



PSYCHIATRIC DISORDERS IN ONCOLOGY PATIENTS: CLINICAL IMPLICATIONS AND THERAPEUTIC CHALLENGES

Zaburzenia psychiczne u pacjentów onkologicznych: znaczenie kliniczne i wyzwania terapeutyczne



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Abstract

Mental disorders are among the most common and most burdensome complications in oncology. They include depression, anxiety, adjustment disorders, cancer-related fatigue, cognitive deficits, and symptoms of post-traumatic stress. Their presence reduces quality of life, impairs adherence to treatment, and worsens prognosis. Among soldiers and uniformed service personnel, these conditions pose an additional challenge, as they coincide with occupational demands and specific stressors. The aim of this study was to review current evidence on the epidemiology, diagnosis, and management of mental disorders in oncology patients, with particular emphasis on the military and uniformed services context in Poland. A review of the literature published between 2019 and 2025 (PubMed, Scopus, Web of Science) and of international guidelines (ESMO, NCCN, ASCO) was conducted. Diagnostic frameworks (ICD-11, DSM-5-TR) and validated psycho-oncological screening instruments were included in the analysis. Depression affects approximately 20–25% of patients with cancer, while anxiety disorders occur in 10–30%. Cancer-related fatigue is reported by up to 40% of patients. The highest risk is observed in individuals with lung, pancreatic, and head and neck cancers. Diagnosis requires combining structured clinical interviews with screening instruments (PHQ-9, HADS, GAD-7, DT). Exercise interventions have been shown to reduce symptoms of depression and anxiety, while early clinical trials of psilocybin suggest its potential efficacy in treatment-resistant depression. In military settings, systematic screening, strict confidentiality of medical data, and interdisciplinary care are of particular importance. Mental health disorders should be considered integral components of oncological care. In the military and uniformed services, priorities include routine psychological screening at key stages of therapy, adaptation of international guidelines to national conditions, and exploration of innovative interventions (physical activity, psychedelic-assisted therapies). Such measures may significantly improve outcomes and quality of life in oncology patients.

Streszczenie

Zaburzenia psychiczne należą do najczęstszych i najbardziej obciążających powikłań w onkologii. Obejmują one m.in. depresję, zaburzenia lękowe, zaburzenia adaptacyjne, zmęczenie nowotworowe, deficyty poznawcze i objawy stresu pourazowego. Ich obecność obniża jakość życia, utrudnia realizację terapii i pogarsza rokowanie. W populacji żołnierzy i funkcjonariuszy służb mundurowych znaczenie tych zaburzeń jest szczególne, ponieważ nakładają się one na wymagania zawodowe i specyficzne czynniki stresowe. Celem pracy była analiza aktualnych danych dotyczących epidemiologii, diagnostyki i leczenia zaburzeń psychicznych u pacjentów onkologicznych, ze szczególnym uwzględnieniem kontekstu wojskowego i służb mundurowych w Polsce. Przeprowadzono przegląd piśmiennictwa z lat 2019–2025 (PubMed, Scopus, Web of Science) oraz międzynarodowych wytycznych (ESMO, NCCN, ASCO). Uwzględniono systemy klasyfikacyjne ICD-11 i DSM-5-TR oraz specyficzne narzędzia przesiewowe stosowane w psychoonkologii. Depresja dotyczy około 20–25% pacjentów z chorobą nowotworową, a zaburzenia lękowe 10–30%. Zmęczenie nowotworowe zgłasza nawet 40% chorych. Najwyższe ryzyko dotyczy osób z rakiem płuca, trzustki oraz głowy i szyi. Diagnostyka wymaga połączenia wywiadu klinicznego z narzędziami przesiewowymi (PHQ-9, HADS, GAD-7, DT). Wykazano, że programy aktywności fizycznej zmniejszają nasilenie objawów depresji i lęku, natomiast badania nad psylocybiną sugerują jej potencjał w terapii depresji odpornej na leczenie. W kontekście wojskowym kluczowe znaczenie mają systematyczne badania przesiewowe, poufność danych medycznych oraz interdyscyplinarna opieka. Zaburzenia psychiczne powinny być traktowane jako integralna część opieki onkologicznej. Priorytetem w wojsku i służbach mundurowych jest wdrożenie przesiewu psychologicznego na kluczowych etapach terapii, adaptacja mię-

dzynarodowych wytycznych do warunków krajowych oraz rozwój innowacyjnych interwencji (aktywność fizyczna, terapie psychodeliczne). Takie działania mogą istotnie poprawić rokowanie i jakość życia pacjentów onkologicznych.

