Although distress is common among people with cancer, the current standard of care does not include consistent distress screening. To acquire or maintain accreditation, the American College of Surgeons Commission on Cancer will require cancer centers to have a distress screening program in place by 2015. When evaluating tools to screen for distress in patients with cancer, researchers should evaluate the literature to ascertain that tools have been tested for validity and reliability in the population of patients with cancer. Regardless of the distress screening tool chosen, studies support that screening patients for distress is beneficial to improving quality of life and outcomes by allowing for referral to appropriate interventions.

Distress Screening

People with lung, brain, and pancreatic cancers are most likely to suffer distress; however, differences in psychological distress by cancer type are small (Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). People with advanced cancer and poor prognosis may be at greater risk for distress (Holland & Alici, 2010). Patients with cancer who have a history of psychiatric disorders, substance abuse, and depression are also at an increased risk for suffering distress (National Comprehensive Cancer Network [NCCN], 2013). Long-term symptoms such as cognitive impairment, fatigue, pain, and anxiety can cause distress in people long after cancer treatments are completed (Zabora, BrintzenhofeSzoc, Curbow, et al., 2001).

Time constraints on healthcare professionals are the main issues cited as contributing to the infrequent use of distress screening questionnaires or tools in cancer care (Schofield, Carey, Bonevski, & Sanson-Fisher, 2006). In addition, knowledge deficit and lack of understanding of psychological distress evaluation may, to some extent, account for the infrequent use of distress screening (Vodermaier, Linden, & Siu, 2009). Other personal and professional obstacles in the use of psychological distress tools may include beliefs, values, and assumptions (Schofield et al., 2006). These barriers are often conveyed in the opinion that screening is pointless or is beyond what can be addressed or capably treated in a cancer care setting (IOM, 2008; Jacobsen & Ransom, 2007; Schofield et al. 2006).