the psycho-social condition
of cancer patients

PsychoOncological Basicdocumentation

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PO-Bado Manual

(2nd Revised version)

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March 2004

Table of Contents:

1. Development of the PO-Bado

Over the past few decades it has become increasingly accepted that the treatment of cancer should not only take into account the “objective” somatic-medical diagnostics, but also a tumour patients’ subjective physical state as well as any relevant emotional and social stressors and concerns. As, generally, a lot of different people from diverse professional backgrounds are involved in the treatment and care of each patient, it is very important that these people “speak a common language” when describing their patients’ psychological condition.

In a qualitative and quantitative development process, **standardized concepts and rating criteria** were set out in the PO-Bado for accurately describing and classifying the psychological condition of tumour patients. The instrument involves an observer rating, and its central evaluation criterion is the patient’s **subjective condition**, i.e. it concerns how strongly the patient suffers from various aspects or consequences of the illness.

The initially very extensive version was progressively structured and reduced down to a set of variables, reflecting only the most important psychosocial factors. The main criteria for determining the set of variables were **validity and reliability**. The validity was established using correlation analyses involving psychometrically tested self-rating instruments in a sample of 500 tumour patients: the Hospital Anxiety and Depression Scale (HADS-D) (1) and the Questionnaire on Stress in Cancer Patients (“Fragebogen zur Belastung von Krebspatienten”,FBK-R23) (2). The reliability was determined by comparison of different observer-ratings of the same patient.

As an instrument to be used across various clinical settings and professions, the PO-Bado was tested during its development phase in over 70 institutions (clinics for acute health care, counselling services, practices, rehabilitation clinics) by more than 100 examiners (incl. psychologists, physicians, and social workers) on nearly 2000 patients. This demonstrated that the instrument was suited to acute health care and rehabilitation settings as well as to in-patient and out-patient treatment.

The PO-Bado enables patient assessment to extend beyond somatic-medical diagnostics and incorporate the psychological aspects of a cancer patient’s condition, using a standardized high quality instrument. Furthermore, it contributes to the **quality assurance** of psychological diagnostics and care.

The project is being carried out in close collaboration with the German Work Group for Psychosocial Oncology (“Deutschen Arbeitsgemeinschaft für Psychosoziale Onkologie”, dapo e.V.) and the Work Group for Psychooncology („Arbeitsgemeinschaft für Psychoonkologie“, PSO) of the German Cancer Association (‘Deutsche Krebsgesellschaft“). It is sponsored by

German Cancer Aid (“Deutsche Krebshilfe”).

Extensive information is available on the website www.po-bado.med.tum.de.

2. How to use the PO-Bado

The PO-Bado is an expert-rating instrument, so the psychosocial condition of the patient is not evaluated by the patient him-/herself but by the healthcare worker (physician, nursing staff, psychosocial worker etc.).

The documentation form is normally filled out after the first interview with the patient and records the patient’s condition over the last three days (in exceptional cases, for example if the patient only heard about the diagnosis two days earlier and the preceding time is of little relevance to the patient’s current condition, the current condition may be recorded). If the patient’s subjective condition varied during this period, the highest level of stress over these last three days is to be recorded. For example, if a patient reports having felt relatively well today but suffered from anxiety two days ago, the anxiety is to be recorded.

The PO-Bado can also be used several times during the course of treatment.

A requirement for the use of the PO-Bado form is a personal interview with the patient. Telephone interviews cannot be adequately recorded as the instrument also takes nonverbal signals into account, which are difficult to evaluate from a telephone conversation. It is an additional requirement that the patient’s condition allows sufficient verbal communication. Patients suffering from strong pain who are only marginally fit for conversation are to be interviewed when a thorough first interview is possible.