Keywords: psycho-oncology; depression; anxiety disorders; soldiers; ICD-11

Słowa kluczowe: psychoonkologia; depresja; zaburzenia lękowe; żołnierze; ICD-11

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Introduction

Malignant neoplasms represent one of the greatest challenges in modern medicine, with consequences extending far beyond somatic health. In everyday clinical practice, increasing attention is now focused on the psychological and social implications of cancer diagnosis and treatment. According to the latest guidelines of the European Society for Medical Oncology (ESMO), symptoms of depression and anxiety are among the most prevalent psychological difficulties experienced by cancer patients, irrespective of tumour type or disease stage [1].

Studies indicate that mood disorders affect approximately one quarter of patients, while anxiety symptoms are observed in 20–30% of individuals undergoing anticancer therapy [1]. The clinical relevance of these conditions is twofold. First, depression and anxiety substantially reduce quality of life and impair daily functioning. Second, they negatively influence prognosis by decreasing treatment adherence, exacerbating somatic symptoms, and increasing suicide risk [1]. Evidence also suggests that certain patient groups – such as those with lung, pancreatic, or head and neck cancers – are at particularly high risk of developing mood disorders [2].

Another increasingly recognised issue is cancer-related distress, defined by the National Comprehensive Cancer Network (NCCN) as the “sixth vital sign in oncology.” This concept encompasses a wide spectrum of emotional responses – from worry and irritability to depressive and adjustment disorders – that can significantly disrupt the treatment process [3]. Similarly, cancer-related fatigue, which often persists beyond the completion of therapy, is frequently reported and strongly associated with functional limitations [4].

Recent reports have highlighted the global dimension of this problem, indicating that it is not solely dependent on healthcare accessibility. For example, a cross-sectional study involving more than 270 patients in Palestine found that over half displayed depressive symptoms, with younger age, limited education, and financial hardship identified as major contributing factors [2]. A meta-analysis of 42 clinical trials demonstrated that psychological interventions – including cognitive-behavioural therapy, acceptance and commitment therapy, mindful-

ness-based interventions, and meaning-centred therapies – were associated with significant reductions in distress and depressive symptoms, alongside improvements in overall quality of life [3].

Despite a growing body of evidence, mental health problems in oncology remain underdiagnosed and undertreated. Many patients do not receive adequate pharmacological or psychotherapeutic support, as confirmed by both clinical observations and population-based studies [1, 4]. Consequently, the implementation of systematic screening, early diagnostic procedures, and interdisciplinary care – integrating oncologists, psycho-oncologists, psychiatrists, and clinical psychologists – is increasingly recognised as an essential component of comprehensive cancer treatment. This study aimed to review current data on the epidemiology, classification, diagnostic approaches, and therapeutic strategies for mental disorders in oncology, with particular emphasis on their impact on the treatment course and patients' quality of life.

Most common mental disorders in oncology patients

Contemporary psycho-oncology clearly demonstrates that mental health disorders are frequent and clinically significant components of cancer care. The latest ESMO guidelines emphasise that depressive and anxiety symptoms occur in many patients across all stages of the treatment trajectory. Their presence is associated with greater psychological distress, poorer quality of life, reduced treatment adherence, and increased suicide risk, particularly in the context of major depression [1]. The identification and differentiation of psychiatric disorders should follow the standards of the International Classification of Diseases, 11th Revision (ICD-11), and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), while recognising the distinct areas of focus within each system. For example, ICD-11 places greater emphasis on hopelessness in depression and autonomic hyperactivity in generalised anxiety disorder [1].

