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## Adapting psychosocial interventions for older adults with cancer: A case example of Managing Anxiety from Cancer

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Medical oncology has come to recognize the needs of older adults and made efforts to address those needs.<sup>1–3</sup> For example, extensive research has been conducted on the Comprehensive Geriatric Assessment, a multi-dimensional assessment developed to identify older adults at risk for chemotherapy toxicities.<sup>4–6</sup> While more work is needed, geriatric oncology is an established subspecialty and increasing numbers of older adults with cancer (OACs) now have access to care that is sensitive to their needs.

Psychosocial oncology lags behind medical oncology in the consideration of the specific needs of older adults. This gap is notable given that over 40% of OACs report elevated distress (e.g., anxiety, depression)<sup>7–12</sup> that is associated with worse physical symptoms,<sup>13–17</sup> poor quality of life<sup>18,19</sup> and treatment adherence and response;<sup>20–22</sup> difficulty communicating with the healthcare team;<sup>23</sup> longer hospitalizations;<sup>24,25</sup> increased risk of an emergency department visit, overnight hospitalization, and 30-day readmission;<sup>26–28</sup> and shorter survival.<sup>29,30</sup>

Tailoring psychosocial interventions for OACs should be rigorous and informed by theory, prior research, and multi-level stakeholder perspectives (e.g., OACs, their caregivers, and oncology providers). This paper describes the initial development and evaluation of a telephone-delivered cognitive-behavioral therapy (CBT) intervention for anxiety in OACs and their caregivers. CBT is an empirically-supported treatment that targets thoughts and behaviors that negatively impact mood.<sup>31,32</sup> CBT has been used in older adults and cancer patients separately but has not been empirically tailored for OACs and their caregivers. We offer our experience as a call for theoretically informed intervention tailoring that includes the voices of older adults and their caregivers. All data collection described was approved by

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the Institutional Review Boards of all participating sites; all research participants provided informed consent.

## Developing initial intervention materials

The intervention described in this paper, Managing Anxiety from Cancer (MAC) includes patient and caregiver workbooks and corresponding therapist manuals (Table 1). Development of the MAC materials was informed by the Contextual, Cohort-based, Maturity, Specific challenge model (CCMSC; Table 2)<sup>33,34</sup> and the Stage Model for Psychotherapy Manual Development (Stage Model; Table 3).<sup>35</sup> The CCMSC integrates principles from gerontology and psychotherapy to inform approaches with older adults. Stressors caused by cancer were integrated throughout CCMSC components. For example, people with cancer may have rational worries about the likelihood of death for which strategies from Acceptance and Commitment Therapy<sup>36,37</sup> are more appropriate than the traditional CBT technique of cognitive restructuring.<sup>31</sup>

The Stage Model informed the development of therapist manuals.<sup>35,38</sup> In the MAC manual, therapist instructions are embedded directly into the patient and caregiver workbooks, allowing therapists to view both simultaneously. An introductory chapter includes information on the rationale for the intervention, unique and essential elements of MAC, and comparison of MAC to other approaches. This chapter also provides information on the specific needs of OACs and their caregivers and strategies for meeting these needs (e.g., slower pace of therapy to account for normal cognitive changes).

## Obtaining stakeholder feedback on intervention materials

Following completion of the intervention materials, OACs (n=15), caregivers of OACs (n=8), and professionals conducting research and/or clinical practice with OACs (n=11) provided feedback on the materials in-person or over the telephone (patients and caregivers) or electronically (providers). Based on this feedback, significant changes were made including adding information on the simultaneous experience of cancer and aging (e.g., symptoms of cancer added to the burden of other age-related illnesses), challenges specific to caring for an OAC (e.g., OAC needs assistance with daily activities and travel to oncology appointments), and caregiver strategies for effective communication with an older adult (e.g., short sentences for older adults with memory impairment).

We also increased the focus on OACs' strengths and the importance of caregiver self-care. We added a section in which the OAC identifies areas of personal expertise and discusses strategies for applying this expertise to anxiety management. A "values and expertise check-in" was added to each session to facilitate the integration of these identified characteristics into MAC. For the caregiver intervention, we added information on the importance of self-care and strategies for improving self-care. A "self-care check-in" and between session self-care exercises were integrated into each session to support continuous caregiver self-care.