The PO-Bado interview guidelines serve to structure the interview and give recommendations on communicative and diagnostic aspects of the interview. Orientation questions, which introduce a set of topics are differentiated from specific questions, which concern individual symptoms or stressors. To achieve a reliable assessment, it is necessary that all sections of the PO-Bado are discussed with the patient:

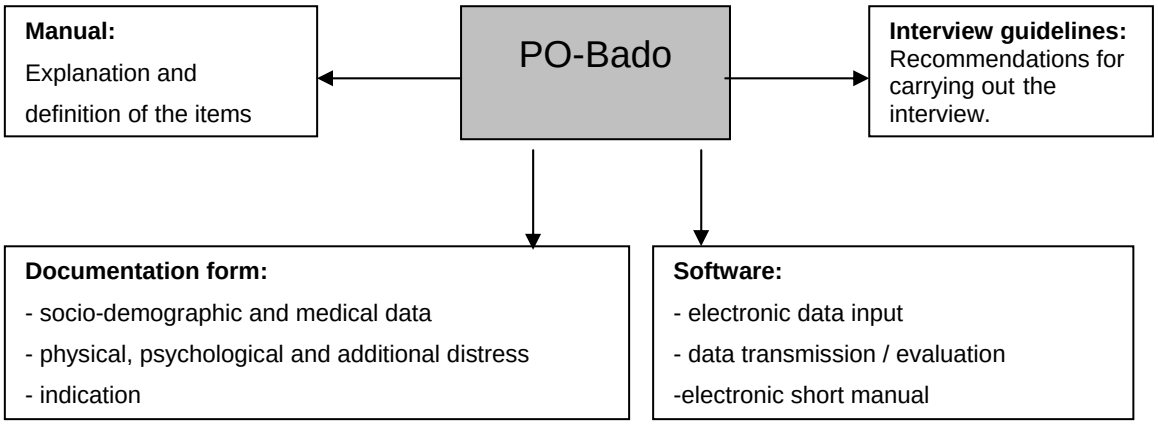
- physical distress
- psychological distress
- additional distress (familial, economic, professional and other illness-related or illness-unrelated problems).

While filling out the form, please pay special attention to the following points:

1. Please answer **every item**.
2. When rating each item, consider **the patient's concrete statements**.
3. The rating should record the patient's **subjective level of disturbance** from the symptom, i.e. how much the patient is suffering from a particular aspect. This does not involve a description of symptoms.
4. Each section contains an open item (other somatic, psychological and additional stressors). This is for complementary information about aspects that are not mentioned in the documentation form but which the rater considers important for recording the patient's condition. These factors are rated in the same way as the other items.
5. Your rating should always refer to the last **three days.**

Knowledge of the manual and interview guidelines is a prerequisite for using of the PO-Bado.

Parts of the PO-Bado:



3. Instructions for the rating of each item

3.1 Sociodemographic und medical data

This section contains:

- central socio-demographic data (age, sex, occupational situation etc.),
- data on the cancer and treatment,
- other clinical details
- contact initiative / way of admission.

Steady relationship refers to spouses or other long-term partners. Whether it is a hetero-sexual or homosexual relationship is not relevant, nor is whether the partners cohabitate. The decisive point is whether the relationship involves commitment and is stable. If, for example, a man lives separated from his wife and has no other relationship it would not be considered a steady relationship.

In the line **work situation,** only one answer possibility should be marked. *Employed* includes full-time and part-time work as well as self-employment, but does not include minor or casual jobs. *Home duties* refers to patients without gainful employment, e.g. housewives or people who are otherwise not gainfully employed (but not to retired or unemployed people). *Sick leave* refers to people with an incapacity to work (or people with medically certified sick leave). *Unemployed* refers to patients receiving unemployment benefits or looking for work. *Retired* includes the age pension and disability pension. *Other* refers to situations not included in the presented options, e.g. study, apprenticeship.

For the current **tumour diagnosis,** one of the twelve response categories is to be marked. The detailed definitions of the diagnostic categories and the corresponding ICD-10 codes are presented in a summary table in the appendix.

In addition, it is recorded whether **metastases** were diagnosed.

Date of first diagnosis refers to the date at which the patient first received a diagnosis of cancer. In the case of several tumour illnesses, the date of the first illness is to be recorded, even if this does not concord with the answer given under *tumour diagnosis*.

