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Cognitive Behavioral Therapy for Patients with Cancer

Section 1: Introduction

References: 8, 9, 14, 15, 20, 24, 38, 43, 45, 46, 47, 48, 52, 55, 57, 58, 59, 61

Cancer in the United States

According to the U.S. Centers for Disease Control and Prevention (CDC) (2025a), more than 1.8 million people were diagnosed with cancer in the U.S., and over 610,000 people died from the disease in 2022 (the most recent data available). Also, from 2019-2022 (the most recent data available), the lifetime risk of being diagnosed with an invasive cancer for both men and women was 1 in 3. This statistic means that 1 in 3 men and 1 in 3 women will be diagnosed with cancer in their lifetime (Siegel et al., 2026).

Since 2022, estimates in the annual American Cancer Society's Cancer Facts and Figures reports show a steady increase in the number of people who will be diagnosed with cancer. This number was expected to exceed 2 million for the first time in U.S. history in 2024 (Collins, 2024).

In January 2026, the American Cancer Society estimated that over 2,110,000 people would be diagnosed with cancer, and over 625,000 people would die from the disease (Siegel et al., 2026). The continuous increase in these numbers is attributed to the U.S. population growing and aging (U.S. Centers for Disease Control and Prevention [CDC], 2025b).

The American Cancer Society also publishes Facts and Figures reports focusing solely on cancer treatment and survivorship. The most recent version of this report estimated that there are over 18 million cancer survivors in the U.S. as of January 2025, which means that about 1 out of every 18 Americans has a history of cancer. The number of cancer survivors is expected to exceed 22 million people by 2035. The increase in cancer survivors is also attributed to a growing and aging

population, as well as advances in cancer screenings and treatments that have improved survival (Wagle et al., 2025).

Cancer not only impacts a significant number of people in the U.S., but it can also change many, if not all, aspects of an individual's life. Though an individual's reactions to the diagnosis may be unique to themselves, there are common themes in the cancer experience. One common theme is that cancer impacts an individual's functioning and their quality of life. The other themes can be categorized into physical and psychosocial (Carlson, 2017).

Physical

Symptoms from the cancer itself and side effects from the treatments can change a person's ability to function day to day, may lead to permanent impairments, and are likely to cause distress (Institute of Medicine [IOM], 2008). Though the symptoms of the disease vary from person to person, common ones include fatigue, fever, loss of appetite, weight loss, skin changes, ongoing pain, and palpable lumps or bumps. Side effects also vary by treatment type and can include fatigue, pain, neuropathy (nerve damage), increased risk of infection, nausea and other gastrointestinal symptoms, weight loss or gain, menopausal symptoms (for example, hot flashes, loss of sex drive), skin irritation or rash, lymphedema, weakness, and cognitive issues (for example, difficulty with concentration, memory, or word-finding) (Cleveland Clinic, 2024). These issues may persist for months or years and can increase an individual's care needs.

Compared to people without a history of cancer, people with a history of the disease are:

- More likely to report having fair or poor health.
- Have higher rates of other chronic illnesses.

- More limited in performing activities of daily living (ADLs).
- Have other functional disabilities.
- Unable to work because of a medical condition (IOM, 2008).

Some of these issues may be because older adults are typically diagnosed with cancer. In 2022 (the most recent data available), approximately 36% of cancer diagnoses occurred in people ages 40-64, followed by about 32% in those 65-74, and about 27% in those ages 75 and over (CDC, 2025b). However, research has shown that a third of people diagnosed with the disease report issues in performing ADLs and having functional disabilities. No matter the age, cancer survivors also report higher rates of chronic illness compared to those who have never been diagnosed with cancer. When cancer co-occurs with another chronic illness, reports of poor health are more likely, and disability rates are 5-10 times higher (Institute of Medicine [IOM], 2008).

Psychosocial

The National Cancer Institute (n.d.) defines psychosocial as "the mental, emotional, social, and spiritual effects of a disease, such as cancer. Some of the psychosocial effects of cancer are changes in how a patient thinks, their feelings, moods, beliefs, ways of coping, and relationships with family, friends, and co-workers" (para. 1).

Psychosocial effects often occur alongside the physical challenges of a cancer diagnosis. The distressing experiences that occur throughout the disease trajectory decrease an individual's ability to cope with their disease and treatment (Carlson, 2017). Studies have shown that about half to two-thirds of cancer patients experience considerable psychosocial distress during the course of their illness (Zingler et al., 2025).

The National Cancer Institute (2025a) defines psychosocial distress as:

> *"A multifactorial unpleasant experience of a psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical nature that may interfere with one's ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis" (para. 9).*

As noted in this definition, part of psychosocial distress is psychological, encompassing cognitive (the way a person thinks and their belief system), behavioral (ways of coping), and emotional (feelings and moods) components of an individual's diagnosis (National Cancer Institute, n.d.). Both patients and their loved ones typically have their own psychosocial experience of cancer, making these concerns a considerable part of all of their lives (IOM, 2008).

The psychosocial impact of the disease can "create new or worsen preexisting psychological distress for people living with cancer, their families, and other informal caregivers. Physical and psychological impairments can also lead to substantial social problems" (IOM, 2008, p. 30). Though psychosocial concerns vary based on where a person is in the disease trajectory, some common ones include:

- Symptoms and diagnoses of anxiety, depression, and adjustment disorders.
- Feelings of guilt, loss of control, uncertainty, fear, anger, sadness, shock, confusion, and grief.
- Alterations in physical appearance and sense of self.
- Changes in relationships and roles, isolation, and communication problems.

- Existential distress and spiritual issues.
- Financial stressors, income and employment reductions, and a lack of health insurance (IOM, 2008; Temple, 2017).

To focus on the psychological aspects of the diagnosis, studies have shown that approximately 30% of people diagnosed with cancer have symptoms of anxiety, and about 25% experience symptoms of depression (Naser et al., 2021, as cited in Caba et al., 2024). In the U.S. population, about 3% of adults are impacted by generalized anxiety disorder (GAD), and about 8% of adults are affected by major depressive disorder (MDD) in any given year (Anxiety and Depression Association of America, 2022; Anxiety and Depression Association of America, 2025). These numbers show that the prevalence of anxiety and depression is higher in people diagnosed with cancer when compared to the general U.S. population.

With the increasing number of people impacted by cancer and the prevalence of cancer-related psychosocial distress, including mental health conditions such as anxiety and depression, social workers and other mental health professionals need to understand the specific psychological care needs of patients with cancer. In addition to gaining this understanding, it is also beneficial to have the knowledge and skills to manage psychological responses to the diagnosis.

One effective management approach is cognitive-behavioral therapy (CBT). CBT "refers to a variety of therapeutic approaches that have in common the basic notion that a patient's thoughts and behaviors are instrumental in the etiology of psychological distress" (Nicholas, 2016, p. 46). This course will outline how social workers and other mental health professionals can help people diagnosed with cancer by using CBT, so that they are equipped to deliver personalized, effective treatment that fosters psychological adjustment and resilience at every stage of the medical continuum. The following topics will be reviewed:

- Identifying and diagnosing common conditions that would benefit from this CBT, including adjustment disorder, anxiety disorders, depressive disorders, and post-traumatic stress disorder (PTSD)
- Detailing the fundamentals of CBT.
- Learning and refining CBT skills for treating patients with cancer.

Section 1 Key Terms

Lifetime risk - “the probability of developing or dying from cancer in the course of one’s lifespan” (National Cancer Institute; Surveillance, Epidemiology, and End Results Program, n.d., para. 1).

Cancer survivorship - “a state of being, including the perspectives, needs, health, and the physical, psychological, social, and economic challenges experienced by people and caregivers after a cancer diagnosis” (National Cancer Institute; Division of Cancer Control and Population Sciences, Office of Cancer Survivorship, n.d., para. 3). “An individual is considered a cancer survivor from the time of diagnosis through the balance of life. There are many types of survivors, including those living with cancer and those free of cancer. This term is meant to capture a population of those with a history of cancer rather than to provide a label that may or may not resonate with individuals” (National Cancer Institute; Division of Cancer Control and Population Sciences, Office of Cancer Survivorship, n.d., para. 2).

Psychosocial - “the mental, emotional, social, and spiritual effects of a disease, such as cancer. Some of the psychosocial effects of cancer are changes in how a patient thinks, their feelings, moods, beliefs, ways of coping, and relationships with family, friends, and co-workers” (National Cancer Institute, n.d., para. 1).

Psychosocial distress - “a multifactorial unpleasant experience of a psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical nature that may interfere with one's ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (National Cancer Institute, 2025a, para. 9).

Section 1 Reflection Question

What are the most common physical challenges and psychosocial concerns that you see in your clinical practice?

Section 2: Common Mental Health Conditions

References: 5, 7, 10, 13, 16, 17, 18, 19, 21, 22, 23, 25, 27, 26, 28, 29, 30, 31, 32, 34, 35, 40, 41, 42, 43, 44, 49, 52, 54, 56, 60

Common mental health conditions that impact cancer patients include adjustment disorder, anxiety disorders, depressive disorders, and post-traumatic stress disorder (PTSD).

