getting good information to make decisions." "In my absence, you can communicate securely with our team by…. We will be working with you to manage any cancer-related problems. I trust that your primary care physician will continue to manage x,y,z." "Many patients struggle with the emotional aspects of cancer. We have a group of specialists who know how to best help you with these issues. I will place a referral for you. Let me know if you don't hear from them in the next week."
Personalization	• Makes the patient feel unique and special • Treats the whole person, not just the disease • Considers the patient's social situation when making treatment plans	"Tell me about your current supports. Who are the people in your life that you can count on?" "Tell me about yourself. What is most important to you? How is cancer impacting your life outside of the medical center?"

Pain and symptom management	• Is not afraid to prescribe pain medications when needed • Takes into account the patient's wishes when treating pain and symptoms • Helps patients and families understand how to provide symptom and pain control	"You might hear a lot of different information on the news about taking pain medications. Many people with cancer take pain medications safely with good effects on pain. Not everyone becomes psychologically addicted to pain medications. We will work closely with you to make sure your pain is treated and that you are safely managing your medications."

Psychosocial Concerns: ***End of Life Communication & Shared Decision Making***

Shared Decision Making: *REMAP*

Reframe	Placing details of patient's illness into context and justifying need to re-evaluate plan of care. • Provides headline • Reorients patient • Asks for teach back Use the "teach back" method to ensure patient understanding. Do not rely on yes/no responses to verify understanding.	"What do you understand about your recent scans?" "It seems we are in a different place now in terms of our planning." "I'm worried that…" "Tell me what you are thinking." "Based on our discussion today, how would you tell your family/friends about where things stand."
Expect Emotion	Use reflective statements acknowledging presence of emotion	"I understand this is hard to hear." "I know this is difficult." "What are you most worried about at this point?" "Can we discuss what this means for our next steps?" (delaying if necessary due to overwhelming emotion)
Map Out Patient Values	Use of open-ended questions to understand patient goals and values	"What is most important to you given this information?" "Let's discuss what you'd like to avoid in this situation." "Are there people you would like to share this information with to guide your decisions?" "How might this impact your goals and relationships?"
Align with Values	Verbally reflect what you have heard from the patient including potential ambivalence. Summarize priorities and values. When values are clarified and clinician has achieved understanding, ask permission to make a recommendation.	"From what you've said, it sounds as if X and Y are important to you, and you absolutely would not want Z." "Are there other things that are important to you?" "Is it okay if I give a recommendation based on what we've discussed today?"
Propose a Plan	Propose plan to maximize patient values and goals.	"Given your goal to X and prevent Z, I'd propose that we…"

	Be clear when goals may not be possible. For patients/families denying recommendation, assess how you can be most helpful moving forward.	"I don't believe Y will be possible given what we know at this point." "When the time comes, it sounds like you would like a natural death, not connected to technology." "What do you think?" "What questions do you have?" Tell me what you understand from our conversation.

Models of Care in Psychosocial Oncology

Table 1. Principles of Psychosocial Model of Care integrated into Cancer Care

Principle 1	Population-based -use of universal distress screening -use of patient registries to track patient population and outcomes
Principle 2	Level of clinical expertise matched to patient needs -mild distress treated with low intensity & less costly interventions -significant distress (e.g., major depression, severe anxiety) given more intensive treatment
Principle 3	Patient-centered -use of patient-centered outcomes (e.g., patient-reported outcomes) to guide a stepped care approach -use shared-decision making and culturally sensitive approaches
Principle 4	Evidence-based treatment delivered in timely fashion & across the continuum of cancer care -positive screenings trigger immediate assessment and treatment -screening occurs at multiple time points during cancer journey -measurement-based care at initial and follow up visits (e.g., PHQ9, GAD7) guide treatment to target

Models of Care in Psychosocial Oncology

Table 2. SAMHSA-HRSA Levels of Integration of Health Care Systems (Adapted from ref 3)

The degree of integration of the psychosocial components of care into cancer care is not 'all or nothing' but can be described as being on a continuum from completely separate services to full integration (**Table 2**).

Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration Onsite	Level 4 Close Collaboration Onsite with Some Integration	Level 5 Close Collaboration Approaching Integration	Level 6 Full Collaboration with Full Integration

Models of Care in Psychosocial Oncology

Table 3a. Models of psychosocial care – oncology outpatients. Provider=Mental health provider. Approaches to delivering a psychosocial component of care

A variety of approaches have been taken to integrating psychosocial care into cancer care. Each have advantages and disadvantages, which are shown in **Tables 3a & 3b**.

Model of Care	Description	Advantages	Disadvantages
Off-site referral	Provider outside of cancer center; receives referral from oncology team or patient self-refers	No cost to cancer center	Minority of patients follow through with outside referrals. Few providers with oncology expertise. High risk of inadequate treatment
Co-located provider	Provider located within the clinic; often available for limited number of visits	Warm-hand offs Increased access	Limited availability of follow-ups. Risk of inadequate treatment. Often limited collaboration with oncology team due to capacity constraints
Joint clinics	Provider & oncologist see patient together	Highly integrated Acceptable to patients	Costly. Only cost effective for patients with complex problems
Collaborative Care	Systematic screening followed by engagement with care manager who is a member of oncology team	Cost-effective Highly integrated Population based Strong evidence for improving outcomes	Initial cost of setup. Requires system changes to create & sustain
Fully Integrated Oncology Team	Psychosocial providers work as members of outpatient oncology team	Highly integrated Highly acceptable to patients	Costly. Not feasible in most settings

Table 3b. Models of psychosocial care – oncology inpatients

Model of Care	Description	Advantage	Disadvantage
Consult Service	Oncology team refers to outside psychosocial consultation service	No cost to cancer center	Often inefficient and fragmented. May not be effective due to lack of oncology expertise
Co-located psychosocial provider	Referrals to a psychosocial team co-located within oncology inpatient unit	Relatively acceptable to patients. Can educate oncology team.	Will not meet population needs. May lack oncology expertise.
Proactive Inpatient Consultation	Systematic screening of all patients and active treatment of needs by dedicated team	Captures whole inpatient population. Likely cost-effective .	Requires system changes to create & sustain. Not fully integrated
Fully integrated psychosocial care	Psychosocial providers work as members of the oncology inpatient team	Highly integrated. Can upskill staff. Highly acceptable to patients	Costly. Not feasible in most settings.

Use of Technology in Psychosocial Oncology

Table 1. Content included in the APOS Psychosocial Oncology Virtual Academy

Program Development	Psychosocial Oncology Knowledge & Skills	Professional Development
Business & Strategic Planning Hiring & Team Development Program Administration/Operations Models of PSO Care Benchmarking Distress Screening & Outcomes Program Evaluation & Quality Improvement Virtual Health Legal & Regulatory Issues	Cancer Basics Emotional/Psychological Impact Sexual & Relationship Challenges Spiritual/Religious Considerations Health Care Communication & Decision Making Social & Practical Problems Caregiver Experience Cognitive Function Physical Symptoms Psychosocial Assessment & Treatment	Interviewing & Negotiation Networking Leadership Skills Professional Boundaries Building Resilience Mentoring & Supervision Writing & Reviewing Manuscripts Teaching & Presentation Tips Research & Grant Writing Basics PSO Ethics

Table 1. Signs and Symptoms of Compassion Fatigue, Burnout, and Moral Injury

Feelings	Thoughts	Behaviors
Feeling disconnected or a lack of compassion for patients and/or colleagues.	Difficulty making decisions or thinking that you aren't able to help patients.	Sleeping too much or too little; difficulty falling asleep.
Feeling overwhelmed by your daily workload.	Ruminating on patients or clients when not at work; dwelling on what you can't do.	Eating too much or too little. Changes in appetite or digestion.
Experiencing anger or frustration routinely; feeling negatively about work that formerly elicited positive feelings.	Feeling preoccupied by losses or suffering that you've witnessed.	New or increased use of alcohol and other substances.
Feeling sad, depressed, or anxious more days than not.	Perceiving that there are more bad days than good days.	Acting irritable or impatient with colleagues or patients.