Current illness status: *First illness* refers to patients for whom a cancer has been diagnosed for the first time. *Recurrence / Progression* refers to cases in which a cancer diagnosed and treated earlier returns as a local recurrence or as metastases. *Second tumour* means that a new tumour has been diagnosed which is independent of an earlier cancer. *Remission* is used in the case of successful cancer treatment and no current evidence of cancer (NED: no

evidence of disease).

In the rubric **treatments in the last two months,** multiple answers are possible, e.g. if following an operation, chemotherapy or radiotherapy was carried out in the last past month. The category *Other* comprises additional treatments such as multimodal procedures (radio-chemotherapy), bone marrow transplantation or stem cell transplantation, cytokines or other complementary treatments.

Other relevant physical diseases: If the patient has other diseases in addition to the cancer, this is to be recorded as accurately as possible with a clear diagnosis, e.g. hypertension, arthrosis (instead of using unclear descriptions such as circulatory problems, joint pain). Alternatively, the **ICD-10 diagnosis code** can be documented. Only diseases which need treatment and which the patient considers significant are relevant. For example, an asymptomatic diabetes mellitus not needing treatment and not experienced by the patient as bothersome does not need to de documented.

Psychoactive Medication / Opiates: All psychoactive medication currently being taken by the patient is to be documented here (e.g. antidepressants, anxiolytics, neuroleptics). This also includes drugs which could affect the patient's emotional and cognitive state, e.g. pain killers which affect the central nervous system (opiates) and cortisone preparations.

Previous psychological / psychiatric treatment refers to e.g. previous psychotherapies, treatments in psychiatric or psychosomatic clinics or treatments with psychoactive medication (e.g. antidepressants).

To assess the current level of functioning, the five-point ECOG-Scale (**E**astern **C**ooperative **O**ncology **G**roup performance scale) (3) was integrated into the PO-Bado booklet (for comparison the corresponding Karnofsky-Index is shown):

ECOG		Karnofsky
0	Normal activity	100 %
1	Symptoms, but nearly fully ambulatory.	85 %
2	Some bed time, but needs to be in bed less than 50% of the waking hours.	65 %
3	Needs to be in bed more than 50% of normal waking hours..	45 %
4	The patient is permanently confined to bed.	20 %

For **Contact Initiative / Way of Admission,** it can be documented whether the patient contacted the examiner on his/her own or whether the initiative came from other people (e.g.

physicians, nursing staff, family members). *Own initiative* would also encompass cases in which the patient asked the physician about a psychosocial professional on his/her own and was then referred by this physician to a counselling service. *Rater's Initiative* refers to cases in which the contact came from the examiner without previous identification of a psychosocial indication, e.g. in the case of a routine admission interview or an introductory meeting with a psychosocial service.

3.2 Physical, psychological and additional distress

The following three central dimensions of the PO-Bado deal with stressors which the patient may suffer from. Physical, psychological, and additional distress are differentiated. These factors were chosen on the grounds of clinical and psychometric quality criteria (including validity and reliability).

With these items the patient's subjective level of disturbance is rated. Hence they do not refer merely to a description of symptoms, but to the patient's personal experience.

> ⇨ The central evaluation criterion is: **How strongly does the patient suffer from each individual aspect or consequence of the illness?**

The following example illustrates this: A patient describing a strong loss of appetite but not suffering from it would be rated as not distressed by this particular aspect, as subjectively the patient does not subjectively suffer from the loss of appetite. On the other hand, a patient only slightly restricted in his ability to move but suffering considerably from it would be rated as distressed by this condition.

The assessment should only take into account the patient's **subjective condition in the last three days**. If a patient reports e.g. having been in pain one week ago but that the pain has been well treated in the meantime and does not disturb him/her any more, the rating 0 (not disturbed at all) would apply.

Each factor is to be rated according the following **general principle**:

0 not at all: There is no evidence that the patient suffers from this aspect or it does not apply to the patient. 0 should also be marked if no information is available.

1 a little: The patient suffers slightly from this aspect but not so strongly that the stressor constitutes a serious distress.