Stakeholders also recommended that MAC content be simplified and reduced. Modifications included replacing technical language with simpler terms (e.g., replacing "behavioral strategies" with "new actions"), removing the model of CBT for anxiety, eliminating

acronyms used to summarize multi-step techniques, and eliminating confusing content on different cognitions (e.g., thoughts about controllable versus uncontrollable stressors). The length of the intervention was reduced from seven to six sessions by removing problem-solving from the OAC intervention and willingness from the caregiver intervention. These sessions were removed because they do not include traditional CBT content (i.e., behavioral strategies and cognitive restructuring). Further, patients with cancer face many uncontrollable stressors (e.g., prognostic uncertainty) appropriate for willingness strategies (Acceptance and Commitment Therapy)<sup>39,40</sup> while caregivers often need to solve problems regarding OAC care (Problem-Solving Therapy).<sup>41,42</sup>

## Pre-post intervention evaluation

Patient-caregiver dyads (n=9) were then enrolled in a pre-post evaluation of the feasibility and acceptability of the modified intervention and study procedures. Eligible patients were 65 years of age or older with a diagnosis of cancer and a primary unpaid caregiver willing to participate. The patient and/or caregiver had a score of  $\geq 8$  on the Anxiety Subscale of the Hospital Anxiety and Depression Scale. Dyads were excluded if one or both members received CBT since the patient's diagnosis, the patient's anxiety was due solely to a medical procedure, or one member met diagnostic criteria for schizophrenia, substance or dependence, and/or bipolar disorder or endorsed active suicidal ideation.

Acceptability was assessed with questions assessing perceived helpfulness of MAC (1="not at all," 5="very"). The a priori benchmark for acceptability was defined as  $\geq 70\%$  of participants scoring rating the intervention as "moderately" to "very" helpful. The a priori benchmark for feasibility was defined as  $\geq 70\%$  of participants completing at least four of the six intervention sessions and post-intervention measures. The benchmark for acceptability was met with 100% of patients and caregivers reporting the intervention was moderately to very helpful. The benchmark for feasibility was also met with 89% of patients and 75% of caregivers completing all intervention sessions and post-intervention measures. Over three-quarters of the sample reported that intervention content was "not at all difficult" to understand (patients: 87.5%, caregivers: 80.0%), the intervention included the "right amount of information" (patients: 85.7%, caregivers: 100.0%), telephone delivery was acceptable (patients: 87.5%, caregivers: 100.0%), and session frequency (weekly) was acceptable (patients: 100%, caregivers: 100%).

Post-intervention, patients and caregivers were given a description of the session that was included in the workbook of the other dyad member but not in theirs and asked whether the content would have been helpful. Patients and caregivers indicated a preference for including the new material and all participants recommended the intervention be extended to seven sessions (patients: 100%, caregivers: 100%). Based on this feedback, the intervention was expanded to seven sessions with willingness and problem-solving techniques included in both workbooks.

## Lessons learned and conclusions

Extensive resources are required to conduct even a small randomized controlled trial. Utilizing theoretically-informed and rigorous methods to develop an intervention creates a strong foundation for future efficacy testing. We conclude with a description of the lessons learned from this process as they apply to OACs and their caregivers, the MAC intervention, and study methods.

### Population specific.

A component of MAC not included in standard CBT interventions is a focus on the dual stressors of cancer and aging. The degree to which OACs and their caregivers would resonate with this novel content was unclear. In fact, OACs and caregivers requested additional support for these dual stressors. Caregivers reported that the intervention did not adequately recognize the burden of caring for an OAC and requested additional strategies for managing this burden and improving self-care.

Stakeholders' resonance with the dual stressors of cancer and aging highlighted the importance of training interventionists in working with older adults. An intervention like MAC cannot provide comprehensive training in geriatric mental health. However, the interventionist manual and training procedures provide general information on characteristics and needs of older adults and their caregivers and strategies for addressing these needs. Given the shortage of mental health providers trained in geriatrics, this strategy may be a cost-effective and efficient method for increasing geriatric-specific mental health care.