Depressive disorders: Depression is one of the most frequently identified psychiatric conditions in oncology patients, with prevalence estimates ranging from 20% to 25%, although rates vary depending on the assess-

ment tools used as well as cancer type and stage [1]. A key diagnostic challenge is the overlap between depressive symptoms (including fatigue, appetite loss, and hypersomnia) and the clinical presentation of cancer and treatment-related adverse effects. Cross-sectional studies illustrate these challenges; for example, in a Palestinian cohort of 271 patients assessed with the Beck Depression Inventory-II (BDI-II), depressive severity ranged from mild to severe, with younger age, lower educational attainment, and socioeconomic disadvantage identified as risk factors [2]. These findings underscore the importance of systematic screening and ongoing reassessment throughout the course of treatment.

- **Anxiety disorders:** Anxiety may present as subthreshold symptoms or meet full diagnostic criteria for conditions such as generalised anxiety disorder (GAD), panic disorder, or adjustment disorder with anxiety. Multicentre studies and meta-analyses cited by ESMO report clinically significant anxiety in 15–25% of oncology patients [1]. Fear of cancer recurrence (FCR) and fear of progression (FoP), although not formal diagnostic entities, are particularly important in survivorship care, as they significantly impair functioning, frequently co-occur with insomnia and depression, and require targeted clinical attention [1].
- **Adjustment disorders:** Emotional responses directly linked to cancer diagnosis and treatment are common. In the ICD-11 and DSM-5-TR, adjustment disorders are characterised by disproportionate distress and/or functional impairment arising within three months of a stressor [1]. In oncology, these disorders are diagnosed more frequently than major depressive disorder (MDD) and are associated with an elevated risk of subsequent psychiatric morbidity, underscoring the importance of early psychoeducation and short-term therapeutic interventions [1].
- **Cancer-related fatigue (CRF):** Chronic fatigue, disproportionate to exertion and unrelieved by rest, is among the most prevalent and burdensome symptoms in oncology, often persisting beyond the completion of treatment. CRF frequently co-occurs with depression and anxiety, contributing to severe limitations in daily and social functioning [4]. Differential diagnosis is crucial (such as anaemia and endocrine dysfunction), and management requires multimodal strategies, including physical activity, psychosocial interventions, and pharmacological support in selected cases [4].
- **Cognitive impairment:** Deficits in attention, working memory, and executive functioning – commonly referred to as chemobrain – may arise not only during or after systemic therapy but also as a direct consequence of cancer itself. Although heterogeneous in presentation, cognitive impairments are often clinically significant for occupational and daily functioning, yet remain underdiagnosed [4]. Recommended approaches include brief cognitive screening (such as the Montreal Cognitive Assessment) and referral for cognitive rehabilitation when symptoms are persistent and disabling.
- **Post-traumatic stress symptoms and the coronavirus 2019 (COVID-19) context:** Individuals experiencing post-traumatic stress disorder (PTSD) in connection with cancer may exhibit intrusive recollections, avoidance behaviours, heightened arousal, and altera-

tions in mood. In DSM-5-TR, PTSD is classified as a trauma- or stressor-related disorder rather than an anxiety disorder [1]. The COVID-19 pandemic has increased rates of depression and anxiety globally, with oncology patients similarly affected [1]. Importantly, it has accelerated the implementation of remote psychological support and evidence-based interventions (including cognitive-behavioural therapy (CBT), acceptance and commitment therapy (ACT), and mindfulness-based programmes), which recent meta-analyses have shown to significantly reduce distress, anxiety, and depression while improving quality of life, even within telehealth models [3]. In clinical practice, routine use of screening tools (such as the Hospital Anxiety and Depression Scale (HADS), Patient Health Questionnaire-9 (PHQ-9), GAD-7, and the Distress Thermometer (DT)) and fast-track access to psycho-oncological care remain essential.

The spectrum of psychiatric disorders in oncology encompasses both core diagnoses (depression, anxiety disorders, and PTSD) and clinically significant but less formally classified conditions (such as FCR, CRF, and cognitive deficits). Early identification – guided by ICD-11/DSM-5-TR criteria and ESMO recommendations – together with evidence-based interventions, constitutes a fundamental component of comprehensive oncological care [1, 3].