2 moderately: The patient feels strained and restricted by this aspect. There is a subjective suffering of medium intensity.

3 considerably: The patient suffers considerably from this aspect und describes a stressor which is quite strongly restricting.

4 very much: The patient is extremely distressed and suffers so strongly that the distress is hard to bear.

The intervals between each point of the scale are to considered **equal**.

Examples of possible ratings for the item „sleep disturbances“:

0 not at all: : The patient has clearly stated that he/she has no problems with sleep. *Or:* The topic sleep difficulties was not addressed and there is no evidence of problems in this area.

1 a little: The patient suffers occasionally from difficulties with falling asleep or staying asleep, lies awake for a while and ruminates, but sleeps well overall.

2 moderately: In the last three days, the patient has needed a long time to fall asleep, as worrying thoughts have kept him/her awake and caused restlessness.

3 considerably: Sleep difficulties are a central stressor for the patient. They are quite strongly restrictive.

4 very much: The patient suffers from sleep disturbances so strongly that it is only very rarely possible to stay asleep after falling asleep. This causes feelings of exhaustion and despondence during the day. In the interview, the patient mentions not being able to bear the thought of the coming nights and sees no way out the problem.

3.2.1 Somatic Distress:

The somatic stressors include **physical complaints** as well as **functional restrictions** which the patient suffers from.

- **Fatigue/Tiredness**

Does the patient suffer from a general impairment of physical vitality, lack of strength, weakness, exhaustion, and/or tiredness?

> *Example: A patient suffers considerably from the fact that he tires from the slightest exertion and needs to rest for a long time after a short walk to recover. (Rating 3)*

Example: A patient reports that she occasionally feels tired and needs to rest more than she normally does. It does not really matter to her because she is able to enjoy having a rest and consciously makes use of it. (Rating: 0)

- **Pain**

Does the patient suffer from physical pain? If so, how strongly does he/she feel distressed by the pain?

Example: A patient with bone metastases has strong back pain which increases markedly under exertion. She has medication but takes it only "in emergency" because she is afraid of side effects. However, the pain and the fear of worsening are then so strong that the medication has almost no effect. The patient says: "The pain dictates my life." (Rating: 4)

If a patient has no pain because the medication is well dosed (e.g. using a pain pump), "a little" should be marked.

Example: A patient with an advanced colon carcinoma reports a pressing pain in the abdomen area which can be well treated pharmaceutically, so that the patient is generally free of pain. (Rating: 1)

- **Restrictions in daily activities**

Does the patient suffer from no longer being able to carry out normal daily activities, e.g. household tasks, washing oneself, dressing, going to the toilet, eating? Is the patient able to move every limb or is he/she disturbed by impairments in walking, standing, sitting or carrying things?

Example: A patient with a mamma carcinoma suffers from a lymph oedema that restricts the load bearing capacity and the motility of her right arm considerably. She is therefore no longer able to carry out many household tasks on her own (cleaning, shopping etc.), which she finds very difficult, as she has always been very active. (Rating: 3)

Example: A fifty year-old patient with ovarian carcinoma is quite weakened after the fourth cycle of her chemotherapy. She has not been able to run her household alone for two days and has to rely on her mother's help provisionally, which she finds unpleasant. As she considers this to be a temporary situation, she feels only a little distressed by it. (Rating: 1)

Inpatients who have had an operation recently are of course subject to considerable restrictions in this area. However, when patients consider this to be a temporary situation and cope with it well, they are to be rated as only "a little" distressed.

Example: A patient operated on three days ago reports that, considering the circumstances, she feels quite good. She is even able to walk a few steps and expects to be released at the planned time. (Rating: 1)

Example: Despite good progress after the operation and a favourable prognosis, an inpatient is very worried by the restrictions in his activity. He worries about whether he will still be able to climb the steps to his apartment. (Rating: 3)

- **Other physical distress**

Here, findings are to be recorded which could not be included in the above categories, but constitute a physical or functional stressor for the patient, e.g. nausea, lack of appetite, fever, sexual function disorders, breathlessness, loss of parts of the body. This item too always has to be rated, even if there are no other physical distress (in that case with 0).