Telephone-delivery was deliberately chosen to maximize OAC and caregiver access to MAC. OACs are often dealing with symptom burden from cancer and its treatment in addition to pre-existing co-morbidities associated with aging. OAC caregivers are often either older adults themselves or adult children caring for aging parents and dependent children. Further, cancer treatment requires numerous appointments; additional appointments for mental health services can be an obstacle to care. CBT delivered by telephone is efficacious for patients with cancer<sup>43-46</sup> and their caregivers<sup>47</sup> and improves psychotherapy access by reducing the time and travel burden associated with in-person appointments.

### Intervention specific.

A strength of MAC is the concurrent treatment of the OAC and caregiver by separate therapists. A preference for this structure emerged during stakeholder interviews and is one example of the benefit of including OACs and their caregivers in the intervention development process. However, this method creates challenges for data analysis, privacy, and feasibility. Specifically, a dyad was eligible for this study if the OAC or caregiver reported elevated anxiety. This method increased dyads' access to the study and the pool of eligible dyads but reduced the average baseline anxiety for each group and the amount of possible change pre-to-post intervention.

The purpose of providing separate therapists for the OAC and caregiver was to allow each dyad member to express concerns independent of their partner. However, this structure created questions about confidentiality across dyad members. To protect OACs' and caregivers' ability to express freely during sessions, we maintained confidentiality within each participant-therapist relationship. However, this strategy limited each therapist's understanding of the dyadic relationship and precluded direct intervention on relationship dynamics.

Finally, an intervention requiring two therapists requires more resources than interventions delivered by a single therapist. This characteristic may reduce feasibility and interfere with dissemination and implementation. In a larger efficacy trial, we will examine whether a dyadic approach improves outcomes or whether the OAC and caregiver versions of MAC can potentially be viewed as independent interventions.

Additional lessons learned included the importance of a comprehensive therapist manual that provides detailed session-specific instructions. This manual facilitated therapist training, increased therapist confidence, and allowed for clear criteria for intervention fidelity. Further, the manual provided a resource with which to train therapists in basic strategies for working with older adults. As with a patient workbook, developing the manual based on an established framework (e.g., Stage Model) enhanced the rigor and comprehensiveness of the manual.

### **Study methods.**

Pressure to complete a research project within a specified timeline can dissuade researchers from making iterative changes to an intervention. Modifying the intervention at multiple time points allowed us to capitalize on many stakeholder perspectives and resulted in a more focused and externally valid intervention. We modified MAC materials based on feedback from the study team, after receiving stakeholder feedback, and after the prepost examination of feasibility and acceptability. Maximizing opportunities to improve the intervention during early phases of development is important; changes are more difficult to make after initiating a large efficacy trial.

One limitation of our study methods was that stakeholders providing feedback on intervention content only reviewed three MAC sessions. This method limited their view of the flow and overall message of MAC but allowed us to obtain detailed feedback on each session while managing study burden. We considered providing participants with a summary of the entire intervention rather than the actual intervention materials. In hindsight, this would have been problematic. OACs and their caregivers are generally unfamiliar with psychotherapy. Providing the actual MAC materials eliminated the need for prior knowledge and provided a direct view of intervention content, format, and structure.

### **Conclusion.**

We present an intervention development process designed to promote evidence-based and theory-driven intervention development. Medical oncology tailored assessments for OACs with the Comprehensive Geriatric Assessment. Psychosocial oncology should consider the

particular needs of OACs and their caregivers in the development of psychosocial interventions informed by fields such as gerontology and geriatric clinical psychology.