Classification and diagnosis of mental disorders

Within oncology, the identification of psychiatric disorders is primarily based on two diagnostic frameworks: the DSM-5-TR, developed by the American Psychiatric Association [5], and the ICD-11, published by the World Health Organization [6]. Although both systems define comparable nosological categories, they differ in emphasis. The DSM-5-TR focuses on numerical symptom thresholds and minimum duration criteria, thereby facilitating standardisation in clinical research, whereas the ICD-11 introduces greater diagnostic flexibility, allowing clinicians to consider the clinical and functional context of the patient more broadly [5, 6].

For example, in depressive disorders, DSM-5-TR requires the presence of at least five symptoms lasting a minimum of two weeks, with the mandatory inclusion of either depressed mood or anhedonia. In contrast, ICD-11 places greater emphasis on hopelessness and provides explicit stratification of severity into mild, moderate, and severe categories. Regarding anxiety disorders, ICD-11 incorporates autonomic hyperarousal features (such as palpitations and excessive sweating), which are particularly relevant for distinguishing psychiatric symptoms from somatic manifestations of oncological treatment [6].

Given the substantial overlap between psychological and physical manifestations (e.g., fatigue, appetite loss, and sleep problems), the evaluation of oncology patients should integrate standardised screening instruments with structured clinical interviews. The most commonly used questionnaires include HADS, PHQ-9, GAD-7, BDI-II, and DT, recommended by the NCCN as rapid screening instruments for distress [7]. The 2023 ESMO guidelines further recommend applying these instru-

ments at key points along the cancer care continuum: at diagnosis, during active treatment, during follow-up, and in the event of recurrence [1].

Increasing attention is also being directed towards psycho-oncology-specific phenomena that, although not formally recognised as diagnostic categories in either DSM or ICD, hold substantial clinical and prognostic significance. The most extensively studied examples are FCR and FoP. Evidence suggests that approximately 40–50% of cancer survivors in remission experience clinically significant FCR, which is associated with poorer quality of life, higher risk of depression and sleep disturbances, and lower adherence to therapeutic recommendations [8]. Although these phenomena are not formally classified within DSM-5-TR, they represent critical targets for psychological intervention and should be systematically monitored as part of comprehensive oncological care [8, 9].

Methodology of diagnosing and assessing mental disorders in oncology patients

The diagnostic process for mental disorders in oncology patients is complex and requires a multidimensional approach. This complexity arises from the convergence of psychiatric, somatic, and treatment-related symptoms, which may stem from the cancer itself, associated complications, or therapeutic interventions such as chemotherapy, hormone therapy, and radiotherapy. Symptoms including fatigue, loss of appetite, sleep disturbances, and weight loss may reflect manifestations of depression as well as treatment-related adverse effects, complicating clinical differentiation [4, 10].

Current guidelines therefore recommend triangulating diagnostic data through: (1) self-report instruments (including BDI-II, PHQ-9, HADS, GAD-7, and DT), which enable rapid symptom screening; (2) structured clinical interviews guided by DSM-5-TR and ICD-11 standards, allowing formal diagnosis consistent with recognised classification systems; and (3) evaluation of psychosocial functioning, including the impact of symptoms on daily life, interpersonal relationships, treatment adherence, and adjustment to illness [1, 2, 7].

The DSM-5-TR (2022) defines diagnostic categories through clearly specified symptom sets and threshold criteria, ensuring standardisation. In contrast, ICD-11 (2019) emphasises severity levels and functional impairment. In psycho-oncology practice, ICD-11 offers greater diagnostic flexibility, facilitating the differentiation of depressive and anxiety symptoms that frequently present with atypical features in somatically burdened patients [5, 6].

Structured or semi-structured interviews remain the “gold standard” for confirming diagnoses and should be implemented in patients with positive screening results [1]. Both ESMO and NCCN guidelines recommend repeated screening at critical points along the cancer trajectory – such as at diagnosis, treatment modification, and follow-up – to identify individuals at risk of depression, anxiety, or adjustment disorders and refer them for specialised care [3, 7].