Example: A patient has erectile dysfunction after the treatment of his prostate cancer which makes him feel very ill at ease. He fears he may never again be able to have "normal" sexual intercourse, which he finds very distressing (sexual disorder, rating: 4).

- **Sum score**

The sum of the ratings (from 0 to 16) represents the overall level of distress due to physical factors.

3.2.2 Psychological distress:

The items in this part refer to *psychological distress*. These are mostly emotional reactions that the patient suffers from or is troubled by. As well as explicit statements by the patient, non-verbal expression (behaviour, posture, voice, facial expression and gesture) should be considered here.

- **Sleeping disturbance**

Does the patient suffer from difficulties falling asleep or staying asleep or from early awakening or other sleep-related problems (e.g. nightmares)?

An inpatient setting can sometimes induce sleep disturbance due to the unfamiliar environment or nightly disturbances such as noise made by nursing staff or other patients. The decisive rating criterion is how strongly the patient feels troubled by the sleeping disorder.

Examples: (see page 9)

- **Mood swings**

Is the patient's mood relatively constant or does he/she report mood swings? Does the patient's mood suddenly change from depressed mood to optimism and euphoria?

Example: Earlier moral concepts and certitudes are being questioned. The patient has had "the rug pulled out from under his/her feet". (Rating: 3)

Example: A patient feels hopeful at times and has confidence in the treatment. But these periods alternate nearly every day with phases of fear and resignation. He feels uneasy because he does not recognize himself in this predicament. (Rating: 2)

Strong feelings of insecurity can indicate a shock reaction, which cause the patient to feel confused, paralyzed, overwhelmed, frozen or unable to act. Affective blockades (emotional laming, withdrawal) or affective overload are possible outcomes. If the shock reaction induces an affective blockade, the patient seems quiet and composed and perceives the environment as rather unreal. Often information does not get through to the patient.

- **Cognitive impairments** (e.g. problems with concentration and memory)

Are cognitive abilities like concentration, memory, spatial or temporal orientation affected? Does the patient suffer from e.g. not being able to remember things?

Example: A patient describes no longer being able to concentrate. He finds it difficult to read the newspaper, which he usually likes to do. He is not able to grasp the sentences he reads and can not remember what he has read. He expresses the fear of "going mad". (Rating 4)

Example: A patient misses two consecutive important doctor's appointments she had forgotten to note in her diary. She reports that "embarrassing" things like that have been happening more often lately and that her memory is "failing". (Rating 2)

- **Helplessness / vulnerability**

Does the patient suffer from feeling helpless or at the mercy of the illness and/or caregivers? Is the situation perceived as a loss of control? Does he/she express feelings of powerlessness or suffer from not being able to influence the situation? Is it a problem for the patient that he/she no longer has important things in check and has to be dependant on others? Helplessness can also be manifested in nonverbal behaviour, for example when patients seem disoriented, overtaxed or lost.

Example: A bedridden patient complains that she does not know where important things are because everyone who comes into her apartment (mobile nurses, daughter, aunt) cleans up and "rummages around" without asking for permission or informing her about it. (Rating: 2)

Example: A patient insists that he is well informed about his illness and the upcoming chemotherapy. He feels he has been consulted about important decisions in his therapy and has confidence in the physicians. (Rating: 0)

- **Anxiety/ Worry / Tension**

The term anxiety encompasses situational anxiety, i.e. of particular things or situations, as well as general anxiety. Anxiety can be accompanied by physiological reactions, e.g. tachycardia, sweating and/or breathlessness, which may be interpreted by the patient as symptoms of a physical illness, inducing more fear. Sudden paroxysmal panic attacks can also occur. Anxiety can also manifest itself nonverbally, e.g. in trembling, inaction or restlessness. A cancer diagnosis understandably produces anxiety and worry in most patients.