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## References

1. Wildiers H, Heeren P, Puts M, et al. International Society of Geriatric Oncology consensus on geriatric assessment in older patients with cancer. *J Clin Oncol*. 2014;32:2595–2603. [PubMed: 25071125]
2. Hurria A, Wildes T, Blair SL, et al. Senior adult oncology, Version 2.2014: Clinical practice guidelines in oncology. *J Natl Compr Canc Netw*. 2014;12:82–126. [PubMed: 24453295]
3. Shahrokni A, Kim SJ, Bosl GJ, Korc-Grodzicki B. How we care for an older patient with cancer. *Journal of Oncology Practice*. 2017;13:95–102. [PubMed: 28972834]
4. Gajra A, Loh KP, Hurria A, et al. Comprehensive geriatric assessment-guided therapy does improve outcomes of older patients with advanced lung cancer. *J Clin Oncol*. 2016;34:4047–4048. [PubMed: 27551131]
5. Mohile SG, Epstein RM, Hurria A, et al. Improving communication with older patients with cancer using geriatric assessment (GA): A University of Rochester NCI Community Oncology Research Program (NCORP) cluster randomized controlled trial (CRCT). 2018;36\_suppl, LBA10003–LBA10003.
6. Hurria A, Akiba C, Kim J, et al. Reliability, validity, and feasibility of a computer-based geriatric assessment for older adults with cancer. *Journal of Oncology Practice*. 2016;12:e1025–e1034. [PubMed: 27624950]
7. Hurria A, Li D, Hansen K, et al. Distress in older patients with cancer. *J Clin Oncol*. 2009;27:4346–4351. [PubMed: 19652074]
8. Canoui-Poitrine F, Reinald N, Laurent M, et al. Geriatric assessment findings independently associated with clinical depression in 1092 older patients with cancer: The ELCAPA cohort study. *Psychooncology*. 2016;25:104–111. [PubMed: 26123351]
9. Nelson CJ, Balk EM, Roth AJ. Distress, anxiety, depression, and emotional well-being in African-American men with prostate cancer. *Psychooncology*. 2010;19:1052–1060. [PubMed: 20077499]
10. Miovic M, Block S. Psychiatric disorders in advanced cancer. *Cancer*. 2007; 110:1665–1676. [PubMed: 17847017]
11. Kasparian NA, McLoone JK, Butow PN. Psychological responses and coping strategies among patients with malignant melanoma: A systematic review of the literature. *Arch Dermatol*. 2009;145:1415–1427. [PubMed: 20026852]
12. Teunissen SC, de Haes HC, Voest EE, de Graeff A. Does age matter in palliative care? *Critical Reviews in Oncology/hHematology*. 2006;60:152–158.
13. Brown LF, Kroenke K. Cancer-related fatigue and its associations with depression and anxiety: A systematic review. *Psychosomatics*. 2009;50:440–447. [PubMed: 19855028]
14. Delgado-Guay M, Parsons HA, Li Z, Palmer JL, Bruera E. Symptom distress in advanced cancer patients with anxiety and depression in the palliative care setting. *Support Care Cancer*. 2009;17:573–579. [PubMed: 19005686]
15. Reddy SK, Parsons HA, Elsayem A, Palmer JL, Bruera E. Characteristics and correlates of dyspnea in patients with advanced cancer. *J Palliat Med*. 2009;12:29–36. [PubMed: 19284260]
16. Salvo N, Zeng L, Zhang L, et al. Frequency of reporting and predictive factors for anxiety and depression in patients with advanced cancer. *Clin Oncol*. 2012;24:139–148.