Adjustment Disorder

An adjustment disorder is defined as:

> *“A stress-related, short-term, nonpsychotic disturbance characterized by emotional or behavioral symptoms occurring in response to an identifiable stressor. Individuals experience clinically significant distress and/or functional impairment that is out of proportion to the expected response to*

> *the event, taking cultural and contextual factors into account" (American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [DSM-5], as cited in Frank, 2026a, para. 1).*

Another way to think about an adjustment disorder is that they develop "when a psychosocial stressor exceeds an individual's capacity to adapt. The degree of distress is influenced not only by the objective severity of the stressor but also by the meaning the individual assigns to the event, available coping strategies, prior life experience, personality traits, developmental stage, and social supports" (Frank, 2026d, para. 1). Most cancer patients are faced with an identified psychosocial stressor, but their response to it helps determine if they meet the criteria for an adjustment disorder (National Cancer Institute, 2025a).

Adjustment Disorders and Cancer

According to the National Cancer Institute (2025a), a meta-analysis of 70 studies across nearly 15 countries and involving more than 10,000 participants found that adjustment disorders were prevalent in approximately 20% of ambulatory cancer patients receiving active treatment. In the United States alone, studies have shown that adjustment disorders are the most common mental health issue experienced by cancer patients.

- For those with advanced cancer, the prevalence ranges from approximately 14% to 35%.
- For patients who are terminally ill, prevalence rates range from about 10% to 16%.

Variables that affect prevalence rates include disease stage, cancer type, diagnostic procedures, and other patient factors (National Cancer Institute, 2025a).

Risk Factors

In general, risk factors for an adjustment disorder include:

- Limited coping skills
- Insecure attachment patterns
- Lack of social support
- Low self-efficacy
- Prior psychiatric condition (Frank, 2026d).

Patient Presentation

Patients typically present with the following symptoms:

- Low mood
- Tearfulness
- Anxiety and/or excessive worry
- Irritability
- Sleep disturbance
- Trouble concentrating
- Feeling overwhelmed
- Reduction in their motivation
- Withdrawing from social relationships
- Decreased performance at work

They may also present with:

- Significant anger
- Shame
- Demoralization

Assessment

Because an adjustment disorder happens after a life stressor occurs, an assessment should focus on the following:

- Identifying the precipitating stressor(s)
- Understanding the patient's interpretation of the stressor
- Timing between the stressor and the onset of symptoms
- Determining the degree of functional impairment in the social and occupational areas of an individual's life
- Any substance use that is occurring, as it may represent maladaptive coping mechanisms and worsen any symptoms (Frank, 2025b)

When completing a full psychosocial assessment, it is important to also obtain information as to whether the patient has experienced the following:

- Prior psychiatric illness
- Suicidal ideation, self-injury, impulsive behavior, and risk of harming others
- Trauma exposure
- Substance use
- Cognitive limitations

- Environmental or social stressors (for example, financial issues or relationship conflicts) (Frank, 2026f).

During the assessment process, it can also be helpful to provide opportunities for the patient to describe the stressor from their perspective in a narrative format, as this may help the mental health professional "clarify vulnerabilities, coping style, and the presence of unresolved conflict or loss" (Frank, 2026f, para. 1).

Diagnostic Criteria

In the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), an adjustment disorder is grouped within trauma and stressor-related disorders. The DSM-5 diagnostic criteria include the following:

- The emotional or behavioral symptoms (disturbance) typically develop within 3 months of the onset of an identifiable stressor.
- Symptoms are clinically significant, meaning the distress is out of proportion to the stressor and/or the individual has a significant impairment in functioning.
- The disturbance does not meet criteria for another disorder in the DSM-5 and is not an exacerbation of a pre-existing mental health condition.
- Symptoms are not representative of normal bereavement.
- The symptoms resolve within six months if the stressor has ended. If the stressor persists, symptoms may also last for more than 6 months.

The DSM-5 includes specifiers that can accompany an adjustment disorder, including:

- Depressed mood

- Anxious mood
- Mixed anxiety and depressed mood
- Disturbance of conduct
- Mixed disturbance of emotions and conduct
- Unspecified

If the onset of symptoms is delayed more than 3 months after the stressor or lasts more than 6 months after the stressor has resolved, this could fall within the other specified trauma- and stressor-related disorder category with adjustment-like presentations, but a delayed onset or prolonged duration.

Though the definition above indicates that an adjustment disorder is time-limited, it can come with significant stress and consequences, including suicidal ideation and attempts, and self-harm (DSM-5, as cited in Frank, 2026d). It can also progress into other mental health disorders, including anxiety and depressive disorders (Frank, 2026b). Of note, an adjustment disorder is often accompanied by other psychiatric diagnoses, especially personality disorders and substance use disorders. These comorbidities may increase the risk of suicidal ideation and attempts (Frank, 2026d).

Treatment

Research has shown that brief psychotherapy is the preferred intervention for an adjustment disorder, which aligns with its time-limited nature. Treatment starts with understanding the stressor(s), the patient's interpretation, coping strategies, and available social support. The goals of treatment include clarifying the stressor(s), exploring their meaning in a person's life, reframing any maladaptive interpretations, reducing stress, and reinforcing positive coping strategies and social support.

CBT is one intervention that can be useful in addressing maladaptive interpretations of the stressor(s) and any avoidance behaviors (Frank, 2026e).

Anxiety Disorders

While worry and anxiety are normal parts of life, anxiety disorders can be diagnosed when the worry and anxiety do not go away, are present in many situations, symptoms impact daily functioning, and can get worse over time (MedlinePlus, 2023). Several different types of anxiety disorders exist within the DSM-5, including generalized anxiety disorder (GAD), panic disorder, phobia-related disorders, agoraphobia, substance or medication-induced anxiety disorder, anxiety disorder due to another medical condition, and more (Bhatt, 2024; MedlinePlus, 2023).

Anxiety Disorders and Cancer

Anxiety can be experienced by people living with cancer in varying degrees at different time points and for different reasons. For example, anxiety can occur around the time of the diagnosis, if the disease progresses, or if treatment becomes more aggressive. It can also be secondary to other physical aspects of the disease, including uncontrolled pain or medication side effects.

A range of statistics related to the prevalence of anxiety in cancer patients exists. Some studies have shown that close to 45% of people with cancer reported some anxiety, while about 20% reported significant anxiety. One meta-analysis that examined over 50 studies found that as high as 23% of patients had anxiety symptoms/disorders (Amiri, 2024).

Patients may present with any of the following anxiety disorders:

- Generalized anxiety disorder (GAD)

- Panic disorder
- Phobia-related disorders
- Obsessive-compulsive disorder (OCD)
- A health anxiety disorder
- Anxiety disorder due to another medical condition

Anxiety disorders, such as generalized anxiety, panic disorder, and phobias, typically predate a cancer diagnosis. The stress that comes with a cancer diagnosis can cause a relapse of any preexisting anxiety disorders that the patient has experienced. These disorders can be disabling for a patient and negatively impact their cancer treatment plan, which is why a timely diagnosis and effective psychological intervention are important (National Cancer Institute, 2025a).

Risk Factors

In general, risk factors for anxiety disorders include:

- Trauma exposure in early childhood or adulthood
- Personality traits (for example, being withdrawn or fearful in new situations)
- Family history of anxiety or other mental health conditions
- Some physical health issues

The following risk factors can increase the chance that an anxiety disorder will develop during cancer treatment:

- History of an anxiety disorder
- Anxiety at diagnosis

- Severe pain or other physical symptoms
- Advancing disease
- Functional limitations
- Trauma history
- Lack of social support
- Female gender
- Cancer diagnosis at a young age
- Problems communicating with family, friends, and doctors (National Cancer Institute, 2025a)

Patient Presentation

Patients with anxiety disorders can present with different symptoms based on the disorder they are experiencing. The following are common symptoms that patients can present with:

- Anxious thoughts that are difficult to control. These thoughts can interfere with daily life and cause feelings of restlessness or tension. They do not go away and can worsen over time.
- Physical issues such as a rapid heartbeat, sweating, aches and pains unrelated to a medical condition, dizziness, lightheadedness, and shortness of breath.
- Behavior changes such as avoiding daily activities that used to be done without issue (MedlinePlus, 2023; National Cancer Institute, 2025a).

The following symptoms may indicate a recurrence of a preexisting anxiety disorder caused by the stress of the cancer diagnosis:

- Intense fear
- Difficulty absorbing information
- Inability to cooperate during medical procedures

Screening and Assessment

Clinical guidelines from the American Society of Clinical Oncology (ASCO) recommend screening for anxiety at the following time points:

- Diagnosis/start of treatment
- Regular intervals during treatment
- 3, 6, and 12 months post-treatment
- Recurrence and/or progression
- End of life
- During personal transitions or reappraisals

The Generalized Anxiety Disorder-7 (GAD-7) is the recommended screening tool for clinical practice. If a patient has a total score of 10-14, they are considered to have moderate symptoms. If the total score is 15-21, moderate to severe symptomatology is considered present. In both situations, the patient's history and risk factors for anxiety should be assessed and identified.