Does the patient suffer from general anxiety or is he/she afraid of certain treatment procedures, e.g. chemotherapy or operative procedures? Is the patient afraid of the further course of the illness or of death? Does he/she worry about the future?

> *Example: (situational anxiety): A relatively old patient with a sigma carcinoma is in hospital for the first time and is anxious about the upcoming operation. This manifests itself in trembling, restlessness and sweating. For organizational reasons, the operation is delayed for a few days, leading to a waiting period which the patients finds hard to bear. (Rating: 4)*
>
> *Example (progression-related anxiety): A patient with a lung carcinoma was successfully operated on but lives in constant fear of a relapse. The follow-up examinations are always very distressing to her. She monitors herself daily and often thinks she has relapse symptoms. (Rating: 3)*

Does the patient suffer from physical or emotional strain, tension or restlessness? Does he/she feel agitated, hasty, “highly strung”, impatient or tense in certain parts of the body?

> *Example: A patient describes feeling as if she were sitting on an ants nest since her cancer was diagnosed. She reports being in a state of turmoil, agitated, and is unable to relax. It is hard for her to sit still during the interview. (Rating: 4)*

- **Shame / Loss of self-esteem**

Does the patient suffer from shame-inducing aspects of the illness or treatment? Does he/she experience it as shameful to be sick, weak or disfigured? Is it embarrassing to be dependent on help? To what extent is the body-image and/or self-image affected by the illness?

> *Example: A patient with a malign testicular tumour no longer perceives himself as a “real man” since the diagnosis. Until now, he has avoided out of shame discussing with his physicians the possible effect his illness could have on his sexual life. He has not yet addressed this topic with his wife. (Rating: 3)*

Example: A patient with a stoma finds it in some respects difficult to accept changes to her body after a recent ostomy. She has nevertheless learnt to take care of her stoma herself and is not hesitant to speak about her feelings with her husband. (Rating: 1)

- **Depression / Grief**

Does the patient seem depressed and sad? Does he/she express feelings of emotional pain? Is he/she no longer able to take pleasure in previously enjoyable activities and suffers from this? Does the patient show resignation or does he/she see the current situation as hopeless? Does he/she experience an unfamiliar lack of drive? Is he/she withdrawn from others? The examiner should pay particular attention to non-verbal signs of depressiveness (facial expression, gesture, vitality, behaviour changes).

Grief / Sadness constitute a frequent response to the manifold cancer-related losses the patients have to deal with. This involves not only the loss of bodily integrity but also the loss of future perspectives and the upheaval of fundamental attitudes and values. Does the patient suffer from a grief reaction? Does he/she feel sad or pained in the face of a permanent loss? A grief reaction sometimes can only be distinguished from a depressive condition after considerable time. Painful and pronounced feelings of sadness often constitute evidence against the presence of depression, as in such cases there is an awareness of the loss.

Example: A patient reports with obvious pain that, after his lung operation, he can no longer realize many of the plans he had made for his retirement. (Rating: 3)

Signs of a depressive reaction are: loss of pleasure and interest in activities previously experienced as pleasant, depressive mood, feelings of worthlessness and hopelessness, experiencing life as pointless, incessant mulling over thoughts the patient does not manage to escape, feelings of guilt or believing oneself to be an encumbrance to others, the inability to make decisions, a diminished ability to think and concentrate, feeling overburdened (“I wont make it”), a lack or loss of drive, sleep disturbances, especially waking up in the early morning, psychomotor slowdown or inner restlessness, social withdrawal, and suicidal thoughts.

- *Example: A breast cancer patient feels worthless since the removal of her left breast und has subsequently restricted her social contacts, as she feels that others do not understand her. She sleeps in until very late in the morning and does not feel like doing things which she used to like. As she can not pursue her profession, she does not feel very hopeful about her prospects. She fears that she soon may become dependant on welfare and sees no way out. (Rating: 3)*

- **Other psychological problems**

This category is for other emotional distress which the patient suffers from which are not covered by the above categories, e.g. anger, annoyance, guilt. This item too should always be rated, even if no other emotional stressors are present (in that case with 0).