Table 2. Coping Skills for a Five-Minute Break

Breathing exercises	When people experience stress, their breathing is often constrained. Take a moment for a few intentional breaths. To be sure you are breathing slowly and with intention, put your finger in your belly button and focus on observing your hand moving out and in for 3 minutes.
Visualization	Briefly close your eyes and imagine that you are in a calm, safe place, or a favorite vacation spot. Imagine what sounds you might hear, the temperature you most prefer, how the scene smells, who is there with you as a loving presence. Now, go back to breathing for a minute or two.
Take a walk	Allow yourself to step away from patient care during a break and take a walk outside or with a peer.
Gratitude	Take five minutes to write down three things that your coworkers or patients have done that inspire gratitude in you.

Exercise: *Choose one of the coping exercises above and try it during your workday today. What do you notice afterward?*

Table 3. Healthy Coping Skills in a Biopsychosocial Frame

Bio: Physical health
• Make time for **physical activity**: pick an activity you enjoy, schedule it several times per week, and engage a friend to stay accountable. • Prepare **healthy foods** and set aside time in your workday for meals and rest breaks. • Stay hydrated: ensure that you are **drinking enough fluids** throughout the day. • Maintain an accurate awareness of your **consumption of alcohol and other substances**. If your intake of substances is increasing or disruptive to your daily life, consider alternative coping skills. • Establish **sleep hygiene routines** that support 7 to 9 hours of sleep each night. As a first step, try going to bed at the same time each night.
Psycho: Cognitive reframing
• Try reframing your negative thoughts and **work to find the positive in difficult situations**. If an issue is bothering you, ask yourself if you can change or improve it. Consider escalating concerns that cause moral distress to a leader or manager and attempt to problem-solve. • Work to **accept what you cannot control or change**. Remind yourself that the faults of the American healthcare system are not your personal faults or failures. Focus on where you *can* be successful and how you can support yourself, your coworkers, and your patients.
Social: Interpersonal connectedness
• Maintain **connection with family and friends**. Set aside time each week to call a loved one or spend time with a friend. • Engage with colleagues in the workplace and **look for opportunities to support and be supported**. Try to make time to express gratitude and praise your peers' hard work. Clinicians that provide and receive praise report higher rates of satisfaction and resilience in the workplace. • Remember that you are part of a team and don't have to do it alone. **Asking for help is a strength** and fosters greater empathy and collaboration. • If you are experiencing emotional or mental distress, **consider finding professional help** with a therapist, psychiatrist, or other mental health provider.

Table 4. Features of Healthy Teams

A team is more…	When it creates…
Productive and creative	Wide diversity, especially of experiences and thinking.
Coordinated	An orchestra-like dynamic, each member having a part to play while being actively supported by colleagues until it is their turn to be in the spotlight.
Efficient and organized	Agreed-upon structure jointly created by the team (not solely by managers): • vision, mission, feedback about personal team accountabilities, frequency of meetings, rotation of meeting leader among staff, and most of all, commitment to Ways of Working, i.e, curiosity, courage, and compassion.
Accountable	A culture of trust where there are no secrets and feedback sessions are regularly scheduled with enough time to get to core of how to bring out the best from each other.

Table 5. When to Seek Mental Health Care

Symptoms warranting professional support	Examples
Self-harming thoughts or behaviors	•Suicidal or self-injurious thoughts, plans, or actions •Unhealthy alcohol or drug use •Increased risk-taking/impulsivity
Depression, anxiety, or trauma (PTSD) symptoms impacting your work or personal life	•Neglecting self-care (hygiene, nutrition, sleep) •Avoiding important work or social commitments •Inability to feel joy or pleasure •Uncontrollable anger •Panic attacks or inability to control worry •Nightmares or re-experiencing traumatic memories •Dissociation (feeling disconnected from your body or the world around you) •Psychotic symptoms (hallucinations, paranoia, delusional beliefs) •Concern for impaired judgment
Burnout, moral injury, or compassion fatigue not improving despite self-care interventions	•Demoralization (helplessness, hopelessness, worthlessness, giving up) •Feeling unable to sustain your current role(s) •Not getting along with colleagues