When assessing anxiety in people living with cancer, it can be difficult to differentiate between normal fears, concerns, and worries from those that are more severe and meet criteria for an anxiety disorder. Therefore, using a screening tool such as the GAD-7 can help identify symptom severity (Andersen et al., 2023). The following symptoms are considered more serious when compared to symptoms of common or normal worry:

- Constant worrying about more than one area of life
- Inability to concentrate
- Irritability
- Cannot turn off thoughts most of the time
- Difficulty falling asleep and/or early wakeups most nights
- Frequent crying spells that interfere with daily life
- Consistent fear and apprehension
- Many physical symptoms (restlessness, feeling on edge, heart racing, etc.)
- Lack of coping skills to decrease anxiety (National Cancer Institute, 2025a)

One important thing to assess and understand is how much symptoms interfere with a person's daily life and their ability to function. It is also important to complete a comprehensive psychosocial assessment to obtain a clear picture of the patient's history and risk factors, current situation, and the diagnostic criteria for an anxiety disorder that they may be experiencing (Andersen et al., 2023).

Diagnostic Criteria

Generalized Anxiety Disorder (GAD)

According to the DSM-5, generalized anxiety disorder (GAD) can be diagnosed when a person feels worried most of the time over the course of 6 months, based on several events that are occurring in their life. They also have difficulty managing their worry to the point that it impacts daily life (Cleveland Clinic, 2025a). Different from an adjustment disorder, a precipitating stressor is not typically present in generalized anxiety; a person may expect something bad to

happen, or they have increasing concerns about various aspects of their life, such as work, finances, or relationships (Theravive, n.d.).

In addition to feeling worried or anxious, a person should have at least three of the following symptoms for the greater part of 6 months to meet criteria for a diagnosis:

- Feeling on edge and restless
- Tiring easily
- Difficulty concentrating or the mind going blank
- Irritability
- Muscle tension
- Trouble sleeping

These symptoms must not be due to the physiological effects of a substance or another medical condition, and must not be explained by another mental health disorder (Cleveland Clinic, 2025a).

In cancer patients, generalized anxiety can be triggered by changes in perceived health and vulnerability (National Cancer Institute, 2025a). A range of statistics related to the prevalence of GAD in cancer patients exists. One meta-analysis found that about 7% of cancer patients had a diagnosis of GAD (Amiri, 2024). One study that used data from eight large cancer centers on patients with advanced cancer found that about 4% met criteria for GAD (Spencer et al., 2010). Another study that examined anxiety disorders among cancer survivors found GAD to be the most common disorder, with 41% of patients meeting criteria for it (Arch et al., 2020).

Panic Disorder

According to the DSM-5, panic disorder can be diagnosed when a person has multiple, unexpected panic attacks, which are "sudden, temporary feelings of fear and strong physical reactions in response to ordinary, nonthreatening situations" (Cleveland Clinic, 2023a, para. 2). These attacks are typically accompanied by physical symptoms, including sweating, trouble breathing, shaking, nausea, and heart racing. Emotionally, a person may feel intense terror, like they are choking or being smothered, losing control, out of touch with reality or oneself, and like they are going to die. In addition to panic attacks, a person must have consistent worries about having more of them and change their behaviors to avoid situations that could trigger an attack, for at least one month. Lastly, the attacks cannot be due to a substance or another medical or mental health condition (Cleveland Clinic, 2023a).

There is a range of statistics related to the prevalence of panic disorder in cancer patients. One meta-analysis found that about 3% of cancer patients had the disorder, while one study in particular found a prevalence rate of close to 9% (Amiri, 2024; Osório et al., 2015).

Phobia-Related Disorders

Phobias happen when a person has an "intense or even overpowering fear and anxiety in certain situations or when they encounter certain objects…people with phobias critically limit their lives to avoid encountering what they fear" (Cleveland Clinic, 2023b, para. 1). In general, these situations and objects do not pose a threat (Millard, 2022).

To be diagnosed with a phobia-related disorder, a person must meet the following criteria in the DSM-5:

- An identified fear or anxiety about a situation or object

- The situation or object most often provokes immediate fear or anxiety
- The fear or anxiety is out of proportion to the danger the situation or object poses
- The situation or object is actively avoided, or when experienced, there is intense fear or anxiety
- Significant distress or impairment in functioning happens because of the fear, anxiety, or avoidance, which usually lasts for 6 months or more.

These symptoms must not be explained by another mental health disorder, such as a panic attack, obsessive-compulsive disorder, or PTSD (Cleveland Clinic, 2023b; Millard, 2022).

In the medical setting, types of phobias include:

- Algophobia (fear of pain)
- Claustrophobia (fear of enclosed spaces, such as an MRI machine)
- Hemophobia (fear of blood)
- Trypanophobia (fear of needles) (Cleveland Clinic, 2023b; National Cancer Institute, 2025a)

One meta-analysis found that about 4% of cancer patients had specific phobia, while those who had social phobia or agoraphobia were about 2% for each disorder (Amiri, 2024).

Obsessive-Compulsive Disorder (OCD)

Obsessive-Compulsive Disorder (OCD) is a “mental health condition that causes a pattern of unwanted thoughts and fears (obsessions). These lead to repetitive behaviors (compulsions) that can interfere with daily life and responsibilities”

(Cleveland Clinic, 2025b, para. 2). Obsessions are not only unwanted thoughts and fears; they can also be urges or mental images that cause significant anxiety. The repetitiveness of compulsions (actions or rituals) becomes necessary for a person to ease or eliminate their obsessions. Neither has to coexist, though, meaning a person can have an obsession without a compulsion, and vice versa.

According to the DSM-5, to be diagnosed with OCD, a person must:

- Have obsessions, compulsions, or both, spending more than one hour a day on them
- Have symptoms that interfere with their daily life, or are experiencing stress

These symptoms must not be due to the physiological effects of a substance, medication, or another medical condition. They must not be explained by another mental health disorder (Cleveland Clinic, 2025b).

People with cancer who have a history of OCD may exhibit certain compulsive behaviors that impact their ability to comply with treatment, including hand washing, checking, or counting. Additionally, their worry about the cancer diagnosis and prognosis can develop into severe obsessive-compulsive symptoms. Notably, OCD is uncommon in cancer patients who do not have a history of an anxiety disorder (National Cancer Institute, 2025a).

Health Anxiety

A health anxiety disorder can be either illness anxiety disorder or somatic symptom disorder. With both disorders, a person is excessively worried about their health and usually has some awareness of that, while also having difficulty tolerating uncertainty related to their health. According to the DSM-5, a person who experiences physical symptoms, which may or may not be due to a medical condition, as well as debilitating worry for at least six months, may be diagnosed with somatic symptom disorder. Illness anxiety disorder may be diagnosed when a

person is preoccupied with developing or having an illness for at least 6 months, even when there are no physical symptoms or when the symptoms are mild. A person with illness anxiety is usually hypervigilant about their body and any changes they are experiencing, which either leads them to seek reassurance from health care professionals or avoid them out of fear (Cleveland Clinic, 2022b).

While a health anxiety disorder is rare in the general population, cancer survivors may develop it because of their fear of recurrence. They may be focused on their cancer status, identify with the role of a patient, be hypervigilant to physical symptoms, somatize, and request frequent care, even when it is not needed or recommended (National Cancer Institute, 2025a).

Anxiety Disorder due to Another Medical Condition

It is common for medical conditions to cause anxiety reactions because of the worry that comes with having a disease and learning, knowing, or living its consequences. An anxiety disorder due to another medical condition is "produced directly from the medical condition and not via a psychological reaction based on the client's evaluation of the condition (although both could be present)" (Stolar, 2025, p. 66). Another way to think about this disorder is that there is always an underlying medical condition present that leads to anxiety.

This type of anxiety disorder is different from a primary anxiety disorder and an adjustment disorder with anxiety. In a primary anxiety disorder, there is no direct connection to a medical condition that causes anxiety. In an adjustment disorder with anxiety, the symptoms occur as a reaction to something like a diagnosis, not produced directly from it (Theravive, n.d.).

Some cancers or aspects of the disease are associated with symptoms that present as anxiety disorders, including:

- Brain cancer

- Cancers that metastasize (or spread) to the brain or spinal cord
- Shortness of breath that can accompany lung cancer
- Cancer treatments that include certain medications, such as steroids (National Cancer Institute, 2025a; Stolar, 2025)

Therefore, it is important to be mindful of these cancer diagnoses and the impact of certain treatments when considering a diagnosis of an anxiety disorder due to another medical condition.