17. Bruera E, Schmitz B, Pither J, Neumann CM, Hanson J. The frequency and correlates of dyspnea in patients with advanced cancer. *J Pain Symptom Manage*. 2000;19:357–362. [PubMed: 10869876]
18. Horney DJ, Smith HE, McGurk M, et al. Associations between quality of life, coping styles, optimism, and anxiety and depression in pretreatment patients with head and neck cancer. *Head Neck*. 2011;33:65–71. [PubMed: 20848428]
19. Smith EM, Gomm SA, Dickens CM. Assessing the independent contribution to quality of life from anxiety and depression in patients with advanced cancer. *Palliat Med*. 2003;17:509–513. [PubMed: 14526884]
20. Fujii M, Ohno Y, Tokumaru Y, et al. Manifest Anxiety Scale for evaluation of effects of granisetron in chemotherapy with CDDP and 5FU for head and neck cancer. *Support Care Cancer*. 2001;9:366–371. [PubMed: 11497391]
21. Pedersen AE, Sawatzky JA, Hack TF. The sequelae of anxiety in breast cancer: A human response to illness model. *Oncol Nurs Forum*. 2010;37:469–475. [PubMed: 20591806]
22. Greer JA, Pirl WF, Park ER, Lynch TJ, Temel JS. Behavioral and psychological predictors of chemotherapy adherence in patients with advanced non-small cell lung cancer. *J Psychosom Res*. 2008;65:549–552. [PubMed: 19027443]
23. Schag CA, Heinrich RL. Anxiety in medical situations: Adult cancer patients. *Journal of Clinical Psychology*. 1989;45:20–27. [PubMed: 2925881]
24. Balentine CJ, Hermosillo-Rodriguez J, Robinson CN, Berger DH, Naik AD. Depression is associated with prolonged and complicated recovery following colorectal surgery. *Journal of Gastrointestinal Surgery*. 2011;15:1712–1717. [PubMed: 21786060]
25. Prieto JM, Blanch J, Atala J, et al. Psychiatric morbidity and impact on hospital length of stay among hematologic cancer patients receiving stem-cell transplantation. *Journal of Clinical Oncology*. 2002;20:1907–1917. [PubMed: 11919251]
26. Mausbach BT, Irwin SA. Depression and healthcare service utilization in patients with cancer. *Psychooncology*. 2017;26:1133–1139. [PubMed: 27102731]
27. Jayadevappa R, Malkowicz SB, Chhatre S, Johnson JC, Gallo JJ. The burden of depression in prostate cancer. *Psychooncology*. 2012;21:1338–1345. [PubMed: 21837637]
28. Cannon AJ, Darrington DL, Reed EC, Loberiza FR Jr., Spirituality, patients' worry, and follow-up health-care utilization among cancer survivors. *J Support Oncol*. 2011;9:141–148. [PubMed: 21809519]
29. Giese-Davis J, Collie K, Rancourt KM, Neri E, Kraemer HC, Spiegel D. Decrease in depression symptoms is associated with longer survival in patients with metastatic breast cancer: A secondary analysis. *J Clin Oncol*. 2011;29:413–420. [PubMed: 21149651]
30. Satin JR, Linden W, Phillips MJ. Depression as a predictor of disease progression and mortality in cancer patients: a meta-analysis. *Cancer*. 2009;115:5349–5361. [PubMed: 19753617]
31. Mooney SG. *Cognitive Behaviour Therapy for People with Cancer*. New York: Oxford University Press; 2002.
32. Freeman A. *Clinical Applications of Cognitive Therapy*. Springer Science & Business Media; 2004.
33. Knight BG, McCallum TJ. Adapting psychotherapeutic practice for older clients: Implications of the contextual, cohort-based, maturity, specific challenge model. *Professional Psychology: Research and Practice*. 1998;29:15–22.
34. Kropf N, Cummings SM, Cummings S. *Evidence-Based Treatment with Older Adults: Theory, Practice, and Research*. Oxford University Press; 2017.
35. Carroll KM, Nuro KF. One size cannot fit all: A stage model for psychotherapy manual development. *Clinical Psychology: Science and Practice*. 2002;9:396–406.
36. Hayes SC, Levin ME, Plumb-Villardaga J, Villatte JL, Pistorello J. Acceptance and commitment therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behav Ther*. 2013;44:180–198. [PubMed: 23611068]
37. Hayes SC, Lillis J. *Acceptance and Commitment Therapy*. Washington, DC: American Psychological Association; 2012.