> *Example: A patient frequently complains to her nursing staff. She says the room is draughty and that when the meals arrive, they are mostly lukewarm. She is very angry at her general practitioner who she says did not diagnose her illness early enough. After all, she has always had preventive medical checkups. (Anger, annoyance, rating: 2)*
>
> *Example: A patient says: "I think the cancer is caused mainly by poor nutrition. I should have taken better care of myself. Now it's too late." (Guilt, rating 3)*

- **Sum score**

The sum of the ratings (a value between 0 and 32) represents the overall level of psychological distress.

3.2.3 Other distress

This section deals with distress related to the patient's social environment and additional problems. These problems could already have existed before the onset of the disease or have been triggered or worsened by the disease. The rating is dichotomous (yes – no), because it does not refer to a subjective state but to the existence (or absence) of concrete problems.

- **Problems in the family or with significant others**

This category deals with relationship problems aroused by the disease as well as problems unrelated to the disease. It encompasses not only tensions and conflicts but also stressors such as e.g. the illness or death of important others, worries about relatives, problems concerning the care of children or relatives requiring nursing, the inability of important others to cope with the cancer, in other words: everything that is distressing in the context of significant social relationships and exceeds what would be the expected reaction (e.g. worry on the part of the relatives).

> *Example: A patient worries a great deal about her disabled child. The child is cared for in an institution for the disabled but usually comes home on weekends. She can no longer look after her child on weekends and fears negative consequences for her child and her family.*

- *Example: A patient who has recently decided to separate from her husband has a relapse. She does not know if she is able to go through with the separation now that she is ill, but she also does not want to stay in this problematic relationship. This disturbs her very much.*

- **Economic/ work-related problems**

Which financial and occupational consequences for the patient does the illness give rise to? Does the illness threaten the patient's financial survival? Is the patient concerned about his/her occupational future or does he/she suffer from no longer being able to work as before? Were there already difficulties in this area before the onset of the disease?

> *Example: A 40 year-old patient has to claim a pension on the grounds of reduction in earning capacity due to his tumour illness. A few years ago, he had a house built which now has a considerable mortgage, and he can no longer meet the monthly payments. He fears that a forced auction may soon be ordered and sees no way out this situation.*

- *Example: A patient's employer has advised him to claim early retirement benefits on account of no longer being able to work. But his profession means a lot for the patient and he had hoped to gradually start working again. His employer's reaction robbed him of all hope and he feels misunderstood and abandoned.*

- **Additional stressful factors**

This category allows further stressors to be recorded which may be related or unrelated to the cancer, e.g. difficulties with the healthcare staff or problems resulting from the need for care or help.

> *Example: After the resection of a rectal carcinoma, a patient suffers from having to be helped by the mobile nursing staff supporting him in the care of his stoma. He finds it unpleasant that unfamiliar people regularly come into his apartment.*
>
> *Example: A patient reports the physician does not have the slightest understanding for her. She says nobody explained the exact meaning of her diagnosis to her, and her questions were answered only monosyllabically and evasively. She can no longer trust the physicians and feels as if she is being treated like a number.*

- **Stressors unrelated to the Illness are affecting the patient's current emotional state.**

The cancer patient's emotional state is frequently attributed to the tumour disease, but other problems unrelated to the illness can also be highly relevant.

Is the psychosocial distress primarily related to the cancer or are there other factors and causes? Were there similar difficulties before the onset of illness?

> *Example: A patient had already suffered from an anxiety disorder before the illness, for instance from nightly anxiety and panic attacks. Now the cancer diagnosis has worsened the anxiety disorder. Hence the patient's current emotional state is not*

exclusively induced by the illness, but rather also by the previous psychological problems.

Example: An older patient has a renal carcinoma. She has just had the operation done and has a good prognosis. She is very depressed and cries whenever she is spoken to. When asked, it emerges that her adult daughter has just been admitted to a psychiatric clinic with the diagnosis "borderline personality disorder". She does not know what the diagnosis means, and experiences a great deal of guilt and anxiety.