According to the DSM-5, to be diagnosed with an anxiety disorder due to another medical condition, a person must:

- Be diagnosed with a certain medical condition
- Have clinically significant symptoms of anxiety due to the direct physiological effects of that condition
- Be diagnosed with the medical condition before the onset of anxiety symptoms
- Have a functional impairment in areas of life
- No longer have anxiety symptoms if/when the disease goes into remission (Stolar, 2025)

Additionally, anxiety symptoms must not be explained by another mental health disorder or substance use. There are a variety of symptom pictures, so it is essential to complete a thorough assessment. For example, anxiety due to another medical condition could manifest as symptoms that are the same as generalized anxiety disorder, panic disorder, or obsessive-compulsive disorder (Theravive, n.d.). Furthermore,

"There must be a close association between the medical condition and anxiety in order for this diagnosis to be appropriate. That is, the anxiety symptoms must occur close in time to the onset, worsening, or lessening of the medical condition. If the features of anxiety that are seen are not typical for a primary anxiety disorder, and there is a medical condition present, this is an indication that anxiety due to another medical condition may be an appropriate diagnosis" (Theravive, n.d., para. 8).

Treatment

Cognitive behavioral therapy (CBT) is a recommended treatment in ASCO guidelines for managing anxiety in adults with cancer. It is also an effective approach to treating anxiety disorders, including GAD, panic disorder, phobia-related disorders, OCD, and a health anxiety disorder. Medications can also help manage symptoms of anxiety.

- In GAD, CBT can help a person notice and change negative thoughts that may worsen their anxiety and/or cause certain behaviors. When done over time, CBT may help reduce worry and develop healthier coping skills (Cleveland Clinic, 2025a).

- Cancer patients with panic disorder may respond well to CBT. It can help a person identify panic attack triggers, enabling them to change their thinking, behaviors, and reactions. As responses change, panic attacks may decrease and eventually stop (Cleveland Clinic, 2023a; National Cancer Institute, 2025a).

- Cancer patients with phobias may also respond well to CBT, as it can help them cope better with the fear and anxiety that they are experiencing. Exposure therapy can also be helpful (Cleveland Clinic, 2023b; National Cancer Institute, 2025a).

- OCD can be treated with CBT, especially when obsessive thoughts and ritualistic behaviors are mild (National Cancer Institute, 2025a).
- Cancer patients with a health anxiety disorder may be treated with CBT, as early clinical guidelines and ongoing research have shown that it may be beneficial (National Cancer Institute, 2025a).
- Cancer patients with an anxiety disorder due to another medical condition may need to receive treatment for anxiety until the underlying medical condition is treated. This decision typically depends on whether the medical condition is life-threatening. It is possible for both the anxiety and the medical condition to be treated simultaneously, but it often depends on the treatment for the medical condition. CBT can be used to treat this type of anxiety disorder as it helps change thinking patterns that cause anxiety and works directly on behaviors that can help people change their reactions to anxiety-provoking situations (Theravive, n.d.).

According to ASCO guidelines, for patients receiving psychological treatment, including CBT, mental health professionals should regularly assess their response to treatment. It is common for people with anxiety to avoid or not follow through on referrals or treatment recommendations. Therefore, the mental health professional should assess symptoms monthly until they have improved. The mental health professional should also assess compliance and, if it is poor, work with the patient to create a plan to address barriers to care or to discuss alternative treatment options that are more attainable. After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are limited, even with good compliance, the mental health professional can modify the treatment course (Andersen et al., 2023)

Depressive Disorders

Depressive disorders are common and involve a depressed mood or loss of pleasure or interest in activities for long periods of time. As stated by the World Health Organization (2025), “depression is different from regular mood changes and feelings about everyday life. It can affect all aspects of life, including relationships with family, friends, and community. It can result from or lead to problems at school and at work” (para. 2). Coryell (2026) also states, “depressive disorders are characterized by a sad, empty, or irritable mood severe enough and persistent enough to interfere with function” (para. 1).

In the DSM-5, there are several depressive disorders, including disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, and more (Coryell, 2026).

Depressive Disorders and Cancer

Depression can be experienced at any phase of the cancer experience, from diagnosis to survivorship or end of life. It has been shown to negatively impact treatment adherence as well as be associated with a poorer prognosis and more limited survival in people living with cancer. It also harms patients and their family members.

It is normal for patients to experience responses to their diagnosis or in different phases of their illness that mimic depression symptoms, such as sadness or grief, but these responses typically last several days to weeks. This normal sadness is considered one part of the spectrum of depressive symptoms, while depressive disorders are on the same spectrum, but are progressive based on the nature of symptoms and the amount of time they are present.

Common depressive disorders experienced by people diagnosed with cancer include major depressive disorder (MDD), persistent depressive disorder (PDD),

and adjustment disorder with depressive mood. Studies have examined the prevalence of depressive disorders in different oncology settings, including outpatient clinics, inpatient settings, and palliative care settings, for many different types of cancer throughout the disease trajectory. Depression is estimated to impact about one in four cancer patients, or about 25%. People diagnosed with cancer are also five times more likely than people in the general population to have depression (Grassi et al., 2023; National Cancer Institute, 2024).

Possible causes of depression symptoms in people diagnosed with cancer include:

- Uncontrolled pain
- Abnormalities in metabolic lab measurements, such as anemia, imbalance in sodium and potassium, and high calcium levels
- Medications such as steroids, some chemotherapy treatments, hormone therapy, and others
- Primary central nervous system (CNS) cancers or cancers that have metastasized to the CNS
- Overactive or underactive thyroid
- Disrupted sleep
- Anticipated and/or actual losses (National Cancer Institute, 2024)

Risk Factors

Risk factors for depression are often related to individual, social, disease, and treatment-related factors. Individual and social risk factors include:

- Younger age

- Female gender (in the general population), though men and women with cancer are affected equally
- History of a mood disorder, substance abuse, or another mental health condition (ex. anxiety)
- Lack of social support
- Being single, separated, or widowed
- Low self-esteem
- Adverse childhood experiences
- Major life stressors (ex. illness)
- Limited sense of meaning and purpose in one's life
- Lower socioeconomic status
- Lower education

Disease and treatment-related factors include:

- Diagnoses of head and neck, pancreatic, lung, or thyroid cancer
- Significant physical burden from the diagnosis itself and/or treatment, including things like fatigue, pain, and lower physical functioning
- Recurrent, advanced, or progressive disease
- Presence of another chronic illness (Andersen et al., 2023; Coryell, 2026; Grassi et al., 2023; National Cancer Institute, 2024)

Patient Presentation

Some patients with a depressive disorder may not present with typical symptoms, such as low mood or anhedonia. They may have physical complaints or note irritability and difficulty concentrating more so than sadness or low mood (Halverson, 2024).

Patients with major depressive disorder (MDD) may,

> *"Appear miserable, with tearful eyes, furrowed brows, down-turned corners of the mouth, slumped posture, poor eye contact, lack of facial expression, little body movement, and speech changes…In some patients, depressed mood is so deep that tears dry up; they report that they are unable to experience usual emotions and feel that the world has become colorless and lifeless…Some depressed patients neglect personal hygiene or their children, other loved ones, or pets" (Coryell, 2026, para. 25 & 27).*

Patients with persistent depressive disorder (PDD) may be "habitually gloomy, pessimistic, humorless, passive, lethargic, introverted, hypercritical of self and others, and complaining" (Coryell, 2026, para. 31).

Screening and Assessment

Clinical guidelines from ASCO recommend screening for depression at the following time points:

- Diagnosis/start of treatment
- Regular intervals during treatment
- 3, 6, and 12 months post-treatment
- Recurrence and/or progression
- End of life

- During personal transitions or reappraisals

The Patient Health Questionnaire-2 (PHQ-2) is the recommended screening tool for clinical practice. If a patient reports a score of 2 or 3, they should complete the remaining 7 items of the Patient Health Questionnaire-9 (PHQ-9). If the total score is 8-14, symptoms are considered moderate. If the total score is 15-19, moderate-to-severe symptomatology is considered present; a score of 20-27 indicates severe symptomatology. In these three situations, the patient's history and risk factors for depression should be assessed and identified.

When assessing depression in people living with cancer, it can be difficult to differentiate between normal sadness and grief, as these are common reactions to a cancer diagnosis and are things that occur throughout the disease trajectory. Therefore, it is important to thoroughly assess symptoms to distinguish between normal sadness and depressive disorders. Using screening tools such as the PHQ-2 and PHQ-9 can help identify symptom severity. It is also important to complete a comprehensive psychosocial assessment to obtain a clear picture of the patient's history and risk factors, current situation (how symptoms are impacting their daily life and functioning), and the diagnostic criteria for a depressive disorder that they may be experiencing (Andersen et al., 2023). The National Cancer Institute (2024) also suggests the following assessment questions:

- How are you coping with your cancer?
- What has your mood been like since your diagnosis/during treatment/after treatment?
- Do you cry? If so, how often? Are you often alone or with someone when this happens?
- Are there things you still enjoy doing?
- How does the future look to you?