38. Onken LS, Blaine JD, Battjes RJ. Behavioral therapy research: A conceptualization of a process In: *Innovative approaches for difficult-to-treat populations*. Arlington, VA, US: American Psychiatric Association; 1997:477–485.
39. Mojtabaie M, Gholamhosseini S. Effectiveness of Acceptance and Commitment Therapy (ACT) to reduce the symptoms of anxiety in women with breast cancer. *J Social Issues Human*. 2014;4:522–527.
40. Hayes SC, Strosahl KD, Wilson KG. *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change*. New York: The Guilford Press; 2003.
41. Alexopoulos GS, Raue PJ, Kiosses DN, et al. Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction: Effect on disability. *Archives of General Psychiatry*. 2011;68:33–41. [PubMed: 21199963]
42. Kiosses DN, Areal PA, Teri L, Alexopoulos GS. Home-delivered problem adaptation therapy (PATH) for depressed, cognitively impaired, disabled elders: A preliminary study. *Am J Geriatr Psychiatry*. 2010;18:988–998. [PubMed: 20808092]
43. DuHamel KN, Mosher CE, Winkel G, et al. Randomized clinical trial of telephone- administered cognitive-behavioral therapy to reduce post-traumatic stress disorder and distress symptoms after hematopoietic stem-cell transplantation. *Journal of Clinical Oncology*. 2010;28:3754–3761. [PubMed: 20625129]
44. Hawkes AL, Pakenham KI, Chambers SK, Patrao TA, Courneya KS. Effects of a multiple health behavior change intervention for colorectal cancer survivors on psychosocial outcomes and quality of life: A randomized controlled trial. *Annals of Behavioral Medicine*. 2014;48:359–370. [PubMed: 24722960]
45. Hegel MT, Lyons KD, Hull JG, et al. Feasibility study of a randomized controlled trial of a telephone-delivered problem-solving-occupational therapy intervention to reduce participation restrictions in rural breast cancer survivors undergoing chemotherapy. *Psychooncology*. 2010;20:1092–1101. [PubMed: 20821373]
46. Marcus AC, Garrett KM, Cella D, et al. Can telephone counseling post-treatment improve psychosocial outcomes among early stage breast cancer survivors? *Psychooncology*. 2010;19:923–932. [PubMed: 19941285]
47. Campbell LC, Keefe FJ, Scipio C, et al. Facilitating research participation and improving quality of life for African American prostate cancer survivors and their intimate partners: A pilot study of telephone-based coping skills training. *Cancer*. 2007;109:414–424. [PubMed: 17173280]



**Table 1.**

## MAC content by session

Session	Content
Session 1: Introduction	<ul style="list-style-type: none"> <li>• Overview of MAC structure and content</li> <li>• Psychoeducation on anxiety</li> <li>• Anxiety symptoms and triggers</li> <li>• Cancer in older adulthood (patients only)</li> <li>• Caring for an OAC (caregivers only)</li> <li>• Personal strengths and values (patients only)</li> <li>• Self-care information and planning (caregivers only)</li> </ul>
Session 2: New Actions	<ul style="list-style-type: none"> <li>• Deep breathing</li> <li>• Guided imagery</li> <li>• Muscle relaxation</li> <li>• Mindfulness</li> <li>• Activity planning (patients only)</li> </ul>
Session 3: New Thoughts	<ul style="list-style-type: none"> <li>• Identify irrational thoughts</li> <li>• Develop new ways of thinking</li> <li>• Apply new thoughts to daily life</li> </ul>
Session 4: Communicating Well	<ul style="list-style-type: none"> <li>• Assertive communication techniques (I-Statements)</li> <li>• Communicating with your loved one</li> <li>• Communicating with family and friends</li> <li>• Asking for what you need</li> <li>• Communicating with the medical team</li> <li>• Communicating about treatment decisions</li> </ul>
Session 5: Problem-Solving	<ul style="list-style-type: none"> <li>• Select a problem</li> <li>• Choose a solution to try</li> <li>• Create a plan</li> <li>• Follow the plan</li> <li>• Decide if the plan worked</li> </ul>
Session 6: Willingness (Acceptance)	<ul style="list-style-type: none"> <li>• Problem with trying to control emotions</li> <li>• Define willingness</li> <li>• Three steps to willingness (notice, imagine, allow)</li> </ul>
Session 7: Planning for the Future	<ul style="list-style-type: none"> <li>• Review effective MAC skills</li> <li>• Make a plan for managing future anxiety</li> </ul>