Diagnostic criteria and assessment tools for mental disorders in oncology

Recognition of mental disorders in oncology patients requires strict adherence to standardised psychiatric classifications and careful consideration of the specific clinical context of this population. DSM-5-TR (American Psychiatric Association, 2022) and ICD-11 (World Health Organization, 2019) provide formal diagnostic criteria that form the basis of psychiatric assessment.

- MDD: requires the presence of ≥ 5 symptoms persisting for at least two weeks, including either depressed mood or anhedonia, accompanied by functional impairment in social or occupational domains [5].
- GAD: diagnosed in cases of chronic (≥ 6 months) tension and excessive worry, accompanied by somatic symptoms such as insomnia, irritability, or muscle tension [5, 6].
- Adjustment disorders: characterised by an emotional or behavioural response disproportionate to the stressor, emerging within three months of exposure [6].

In oncology, diagnostic assessment requires particular caution, as many symptoms typical of depression or anxiety (such as fatigue, anorexia, and insomnia) may result directly from the malignancy or treatment-related adverse effects, including chemotherapy, radiotherapy, and hormone therapy [1, 2].

Screening and assessment tools

Guidelines from ESMO and the American Society of Clinical Oncology recommend routine screening for psychological symptoms at key points along the cancer continuum, including at diagnosis, during treatment, post-treatment, and throughout survivorship follow-up [1]. The most frequently used and validated instruments include:

- BDI-II: evaluating the severity of depressive symptoms (range 0–63; categories: minimal, mild, moderate, and severe). Its reliability and validity have been confirmed in oncology populations [2].
- PHQ-9: a DSM-based instrument for depression; scores ≥ 10 are typically considered clinically significant [1].
- HADS: consists of two subscales, HADS-A (anxiety) and HADS-D (depression). Scores ≥ 8 indicate borderline cases, whereas ≥ 11 strongly suggest the need for further diagnostic evaluation [1].
- GAD-7: designed for screening GAD; a threshold of ≥ 10 suggests clinical relevance and warrants further assessment [1].
- DT: a rapid, single-item screening tool for distress; scores ≥ 4 –5 indicate the need for additional psychological evaluation [3].

Supplementary questionnaires

In addition to general screening instruments, oncology-specific questionnaires are widely used:

- The European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ) provides a multidimensional evaluation of quality of life, including emotional and cognitive functioning.

- The Functional Assessment of Cancer Therapy-General (FACT-G) evaluates how the illness and its management affect physical, emotional, and social quality of life.
- The Fear of Cancer Recurrence Inventory measures the intensity of fear of recurrence, a construct not formally classified in DSM or ICD but with substantial clinical and prognostic implications [1, 3].

Diagnostic procedure

An optimal diagnostic pathway includes four stages:

- Screening: application of brief instruments such as DT, HADS, or PHQ-9.
- In-depth assessment: for patients with positive screening results, more detailed scales are administered (such as BDI-II and GAD-7).
- Clinical interview: conducted by a mental health specialist, using DSM-5-TR and ICD-11 criteria, and interpreted in the context of the patient's medical background and physical condition [1, 2].
- Therapeutic decision-making: involves psychoeducation, psychotherapeutic interventions (including CBT, ACT, and Meaning-Centred Psychotherapy), and pharmacotherapy when indicated. Ongoing monitoring of treatment effectiveness is essential [3].

Methodological challenges

The greatest challenge lies in the overlap between somatic and psychiatric symptoms, necessitating clinical expertise and interdisciplinary collaboration among oncologists, psychiatrists, and clinical psychologists. Another substantial issue is the insufficient availability of screening. Studies indicate that a considerable proportion of patients with clinically relevant symptoms of depression and anxiety do not receive appropriate psychological support [2, 3]. Systematic use of standardised tools and the early identification of symptoms increase the likelihood of improved quality of life and better adherence to oncological treatment [1, 3].