- Do you feel you can impact your care, or is it under someone else's control?
- Do you worry about being a burden to your loved ones?
- Do you feel other people would be better off without you?
- Do you have pain that is not being managed?
- How much time do you spend in bed?
- Do you feel weak or fatigued?
- How is your sleep? After you have slept, do you feel rested?
- How is your appetite?
- How is your interest in sex?
- Do you feel your thinking or movement is slower than normal?

Diagnostic Criteria

Major Depressive Disorder

The DSM-5 diagnostic criteria for major depressive disorder (MDD) include a person having five or more of the following symptoms that last every day, nearly all day, within the same two-week period:

- Feeling very sad, empty, or hopeless
- Loss of interest in activities that used to bring enjoyment
- Increase or decrease in appetite, resulting in weight gain or loss
- Slowed speech, decreased movement, or impaired cognitive functioning
- Trouble sleeping or sleeping too much

- Low energy or fatigue
- Feeling worthless or very guilty
- Trouble concentrating and making decisions
- Thoughts of death or suicide

The symptom of low mood or loss of interest must be present. MDD is a chronic condition, but it usually happens in episodes that last weeks to months (Cleveland Clinic, 2022a).

Persistent Depressive Disorder

According to the DSM-5, persistent depressive disorder (PDD) can be diagnosed when a person has a depressed mood for most of the day, for more days than not, for 2 years or more without remission. They must also have two or more of the following symptoms:

- Increase or decrease in appetite, resulting in weight gain or loss
- Trouble sleeping or sleeping too much
- Low energy or fatigue
- Low self-esteem
- Trouble concentrating and making decisions
- Feelings of hopelessness

During the 2 years, the person has never been without symptoms for more than 2 months at a time.

People with PDD are also more likely to have an underlying anxiety disorder, substance use disorder, or personality disorder (Coryell, 2026).

Treatment

Cognitive behavioral therapy (CBT) is a recommended treatment in ASCO guidelines for managing depression in adults with cancer. Individual CBT or group CBT is recommended for patients with moderate symptoms; however, only individual therapy is recommended for patients with moderate-to-severe or severe symptoms. Medications can also help manage symptoms of depression.

According to ASCO guidelines, for patients receiving psychological treatment, including CBT, mental health professionals should regularly assess their response to treatment. It is common for people with depression to lack the motivation to follow through on referrals and/or comply with their treatment plan. Therefore, symptoms should be assessed regularly, at least bi-weekly to monthly, until symptoms have improved. The mental health professional should also assess compliance, and if it is poor, work with the patient to develop a plan to address barriers to care or to discuss alternative treatment options that are more attainable. After 8 weeks of treatment, if symptom reduction and satisfaction with treatment are limited, even with good compliance, the mental health professional can modify the treatment course (Andersen et al., 2023)

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) develops after a person witnesses or experiences a traumatic event, which is something that “feels life-threatening or deeply stressful” (Cleveland Clinic, 2026, para. 18). Cancer-related examples of the events include severe injury or sudden illness. Patients with cancer may have also experienced other traumatic events, including natural disasters, war, physical, verbal, or sexual abuse, a serious accident, or the sudden death of a loved one.

There are different subtypes of PTSD, including dissociative, delayed expression, and complex.

- Dissociative PTSD includes feelings of being disconnected from one's body and distanced from reality.
- PTSD with delayed expression occurs when full symptoms do not appear until 6 months after the event, though mild symptoms may appear earlier.
- Complex PTSD happens when a person experiences long-term or repeated trauma. PTSD symptoms are present along with ongoing emotional problems, self-image issues, and relationship difficulties (Cleveland Clinic, 2026).

Post-Traumatic Stress Disorder and Cancer

PTSD has been studied in a variety of cancers. The prevalence of PTSD is about 3-4% in patients who are newly diagnosed with early-stage disease, and it increases to about 35% of patients after treatment. The prevalence of PTSD-like symptoms, but not meeting the full diagnostic criteria, is about 20% in patients with early-stage cancer, and up to 80% in people with recurrent disease (National Cancer Institute, 2025b).

Risk Factors

Risk factors for PTSD include:

- Being a first responder or military service member
- Adverse childhood experiences or other negative past event(s)
- Limited social support before or after the event
- Feeling intense fear, panic, or numbness during the event
- Having ongoing stressors, such as financial hardship

- Personal or family history of a mood disorder, another mental health condition, or PTSD (Cleveland Clinic, 2026)
- High levels of general psychological distress
- Limited or dysfunctional coping strategies, including avoidance

Cancer-specific risk factors include:

- People who received a bone marrow transplant
- Pain and other physical symptoms
- Threat to life and body integrity
- Recurrent disease (National Cancer Institute, 2025b)

Patient Presentation

Patients with PTSD may display physiological arousal, such as tremors, sweating, agitation, or emotional distress, when talking about their trauma. They may also be hypervigilant and have an increased startle response. They may have noticeable physical changes related to the trauma. Cognitively, they may not be able to remember certain parts of the trauma event or have distorted thoughts. Emotionally, they may show less positive emotions and present in a persistent negative emotional state (Gore, 2024).

Screening and Assessment

The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID)is a screening tool that has been used in many studies to diagnose PTSD (Doolittle & DuHamel, 2021). However, it is time-intensive and must be administered by an adequately trained mental health professional. The Impact of Event Scale-Revised and the PTSD Checklist, Civilian Version have also been used in research to assess for post-

traumatic stress symptoms, but not to diagnose PTSD (National Cancer Institute, 2025b). These two tools may be better suited to the oncology setting, as they are shorter than the SCID.

The diagnosis of PTSD itself in the cancer setting can be complicated because "cancer is not an acute or discrete event, but an experience marked by repeated trauma and indeterminate length" (National Cancer Institute, 2025b, para. 37). According to the National Cancer Institute (2025b), a timely, thorough assessment of PTSD symptoms is critical. However, one of the most difficult parts is determining the optimal time to assess, as symptoms may appear at any point along the disease trajectory. When an assessment occurs, though, it is important to distinguish between full PTSD symptoms that meet diagnostic criteria in the DSM-5 and post-traumatic stress symptoms. It is also important to assess the person's history of trauma and how much the symptoms are impacting their daily functioning. Additionally, a comprehensive psychosocial assessment is needed to obtain a clear picture of the patient's situation (National Cancer Institute, 2025b).

In addition to assessing for the items listed above, the mental health professional can consider that PTSD symptoms usually occur within 3 months after the traumatic event. However, they may appear anywhere from 4 months to years. Furthermore, early symptoms can predict a later diagnosis of PTSD, which should also be considered (National Cancer Institute, 2025b).

Diagnostic Criteria

In the DSM-5, PTSD is grouped within trauma and stressor-related disorders. In order to be diagnosed with PTSD, a person must have:

- Criterion A (1 required)

    - Exposure to a traumatic event, either by directly experiencing it, witnessing it, learning it happened to a family member or friend, or through repeated exposure at work
    - The traumatic event can be death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence.
- Criterion B (1 required)
    - Intrusion symptoms
        - Intrusive thoughts and distressing memories
        - Nightmares
        - Flashbacks, which are related to past trauma, occur when a person feels as though they are reliving prior events. Flashbacks can include sights, sounds, and smells.
        - Psychological distress and physiological reactions occur when exposed to internal or external cues associated with the trauma.
- Criterion C (1 required)
    - Avoidance symptoms
        - Avoiding internal aspects of the trauma, including thoughts, feelings, or memories.
        - Avoiding external things that could trigger past trauma, like the anniversary date, situations, social events, activities, places, and people.
- Criterion D (2 required)

    - Negative changes in thoughts and mood
        - Inability to remember important aspects of the trauma
        - Exaggerated, negative beliefs about oneself, others, or the world
        - Self-blame or blaming others based on distorted thoughts about the trauma
        - Ongoing negative emotional state (guilt, shame, despair, anger, fear)
        - Lack of interest and participation in activities
        - Distance in relationships and difficulty trusting other people
        - Ongoing inability to experience positive emotions or numbness
- Criterion E (2 required)
    - Negative changes in arousal and reactivity
        - Acting aggressively, violently, and/or having a short fuse. Outbursts happen with little or no prompting and are expressed verbally or physically.
        - Reckless or self-destructive behavior
        - Hypervigilance and operating on high alert
        - Feeling on edge, tense, anxious, or startling easily
        - Difficulty concentrating
        - Sleep disturbances

Symptoms from the four categories that persist for more than one month. These symptoms impact how a person thinks, feels, or reacts to a traumatic event. They must cause significant problems in daily life, including at work, in school, and in relationships. They must not be due to the physiological effects of a substance, medication, or another medical condition (Cleveland Clinic, 2026).