3.2.4 Indication:

- **Professional psychosocial support is currently indicated for the patient**

Should the patient be offered professional psychosocial support/counselling?

For this item "yes" should be marked if the examiner has the impression that the patient needs psychooncological treatment (e.g. one-to-one counselling, relaxation training, psychoeducation), i.e. if support has been planned or explicitly recommended. This item is to be marked "yes" regardless of whether the patient shows interest or motivation to accept any offers of therapy.

If an agreement has been reached that the patient can contact the examiner again if required but currently needs no further support, "no" should be marked under indication.

3.3 Additional Information

It is possible to include additional information on a supplementary sheet using an open format, for example, concerning the following aspects:

- **Central issue / Overall impression**

What impression does the patient make on the whole? / How can the patient's emotional and physical condition be summarized? What was particularly important in the interaction with the patient? What is the main problem or the central aspect of the ratings?

- **Further measures**

This category encompasses the kind of support which is recommended and any explicit agreements made with the patient, as well as the goals which have been set.

4. References

(1) Zigmond, A. and R. Snaith. (1983). The hospital anxiety and depression scale. *Acta Psychiatr. Scand.* 67: 361-370.

(2) Herschbach P, Marten-Mittag B, Henrich G. 2003. [Revision and psychometric evaluation of the Questionnaire on Stress in Cancer Patients (QSC-R23).] German. *Z Med Psychol* **12:**1–8.

(3) Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P. (1982). Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. *Am J Clin Oncol* 5:649-655, 1982.

(4) Knight, L., Mussell, M., Brandl, T., Herschbach, P., Marten-Mittag, B.,Treiber, M., Keller, M. (2008). Development and psychometric evaluation of the Basic Documentation for Psycho-Oncology (PO-Bado), a tool for standardized assessment of cancer patients. *J Psychosom Res*, Apr;64 (4):373-81.

(5) Herschbach, P., Book, K., Brandl, T., Keller, M., Lindena, G., Neuwöhner, K., Marten-Mittag, B. (2008). Psychological distress in cancer patients assessed with an expert rating scale. *Br J Cancer*. Jul 8;99(1):37-43. Epub 2008 Jun 24.

(6) Herschbach, P., Book, K., Brandl, T., Keller, M., Marten-Mittag, B. (2008). The Basic Documentation for Psycho-Oncology (PO-Bado) - An Expert Rating Scale for the Psychosocial Condition of Cancer Patients. *Onkologie*, 31:591-596; Epub Oct 2008..

Appendix: Definition of the PO-Bado diagnostic categories

PO-Bado diagnosis category	Definition: Malignant growths ...	Subgroups	IDC-10 Code
Mamma	... the mammary gland		C50
Gyn. Tumours	...the female genitals	Vulva/Vagina Cervix Uteri Corpus Uteri/ Endometrium Ovaries	C51/C52 C53 C54 C54.1 C55
Lungs / Bronchia	...the bronchi and the lungs		C34
Prostate / Testicles	...the male genitals	Prostate Testes	C61 C62
Colon / Rectum	...the colon and the rectum	Colon Rectum Anus	C18 C20 C21
Ear, nose, throat	... the nose and throat area	Nasal cavity Paranasal sinus Larynx Oropharynx Nasopharynx Oral area	C30 C31 C32 C10 C11 C00-06
Haematological illnesses	…the lymphatic and haematopoietic tissue	Leucemia Lymphoma Morbus Hodgkin Multiple Myeloma	C91-95 C82-85 C81 C90
Skin	...the skin	Melanoma Basalioma	C43 C44
Sarcoma	...the soft tissue	Sarcoma	C46
Urological tumours	...urinary system	Kidneys Renal pelvis Ureter Urinary bladder	C64 C65 C66 C67
Stomach, oesophagus, pancreas	...the upper digestive system	Stomach Small intestine Oesophagus Pancreas Liver	C16 C17 C15 C25 C22
Others	Tumour diagnosis not encompassed in the above mentioned categories.	e.g. CUP (carcinoma of unknown primary)	