Future research challenges and proposed clinical recommendations for patients with mental disorders

- Exercise interventions as a strategy to support mental health

Physical activity is among the most thoroughly investigated supportive approaches for enhancing mental health in cancer populations. A recent meta-analysis of 27 randomised controlled trials, published in *JAMA Network Open* (2025), found that structured exercise interventions in older patients with cancer significantly reduced depressive symptoms (SMD = -0.53; 95% CI: -0.79-(-0.28)) and anxiety (SMD = -0.39; 95% CI: -0.66-(-0.12)), while improving quality of life (SMD = 0.63; 95% CI: 0.10-1.17) [11]. The greatest benefits were observed in mind-body interventions (including yoga and tai chi), which produced stronger therapeutic effects than standard exercise programmes - depression: SMD = -0.89 (95% CI: -1.51-(-0.27)); anxiety: SMD = -0.77 (95% CI: -1.54-(-0.01)) [11].

These findings confirm that physical activity should be regarded not only as a means of promoting general well-being but also as a structured psycho-oncological intervention. Incorporating individualised, supervised exercise programmes into the care of older adults with cancer may enhance self-efficacy, reduce distress, and improve psychosocial functioning [11].

- Therapeutic potential of a single dose of psilocybin

Growing interest has also turned towards the use of psychedelics in managing cancer-related depression. A phase II clinical study published in *Cancer* (2025) found that a single 25 mg administration of psilocybin, delivered with psychotherapeutic support in oncology care, was safe, well tolerated, and showed therapeutic efficacy. After two years of follow-up, 50% of participants achieved full remission of major depression, whereas 42.9% experienced sustained reductions in anxiety symptoms [12].

These results suggest that psilocybin-assisted therapy may represent a breakthrough adjunct to conventional pharmacotherapy, particularly for treatment-resistant depression. Nevertheless, larger multi-centre randomised trials are required to verify its long-term safety and efficacy and to optimise treatment protocols [3].

Key research challenges

Although evidence is growing for the effectiveness of exercise and psychedelic therapies in alleviating psychological symptoms in cancer patients, significant methodological, clinical, and organisational barriers persist.

- Accessibility and scalability of interventions: implementing exercise programmes in routine clinical practice is hindered by logistical barriers, including limited infrastructure, insufficient availability of specialised therapists, and patient-related adherence challenges (such as cancer-related fatigue and transportation difficulties). Hybrid and remote programmes have shown promise in improving accessibility, particularly in rural populations and during public health crises [3, 11].
- Durability of therapeutic effects: most clinical studies assess outcomes over the short term (≤ 6 months), and data on the long-term persistence of benefits from exercise or psychedelic interventions remain limited. For example, Soong et al. (2025) reported sustained improvements in depression and anxiety for up to six months; however, no follow-up beyond one year was available [11]. By contrast, Agrawal et al. (2025) found that a single administration of psilocybin could yield benefits lasting up to two years, although the limited sample size restricts the broader applicability of these findings [12].
- Safety and risk profile: exercise interventions must be tailored to patient age, cancer stage, and comorbidities to prevent complications such as injury or overexertion [13]. Psychedelic therapies require rigorous clinical supervision owing to potential adverse effects, including anxiety, derealisation, or exacerbation of psychotic symptoms in predisposed

individuals [14]. Careful patient selection and strict control of the treatment environment are therefore essential.

- Ethical and legal considerations: psilocybin and other psychedelics remain controlled substances in many jurisdictions, creating barriers to clinical research and funding. In addition, societal stigma rooted in historical and cultural factors continues to hinder broader acceptance. Experts emphasise the urgent need for international ethical guidelines and regulatory reforms to facilitate clinical investigation [14, 15].
- Diversity of the patient population: existing studies have often focused on relatively homogenous groups (such as women with breast cancer). Broader inclusion of patients with diverse tumour types, advanced disease stages, and those receiving palliative care is necessary to develop more generalisable clinical recommendations [10].
- Treatment integration and personalisation: developing models that integrate pharmacotherapy, psychotherapy, exercise, and potentially psychedelic interventions remains a major challenge. There is a clear need for predictive instruments capable of identifying which patients are most likely to respond to specific interventions [1, 3].
- Funding and health policy: limited financial support for psycho-oncology research, together with insufficient integration of psychiatry and psychology into standard cancer care pathways, continues to constrain progress. Incorporating mental health assessments into oncology standards of care, as advocated by ESMO and NCCN, may expand access to interventions and improve patient outcomes [7, 10].