Notably, a cancer diagnosis itself, the side effects from treatment, distress, worries, and negative thoughts do not automatically qualify as trauma. In order for the cancer experience to meet criterion A, “it must entail acute and extreme adverse events in the content of cancer and/or cancer treatments” (National Cancer Institute, 2025b, para. 33). Cancer patients can also only be diagnosed with PTSD if they have specific trauma-related symptoms which are related to re-experiencing symptoms and intrusive memories (National Cancer Institute, 2025b).

Treatment

CBT with a trauma-focused approach can be used to treat PTSD. This treatment helps a person understand their symptoms and become aware of unhelpful thoughts that are linked to the trauma experience and replace them with helpful ones instead (also called cognitive restructuring). Coping and stress management skills are also taught through CBT. Medications can help manage symptoms of PTSD as well (Cleveland Clinic, 2026; National Cancer Institute, 2025b).

Section 2 Reflection Questions

What mental health conditions do you commonly experience in your practice?

What is your comfort level with diagnosing mental health conditions? If your comfort level is less than you would like it to be, what additional training or support do you need?

Section 3: Cognitive Behavioral Therapy

References: 3, 33, 39

As stated by Gillihan (2018),

> *"Cognitive behavioral therapy (CBT) is a solution-focused form of psychotherapy, designed to reduce symptoms and boost well-being as quickly as possible. As the name suggests, CBT includes both a cognitive component, which focuses on changing problematic patterns of thinking, and a behavioral component, which helps develop actions that serve us well" (p. 2).*

To provide some history on CBT, Dr. Sigmund Freud founded psychoanalysis, one of the earliest and most common forms of talk therapy. While it had many benefits, it often required several years of regular psychotherapy. As time passed and the mental health field progressed, human behaviorists became interested in looking for ways to provide relief from psychological conditions in less time. Psychiatrist Dr. Joseph Wolpe and psychologist Dr. Arnold Lazarus found that behavior therapy, or making straightforward changes to one's behavior, could provide this relief more quickly than psychoanalysis. Not long after this finding, psychiatrist Dr. Aaron Beck and psychologist Dr. Albert Ellis proposed that thoughts have a powerful impact on feelings and behaviors. They, along with other mental health professionals and researchers, developed cognitive therapy, which focuses on the idea that treatment for psychological conditions first requires identifying negative thought patterns and replacing them, a practice that helps them develop new ways of thinking and, in turn, promotes positive feelings and behaviors.

While mental health professionals and researchers developed behavioral and cognitive therapies somewhat independently, they later integrated them into a single therapy known today as CBT. Combining these therapies can help a person

see how their thoughts, feelings, and behaviors fit together and interact. Once the connection is understood, it can be easier to find ways to relieve psychological conditions. More recently, mindfulness has been integrated into some CBT programs, which have been shown to have benefits in terms of treating depression and anxiety among other conditions (Gillihan, 2018).

The goal of CBT is to:

> *"Equip clients with the skills necessary to become proficient in the management of their own psychological well-being. To assist clients in comprehending the ways in which their negative thought patterns influence their emotions and actions, therapists aim to provide them with guidance. During sessions, therapists guide conversations with their clients with an emphasis on how the clients' ideas, opinions, and thoughts influence their emotional states and actions. The goal of therapeutic interventions is to provide clients with the skills necessary to transform maladaptive thought patterns, such as cognitive distortions, and ineffective behaviors. Thus, therapists assist clients by teaching them practical skills to apply during day-to-day living" (Kaidbay, 2025, para. 1).*

The effectiveness of CBT and its advancements have been established through research and clinical practice. CBT is based on the following ideas:

- Psychological problems are partly based on faulty or unhelpful ways of thinking, and on learned patterns of unhelpful behaviors.
- People dealing with psychological problems can learn better ways to cope with them, which ultimately relieves their symptoms and supports them in becoming more effective in living their lives (American Psychological Association, 2017, para. 3).

CBT is effective in treating a range of mental health conditions in people of all ages. It is particularly effective for people who have cognitive distortions and avoidance behaviors. It is also more likely to be effective when a person is highly self-aware and can express their thoughts and emotions without becoming discouraged or ashamed. When a patient or client is cooperative and collaborative with the mental health professional and motivated to set goals and achieve them, they are more likely to succeed with CBT (Kaidbay, 2025).

CBT is considered effective because it can help a person understand what they do and how they do it. Another reason it is considered effective is that it provides structured training that helps a person know what they need to do to relieve issues troubling them. CBT can also break a larger challenge into smaller, manageable pieces and match specific techniques to each piece, making dealing with the problem feel more attainable. Additionally, with repeated practice of these techniques, automatic responses to difficult situations are reprogrammed and become more helpful to a person over time (Gillihan, 2018).

Some limitations of CBT include that it overemphasizes logic and limits a person's ability to experience their emotions, and instead emphasizes controlling them. Additionally, while it is effective for many people, not everyone will experience the same benefits, and further research is needed to determine the best way to apply and implement it across a range of clinical situations (Kaidbay, 2025).

Section 3 Reflection Question

What is your current experience with using CBT in clinical practice?

Section 4: Fundamentals of Cognitive Behavioral Therapy

References: 3, 15, 39, 50, 55

Several core principles underpin cognitive-behavioral therapy (CBT). First, a person is encouraged to actively participate in and collaborate with a mental health professional in the therapeutic process, including goal setting and determining how they will be achieved. Second, CBT is noted to be time-limited, problem-focused, and goal-oriented, which can make managing a problem feel more manageable and attainable. CBT is also structured, providing predictability and efficiency. Next, CBT is more focused on the present moment compared to some other therapies. It homes in on how a person's current thoughts and actions are part of their ongoing struggles and how to change negative patterns, especially those that are automatic, which is empowering because it helps them realize what can be controlled versus what cannot. Additionally, CBT involves a variety of therapeutic techniques, making the therapy unique and adaptable to each person (Gillihan, 2018).

Furthermore, mental health professionals should hold the belief that patients have the capacity to grow and change, with acceptance being a prerequisite. Empathic understanding, non-judgmental positive regard, authenticity, efforts to understand the patient's reality, and the belief that they are doing their best are essential skills for a mental health professional administering CBT (Carlson, 2017).

CBT typically has six phases:

- **Assessment** - gathering information about the degree of functional impairment and setting a person up for treatment
- **Reconceptualization** - challenging negative thought patterns

- **Skills acquisition** - teaching skills to address daily challenges
- **Skills consolidation** - using homework to apply skills in daily life
- **Generalization and maintenance** - using skills outside of therapeutic sessions
- **Post-treatment assessment and follow-up** - monitoring skill application (Carlson, 2017)

In addition to core principles and essential skills for mental health professionals, there are fundamental CBT methods and strategies that are vital to the therapeutic process. CBT treatment typically involves changing thinking and behavioral patterns.

Cognitive strategies include:

- Identifying and addressing negative thought patterns, including cognitive distortions that are creating problems, and reevaluating them through the lens of reality
- Identifying and changing core beliefs
- Practicing mindfulness

Behavioral strategies include:

- Goal setting
- Behavior activation
- Engaging in self-care (Gillihan, 2018)

Cognitive Strategies

Identifying and Addressing Negative Thought Patterns

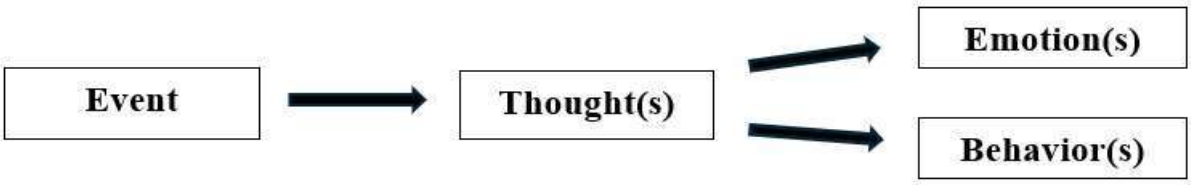
Thoughts can significantly affect a person's mood and behavior. Distressing thoughts are referred to as negative automatic thoughts in CBT because they do not require any effort when they are triggered. CBT can help a person become aware of their thoughts, take ownership of them, and change them to be more favorable.

There are certain strategies that a person can use to become aware of negative or problematic thoughts.

- Noticing when there is a shift in one's mood towards something negative, such as significant anxiety. Tuning into one's thoughts at this time can provide insight into what is driving the shift.
- Paying attention to when a negative emotional state is difficult to get out of. There are likely certain thought patterns that keep a person in that state.
- If there is difficulty achieving goals, explore what may be causing it.

A person can also ask themselves about what they are thinking. Sometimes this comes easily, while at other times, more processing may be required. First, they can think about their thoughts in terms of whether they are from the past, present, or future. Next, they can understand that thoughts are not always words; they can also be images. Then, they can give themselves the space they need to identify what is happening in their mind by finding a quiet place to think and reflect, visualizing what happened, and breathing through it. Lastly, they can record their thoughts and their effects. This strategy is helpful because it provides opportunities to record events, their interpretations (or thoughts), and the emotions or behaviors that result from those interpretations.