**Table 2.**

Application of the CCMSC model to intervention materials

Domain	Components	Intervention Characteristics
Contextual	<ul style="list-style-type: none"> <li>• Interdisciplinary medical context</li> <li>• Caregivers may play a large role in patient care</li> <li>• Patient and caregiver distress interdependent</li> <li>• Shrinking social networks</li> </ul>	<ul style="list-style-type: none"> <li>• Teaches strategies for effective communication</li> <li>• Teaches strategies for communicating with the medical team</li> <li>• Treatment of caregiver distress</li> <li>• Includes strategies for increasing social interactions</li> </ul>
Cohort-based	<ul style="list-style-type: none"> <li>• Lower levels of education</li> <li>• Less familiar with psychotherapy</li> <li>• Greater stigma toward psychotherapy</li> <li>• Paternalistic view of medical providers</li> </ul>	<ul style="list-style-type: none"> <li>• Manual uses simple language and case examples</li> <li>• Provides basic information on psychotherapy</li> <li>• Normalizes anxiety in the context of cancer</li> <li>• Uses a collaborative model between patient and therapist</li> </ul>
Maturity	<ul style="list-style-type: none"> <li>• Cognitive slowing</li> <li>• Slower processing speed</li> <li>• Memory impairment</li> <li>• Expertise and values developed over a lifetime</li> </ul>	<ul style="list-style-type: none"> <li>• Information is presented in small pieces</li> <li>• Therapy proceeds at a slower pace</li> <li>• Material presented visually and orally</li> <li>• Teaching aids used (e.g., binders, worksheets)</li> <li>• Between session exercises to promote repetition</li> <li>• Review prior session content to “bridge” sessions</li> <li>• Integrates personal values and expertise</li> <li>• Utilizes individual strengths to manage anxiety</li> </ul>
Specific challenge	<ul style="list-style-type: none"> <li>• Reduced mobility</li> <li>• Sensory impairment</li> <li>• Lower energy levels</li> <li>• Cancer diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Telephone-delivered sessions</li> <li>• Manual is easy to read</li> <li>• Sessions focus on the most important elements</li> <li>• Content addresses unique stressors caused by cancer (e.g., prognostic uncertainty, rational thoughts about death)</li> </ul>

**Table 3.**

Application of the Stage Model for Psychotherapy Manual Development to the MAC interventionist manual

Section	MAC Interventionist Manual
Overview, description, rationale	<ul style="list-style-type: none"> <li>• Overview of the goal, theoretical rationale, and structure of MAC</li> <li>• Treatment rationale: Large number of older adults with cancer; High prevalence and under-treatment of anxiety</li> </ul>
Conception of the problem	<ul style="list-style-type: none"> <li>• Description of behaviors and cognitions that drive anxiety</li> <li>• Overview of cognitive behavior therapy</li> <li>• Description of additional techniques: Communication strategies, Problem solving, Acceptance</li> <li>• Application of the CCMSC to MAC</li> <li>• Description of patient/caregiver as primary agent of change</li> </ul>
Treatment goals	<ul style="list-style-type: none"> <li>• Primary goal: Improve patient/caregiver ability to manage anxiety</li> <li>• Secondary goals: Improve patient/caregiver communication and problem-solving skills, ability to accept uncontrollable situations, and relationship quality</li> </ul>
Contrast to other approaches	<ul style="list-style-type: none"> <li>• Similarities/differences from traditional CBT</li> <li>• Description of modifications for older adults and their caregivers</li> <li>• Difference from supportive psychotherapy and psychoanalytic treatment</li> </ul>
Specification of defining interventions	<ul style="list-style-type: none"> <li>• Unique/essential: Coping with cancer and aging, cancer and aging caregiving issues, interventionist education in working with older adults</li> <li>• Essential/not unique: Strong rapport, plan for between session exercises</li> <li>• Acceptable/not necessary: Informal conversation (“chatting”), appropriate clinician self-disclosure</li> <li>• Elements to avoid: Extensive reminiscing, exploration of unconscious processes or defense mechanisms</li> </ul>
Session content	<ul style="list-style-type: none"> <li>• Therapist instructions specific to session content</li> </ul>
General format	<ul style="list-style-type: none"> <li>• Delivered individually over the telephone</li> <li>• Seven weekly sessions, 45–50 minutes each</li> <li>• Limited flexibility across session</li> <li>• Consistent session format: Session plan, review of prior session, new information, take home messages, practice plan, worksheets</li> </ul>

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