Conclusions

This study demonstrated that mental disorders in oncology patients are both prevalent and insufficiently recognised, underscoring the need for systematic screening and comprehensive interdisciplinary care. In line with ESMO, NCCN, and ASCO guidelines, mental health assessment must be regarded as an integral component of the diagnostic–therapeutic pathway in oncology, rather than an optional adjunct to somatic treatment [1, 16, 17].

First, adapting established diagnostic frameworks (DSM-5-TR and ICD-11) to psycho-oncology is crucial, with close attention to the unique clinical features of this population. Distinguishing psychiatric manifestations from cancer-related somatic symptoms and adverse effects of treatment requires specialist expertise and the use of validated screening tools, including PHQ-9, HADS, GAD-7, and DT [2, 18, 19]. Their systematic use at key stages of care (diagnosis, active treatment, follow-up, and recurrence) should be implemented as routine practice in oncology centres in Poland.

Second, the provision of comprehensive care requires interdisciplinary collaboration among oncologists, psycho-oncologists, psychiatrists, and clinical psychologists. Evidence shows that integrated care approaches (“collaborative care”) effectively alleviate depression and anxiety while enhancing quality of life in cancer patients [20, 21]. However, implementing such models in Poland

necessitates systemic organisational and financial solutions, including linking the quality of screening to reimbursement mechanisms.

Third, adapting international guidelines to Polish conditions is indispensable – particularly within the military and uniformed services, where the burden of mental disorders among oncology patients is compounded by the specific demands of service. In this context, incorporating brief screening instruments (e.g., DT, HADS, PHQ-9) into clinical assessments and official health records may significantly improve access to early interventions while upholding rigorous confidentiality standards [21–23].

Fourth, future studies should focus on assessing the effectiveness of innovative interventions, both in the domain of physical activity and psychedelic-assisted psychotherapies (psilocybin). Recent evidence indicates that physical activity programmes in older adults can markedly reduce depressive and anxiety symptoms while enhancing quality of life [11], whereas clinical trials of a single psilocybin dose have shown sustained remission of depressive symptoms [12]. Although both approaches require further validation, their emerging clinical potential positions them as promising directions for psycho-oncology development.

In summary, the implementation of systematic screening and interdisciplinary care, together with the adaptation of international guidelines to the Polish healthcare system – with specific consideration for military and uniformed service settings – should be regarded as priority measures. Broadening the availability of novel interventions, grounded in robust clinical evidence, has the potential to significantly improve outcomes and quality of life for cancer patients in Poland.

References

1. Grassi L, Caruso R, Riba MB, et al.; ESMO Guidelines Committee. Anxiety and depression in adult cancer patients: ESMO Clinical Practice Guideline. *ESMO Open*, 2023; 8(2): 101155. doi: 10.1016/j.esmoop.2023.101155.
2. Battat M, Omair N, WildAli MA, et al. Assessment of depression symptoms among cancer patients: a cross-sectional study from a developing country. *Sci Rep*, 2024; 14: 11934. doi: 10.1038/s41598-024-62935-x
3. Paslaru AM, Plesea-Condratovici A, Moroianu L-A, et al. Mind over malignancy: a systematic review and meta-analysis of psychological distress, coping, and therapeutic interventions in oncology. *Medicina* (Kaunas), 2025; 61(6): 1086. doi: 10.3390/medicina61061086
4. Talarowska M. Zaburzenia psychiczne u pacjentów onkologicznych. *Psychiatria po Dyplomie*, 2020; 17: 50–57
5. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, 5th edition, text revision (DSM-5-TR)*. Washington, DC: APA, 2022
6. World Health Organization. *International classification of diseases 11th revision (ICD-11): clinical descriptions and diagnostic guidelines*. Geneva, WHO, 2019
7. Riba MB, Donovan KA, Ahmed K, et al. NCCN Guidelines® Insights: Distress Management, Version 2.2023. *J Natl Compr Canc Netw*, 2023; 21(5): 450–457. doi: 10.6004/jnccn.2023.0026