The following is one framework for recording thoughts:



Using this framework over time can help a person recognize their negative thoughts and the patterns that lead to certain emotions and behaviors (Gillihan, 2018). Then, once they have a handle on recognizing these thoughts, they can take a closer look at them, but should first assess their openness to doing so. In therapy, the mental health professional can lead this assessment by checking in with the patient and providing education about this part of the CBT process or about how the mind works (Temple, 2017). Once the process takes place, it includes identifying facts that support and do not support thoughts, and identifying errors in thinking, called cognitive distortions.

Cognitive Distortions

Psychiatrists, including Dr. Aaron Beck, have identified many different types of thinking errors, or cognitive distortions (Gillihan, 2018). These distortions are “false or harmful patterns of thinking that can cause suffering, " and are something that cognitive behavioral therapy assists clients in recognizing and challenging. Cognitive distortions involving irrational ideas or biases may result in distress, anxiety, or depression” (Kaidbay, 2025, para. 3). Some cognitive distortions include:

- **Catastrophizing** - Making a situation seem much worse than it actually is
- **Overgeneralization** - Applying one instance to every situation

- **Black-and-white thinking** - Thinking of a situation from one extreme viewpoint or another
- **Personalization** - Thinking each situation is about oneself when it has nothing to do with a person
- **Emotional reasoning** - Giving more credit to feelings or assuming they provide accurate, useful information about a situation
- **Outsourcing happiness** - Giving up control of happiness to outside factors instead of taking ownership
- **Discounting the positive** - Minimizing the factors that contradict negative automatic thoughts
- **Entitlement** - Expecting a certain outcome because of one's actions or position
- **False sense of responsibility or helplessness** - Believing that oneself has more power or less power than what exists in reality

Next Steps for Addressing Negative Thought Patterns

After a person has examined the evidence for or against their thoughts and identified cognitive distortions, they can look for a more helpful way to see the situation, then pay attention to the effects the new thoughts have on their feelings and behaviors. This process is also called cognitive restructuring (Gillihan, 2018). When cognitive distortions are replaced with more adaptive, realistic thinking, mood and functioning can improve (Kaidbay, 2025).

Some suggested questions to address negative thought patterns include:

- What evidence is causing you to think this thought is true? Is there any evidence that it is not true?

- Could there be an alternative explanation? If so, what is it?
- What is the worst-case scenario? If that happens, how will you cope?
- What is the best thing that can happen?
- What is the most realistic outcome?
- What effect are you experiencing when you believe the automatic thought? If you change your thinking, what could the effect be?
- What would you tell someone you love if they were in the same situation? (Roberts, 2018).

Identifying and Changing Core Beliefs

Core beliefs drive their automatic negative thought patterns. These beliefs encompass the internal models through which a person sees the world and performs certain tasks automatically without conscious thought. They also encompass how people deal with emotional situations. Core beliefs are shaped by many things, including what a person observes as they grow up, significant events, how others treated them, and dynamics in their relationships. CBT strategies can change core beliefs through identification, understanding, and practice.

The first step to identifying a core belief is to consider the automatic thoughts that arise in various situations and notice whether any recurrent messages or themes emerge. Next, the belief can be examined through the lens of whether a cognitive distortion is present. Then, the person can reflect on their history and the facts that support or contradict the belief, and determine whether the belief is accurate. Lastly, they can consider an alternative belief, practice it, and take time to reflect and/or write about the changes that result from repeating a more positive and helpful belief.

Practicing Mindfulness

More recently, mindfulness has been incorporated into CBT. It is the practice of focusing on what is happening in the present moment, or connecting to it, without judgment, but instead with acceptance, or being open to the experience as it unfolds. Mindfulness promotes greater awareness of thoughts and emotions, leading to a deeper understanding of the self, less value placed on all of our thoughts as providing useful information, and more control over emotions and space to consider reactions to situations. Mindfulness practices include meditation, breathing exercises, body scanning, yoga, and focusing on everyday activities when they are being done.

Other Strategies

Other cognitive strategies include understanding others' behaviors and motivations, developing and using problem-solving skills to cope with challenging situations, and building confidence in personal abilities (American Psychological Association, 2017).

Behavior Strategies

Goal Setting

One of the first steps in therapy is identifying what a person would like to change about themself or their situation. Discovering and accepting individual strengths and limitations is part of this process, providing a foundation for setting goals. Goals provide clarity on what a person would like to work on or where they hope therapy will take them in their life, while also helping them stay on track when they hit challenges or need to evaluate how treatment is progressing. Goals support a person’s success when they are specific, moderately challenging,

require effort, and are based on something a person is invested in. It may be helpful for a person to focus their goals within six important life domains:

- Relationships
- Faith/Meaning
- Education and Work
- Physical Health
- Roles and Responsibilities
- Recreation and Leisure

Behavior Activation

After goals have been identified, behavior activation involves a plan to achieve them. Behavior activation is especially important for people living with depression who may be avoiding certain people or situations, isolating themselves, and struggling with motivation. There are six steps in behavior activation:

- **Step 1** - Determine what is important in each life domain in which a person has set a goal. Thinking about what or who is valued in each particular area provides clarity.
- **Step 2** - Identify life-giving activities for each value. These activities should bring enjoyment and a sense of accomplishment.
- **Step 3** - Rate the difficulty of each life-giving activity. Using a 1 to 3 rating scale is straightforward: 1 is easy, 2 is moderate, and 3 is hard.
- **Step 4** - Order the activities in the way that they will be completed.
- **Step 5** - Schedule activities to help with following through.

- **Step 6** - Complete the activities, and set an intention before doing them.

When engaging in behavior activation to achieve a goal, it can be helpful to have a clear plan, work progressively through activities (from easiest to hardest), and think holistically about how the different life domains interact. It can also be helpful to track activities using a log that includes time intervals and space to write about each activity, while also rating the level of enjoyment and importance.

It is common to encounter challenges when moving through the behavior activation steps. Some tips to move through challenges include:

- Ensuring activities are rewarding, enjoyable, and meaningful to each individual.
- Planning activities at specific times and holding oneself accountable to follow through.
- Completing one activity at a time, and if it feels too overwhelming, it can help to break it down into smaller tasks.

Addressing limiting or problematic thoughts is another way to deal with challenges that arise during behavior activation.

Engaging in Self-Care

Engaging in self-care can help a person move towards their goals and practice the strategies provided by CBT. Acts such as getting enough sleep, proper nourishment, and exercise, managing stress, being social, spending time outside, practicing gratitude, and helping others are all effective ways to take care of oneself (Gillihan, 2018).

Other Strategies

Other behavioral strategies include facing fears rather than avoiding them, role-playing problematic situations to prepare for them, and learning strategies to calm the mind and relax the body (American Psychological Association, 2017).

Resource

The Beck Institute for Cognitive Behavioral Therapy provides resources for individuals, including a worksheet packet for mental health professionals to use when administering CBT to their clients.

Section 4 Reflection Questions

Is there a fundamental method of CBT that you find to be more interesting than others?

Does one method seem more challenging to implement? If so, which one and why?

Section 5: Cognitive Behavioral Therapy and Cancer

References: 1, 2, 4, 6, 11, 12, 14, 15, 37, 48, 51, 55

Cognitive behavioral therapy (CBT) is the "most widely developed and tested theory for cancer patients" (Nicholas, 2016, p. 47). CBT interventions are "based on the view that an individual's beliefs, evaluation, and interpretation, in addition to their pain, disability, and coping abilities, will impact the degree of both physical and emotional disability of the disease condition" (Gatchel et al., 2007, as cited in Carlson, 2017, p. 13). The interventions that have been used with people living with cancer include the following therapeutic approaches:

- Problem-solving therapy
- Cognitive-behavioral stress management and coping skills training
- Cognitive therapy
- Folkman's cognitive model of stress
- Behavioral marital therapy

CBT-based strategies that are outlined in the literature include distraction, motivational self-talk, biofeedback, goal setting, developing coping strategies, and changing maladaptive beliefs about illness and pain. Specific CBT intervention techniques used in psycho-oncology include relaxation exercises and guided imagery (Nicholas, 2016).

According to the American Society of Clinical Oncology (2024), "the goal of CBT is to target automatic thoughts or core beliefs that may be harmful to mental health" (para. 5). Automatic thoughts are those that come naturally in response to something. They are often first, immediate, and fast. Core beliefs are those people hold about themselves, others, and the world that shape their perspective and how they interpret experiences (Safion, n.d.). When a cancer diagnosis happens, it can challenge core beliefs and assumptions while a person grapples with the idea that the way they lived life before will never be the same (Temple, 2017).

When a person's thoughts and beliefs are negative, overwhelming, and/or problematic, it can eventually lead to mental health issues, such as depression or anxiety. CBT can help patients focus on the unwanted mental health symptoms they are experiencing in conditions like depression and anxiety by:

- Identifying their automatic thoughts, which typically result from a person's cognitive appraisal of a life event or situation.

- Explore the connections between automatic or problematic thoughts, feelings, and maladaptive coping behaviors.
- Develop interventions that address both thoughts and behaviors, so that an individual can manage any mental health symptoms and cope more effectively with their illness (Association for Behavioral and Cognitive Therapies, n.d; Caba et al., 2024; Nicholas, 2016).

CBT can be used for patients with early- and advanced-stage cancers, but it is particularly effective in early-stage cancers. It has been shown to improve the "emotional, psychological, and social well-being of cancer patients because of its well-established effectiveness in the treatment of depression, anxiety disorders, and PTSD" (Horne & Watson, 2011, p. 35). CBT can also be effective in treating patients with chronic psychological symptoms and problems that have been very difficult for them to change. Cognitive techniques seem to be most effective with patients who are analytic thinkers, comfortable with self-reflection, and tend to be introspective, who can examine their thinking and step back from a problem to consider why it affects them. Behavioral techniques seem applicable across a variety of patients because they are straightforward and easier to implement than some cognitive techniques.

Major Depressive Disorder (Clinical Depression)

As noted above, CBT is an effective treatment for patients living with cancer and depression. In cases of severe depression, it may be important to assess a patient's appropriateness for CBT and consider an antidepressant before starting it. Then, after a period of time, the mental health professional can reassess the patient to determine if they are having any benefits from their antidepressant therapy and if they are ready to start CBT. However, some patients may be hesitant to take an antidepressant for various reasons, including concern that it

may interact with their cancer treatment and/or other medications, or they may want to limit the number of medications they are taking. In these instances, the mental health professional can consider starting CBT, and an antidepressant can be considered a second-line treatment option. It is not always necessary for a patient to be on an antidepressant or to have a benefit from it, though, especially if they are motivated to work on the problems themselves (Horne & Watson, 2011).

When using CBT to treat depression in cancer patients, there are three components:

- Behavior activation
- Correcting negative, automatic thoughts
- Identifying and changing core beliefs

Some studies have shown that all three components must be present in the therapeutic process, while others have shown that behavior activation alone is sufficient.

Depressed patients with cancer may view their situation as overwhelming and filled with challenges, which in turn may make them feel helpless or hopeless (Andersen et al., 2021). Therefore, CBT interventions for depression are focused on addressing these feelings, changing coping strategies to improve overall adjustment to the diagnosis, and understanding and changing specific thoughts and their relationship to emotions and behaviors (National Cancer Institute, 2024). Additionally, the distress that accompanies a cancer diagnosis may trigger core beliefs about the self, which CBT interventions can identify and challenge (Andersen et al., 2021).

Case Example

A patient has recurrent thoughts that they are a burden to their loved ones. One event that causes these thoughts to occur is when they are not feeling well after their chemotherapy treatment and need additional support managing side effects and with daily activities. Another event is when they need transportation and someone to accompany them to their medical appointments. Over time, they have developed a self-schema of being worthless. In turn, they have been experiencing symptoms of depression for about a month, including feeling very sad, helpless, sleeping too much, feeling worthless and guilty, and moving more slowly than normal. They have been withdrawing from others, sleeping more, and, when awake, pushing themselves to do more than they physically can.

In this instance, a cognitive-behavioral intervention would focus on their recurrent, intrusive thoughts about being a burden, examine if any cognitive distortions are present, and then challenge the accuracy of the thoughts and self-schema. The patient can also develop coping strategies that change their behaviors. For example, they can focus on what they can do, anticipate fluctuations in how they feel, engage in behavior activation, and learn to pace themselves.

Anxiety

When using CBT to treat anxiety in cancer patients, there are several essential components:

- Attending to the cues that trigger worry
- Learning and practicing progressive muscle relaxation for symptom reduction

- Developing cognitive coping strategies, including correcting negative, automatic thoughts and perceptions of future threats
- Practicing skills in-session using imagery and completing out-of-session homework

Some studies have shown that all components must be present in the therapeutic process. In contrast, more recent studies have shown that cognitive therapy, applied relaxation with desensitization, and their combination are similarly effective.

Anxious patients with cancer may have significant worries and overestimate negative events or engage in catastrophizing. Therefore, CBT strategies can help them identify their worries, and even if they are realistic, shift their focus from constant worrying to regular daily events that bring happiness or satisfaction to their lives. Additionally, the relaxation components help cope with anxiety symptoms (Andersen et al., 2021).

Case Example

A patient in survivorship has overwhelming thoughts that their cancer is recurring despite not having any symptoms, and her most recent CT scan does not show any evidence of disease. These thoughts are triggered throughout the day whenever she thinks about her diagnosis and encounters the ways her life has changed as a result. Daily, she is having constant worry about her health, trouble turning off her thoughts and concentrating, difficulty sleeping, and feelings of restlessness. She is also having difficulty developing and maintaining coping mechanisms.

In this instance, a cognitive-behavioral intervention would focus on her health anxiety and persistent thoughts about the cancer recurring. The intervention would also examine if any cognitive distortions are present and then challenge the accuracy of her thoughts. She can also develop cognitive and behavioral coping

strategies, such as relaxation and/or mindfulness, that change her reactions, which ultimately would decrease her anxiety symptoms.

Procedural and Treatment Related Anxiety

For patients with anxiety related to having procedures (ex. surgery) and other cancer treatments (ex. chemotherapy or radiation), early intervention using some form of CBT can reduce anticipatory anxiety and post-treatment distress, including pain. Some forms of CBT that have been effective include systematic desensitization, modeling, and cognitive restructuring (Horne & Watson, 2011).

- The goal of systematic desensitization therapy is to change an individual's response to situations that trigger fear and anxiety. It is recommended that a mental health professional have specific training in this therapy before using it in practice. There are three main steps to systematic desensitization:
    - Deep muscle relaxation: an individual learns muscle-relaxation techniques and breathing exercises, such as progressive muscle relaxation and visualization. Learning relaxation is important because an individual cannot be relaxed and fearful at the same time (also called reciprocal inhibition). It is more difficult to feel tense while relaxed. Since tension often comes with fear and anxiety, learning relaxation also provides an opportunity to learn a different response to these emotions.
    - Creating a fear hierarchy: an individual creates a list of all their fears and ranks them on a scale of 1 to 10, from the fear that causes the most anxiety (10) to the one that causes the least (1). After the events associated with the highest and lowest amounts of anxiety, an individual thinks about their other fears and lists them in order from

2 to 9. Once the list is created, the patient and mental health professional discuss it and work on an exposure plan starting with the least anxiety-provoking fear and working up to the highest anxiety-provoking fear.

    - Working through the fear scale through exposure: two processes for exposure exist:
        - In vitro: the patient imagines being exposed to the fear.
        - In vivo: the patient is exposed to the fear (Bhandari, 2023).

- The goal of modeling is to help an individual learn new behaviors and emotional responses through observation. When an individual observes another person's behavior, they learn its consequences and decide whether to adopt it in their own life. They also learn how another person's behavior cues them to engage in a specific behavior (Alden, 2005).
- The goal of cognitive restructuring is to help an individual identify, challenge, and modify their irrational or negative thoughts, which are also called cognitive distortions (Ackerman, 2025).

Post-Traumatic Stress Disorder (PTSD)

For patients with PTSD, the high levels of anxiety associated with the disorder can negatively impact their ability to cope with cancer treatment. CBT is an effective therapy for PTSD, so it is important to detect when it is present in cancer patients (Horne & Watson, 2011). Components of CBT that have been used in the literature to treat PTSD include psychoeducation about distress and PTSD after a diagnosis, relaxation training, imaginal and in vivo exposure, cognitive restructuring, activity scheduling, enhancing social support, and generalizing skills.

Other Cancer-Related Issues

Fatigue

CBT can help patients think less catastrophically about their fatigue and encourage them to change behaviors that contribute to it. They may receive education about fatigue and be encouraged to use behaviors that help manage it, including pacing themselves, using rest techniques, and incorporating exercise into their routine.

Pain Management

CBT is effective in managing pain that is both acute (ex. surgery-related pain) and chronic.

Sexuality and Intimacy

CBT can treat sexual dysfunction in patients with cancer by helping them identify their anxiety related to intimacy and reducing it while also helping them change any unhelpful assumptions about sex and communication in relationships.

Survivorship

In survivorship, patients often experience readjustment and transition concerns after experiencing the emotional trauma of a cancer diagnosis (Horne & Watson, 2011).

Section 6: Summary

Cognitive behavioral therapy (CBT) has been well studied in patients with cancer. It is an effective treatment for mental health conditions, including adjustment disorder, anxiety disorders, depressive disorders, and PTSD. It is important to understand how to assess and diagnose these conditions as they are common

among people living with cancer. It is also important to receive appropriate CBT training, as many cognitive and behavioral strategies can be used when working with patients with these conditions and other cancer-related issues.

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