8. Simard S, Thewes B, Humphris G, et al. Fear of cancer recurrence in adult cancer survivors: a systematic review of quantitative studies. *J Cancer Surviv*, 2013; 7(3): 300–322. doi: 10.1007/s11764-013-0272-z
9. Tauber NM, O'Toole MS, Dinkel A, et al. Effect of psychological intervention on fear of cancer recurrence: a systematic review and meta-analysis. *J Clin Oncol*, 2019; 37(31): 2899–2915. doi: 10.1200/JCO.19.00572
10. Mitchell AJ, Chan M, Bhatti H, et al. Prevalence of depression, anxiety, and adjustment disorder in oncological, hematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. *Lancet Oncol*, 2011; 12(2): 160–174. doi: 10.1016/S1470-2045(11)70002-X
11. Soong RY, Low CE, Ong V, et al. Exercise interventions for depression, anxiety, and quality of life in older adults with cancer: a systematic review and meta-analysis. *JAMA Netw Open*, 2025; 8(2): e2457859. doi: 10.1001/jamanetworkopen.2024.57859
12. Agrawal M, Roddy K, Jenkins B, Leeks C, Emanuel E. Long-term benefits of single-dose psilocybin in depressed patients with cancer. *Cancer*, 2025; 131(12): e35889. doi: 10.1002/cncr.35889
13. Schmitz KH, Campbell AM, Stuiver MM, et al. Exercise is medicine in oncology: engaging clinicians to help patients move through cancer. *CA Cancer J Clin*, 2019; 69(6): 468–484. doi: 10.3322/caac.21579
14. Reiff CM, Richman EE, Nemeroff CB, et al.; the Work Group on Biomarkers and Novel Treatments, a Division of the American Psychiatric Association Council of Research. Psychedelics and psychedelic-assisted psychotherapy. *Am J Psychiatry*, 2020; 177(5): 391–410. doi: 10.1176/appi.ajp.2019.19010035
15. Nutt D, Carhart-Harris R. The current status of psychedelics in psychiatry. *JAMA Psychiatry*, 2021; 78(2): 121–122. doi: 10.1001/jamapsychiatry.2020.2171
16. Deshields TL, Wells-Di Gregorio S, Flowers SR, et al. Addressing distress management challenges: Recommendations from the consensus panel of the American Psychosocial Oncology Society and the Association of Oncology Social Work. *CA Cancer J Clin*, 2021; 71(5): 407–436. doi: 10.3322/caac.21672
17. Andersen BL, Lacchetti C, Ashing K, et al. Management of anxiety and depression in adult survivors of cancer: ASCO guideline update. *J Clin Oncol*, 2023; 41(18): 3426–3453. doi: 10.1200/JCO.23.00293
18. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand*, 1983; 67(6): 361–370. doi: 10.1111/j.1600-0447.1983.tb09716.x
19. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med*, 2006; 166(10): 1092–1097. doi: 10.1001/archinte.166.10.1092. PMID: 16717171
20. Sharpe M, Walker J, Holm-Hansen C, et al.; SMaRT (Symptom Management Research Trials) Oncology-2 Team. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicenter randomized controlled effectiveness trial. *Lancet*, 2014; 384(9948): 1099–1108. doi: 10.1016/S0140-6736(14)61231-9
21. Decyzja Nr 155/MON Ministra Obrony Narodowej z dnia 26 października 2021 r. w sprawie organizacji i funkcjonowania opieki psychologicznej w resorcie obrony narodowej. *Dz.Urz. MON* 2021 poz. 235
22. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*, 2001; 16(9): 606–613. doi: 10.1046/j.1525-1497.2001.016009606.x
23. Weathers FW, Bovin MJ, Lee DJ, et al. The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5): development and initial psychometric evaluation in military veterans. *Psychol Assess*, 2018; 30(3): 383–395. doi: 10.1037/pas0000486