



Screening and Evidence-Based Interventions for Distress in Patients With Cancer: Nurses Must Lead the Way

Oncology nurses have known for a long time that survivorship can be wrought with psychological and physical effects for both the patient and family from the time of diagnosis onward. We all have worked with patients who seem to be in significant distress—some patients may be teary eyed, confused, perhaps angry, or even withdrawn. And we also have worked with patients who seem to manage everything with little outward indication of distress. Every patient is different, with each individual possessing his or her own coping mechanisms. But one thing is true, cancer takes an emotional toll on the patient and their caregivers. This emotional toll deserves better focus and oncology nurses are in a perfect position to do something about it.

The American College of Surgeons Commission on Cancer (CoC) will require routine screening of psychological distress for all patients with cancer beginning in 2015 (American College of Surgeons, 2012). If a hospital or other healthcare organization seeks accreditation in 2015 and beyond, they will need to show evidence of distress screening (see Figure 1). Therefore, many nurses and cancer committees are working to implement a psychological distress screening assessment for patients with cancer coupled with a program to offer evidence-based interventions for those patients with moderate-to-severe distress.

Background

More than 12 million cancer survivors (Parry, Kent, Mariotto, Alfano, & Rowland, 2011) are living in the United States. Research suggests that 20%–40% of survivors experienced high levels of distress during their treatment (Holland & Alici, 2010).

Many of those patients likely never had their distress assessed or treated, potentially creating an even longer and more complex cancer experience. Distress can present itself anywhere along the cancer trajectory, whether it be on the day of diagnosis, on the first day of treatment, or other times throughout the cancer continuum.

I recall caring for a woman who was receiving standard doxorubicin and cyclophosphamide for her breast cancer treatment. It was during that morning, when I was administering her first chemotherapy treatment, that she began to cry softly and continued throughout the entire treatment. As I assessed her and attempted to get to the bottom of what was making her cry, she began to open up to me and what I learned was simply mind boggling. The patient had fears of hair loss, nausea and vomiting, and of her own mortality, but she also was worried about her family's financial well-being given that she was the sole financial support for her and her children. She also verbalized distress related to spirituality and a fear that her illness could genetically be passed to her young daughters. That was 20 years ago when no assessment tools were in place to help the healthcare team evaluate patients for distress. I can't help thinking how much things have changed—distress screening tools are now available to help nurses and other healthcare providers focus on those issues that commonly cause distress for patients. Still, we have a long way to go.

Assessment Needs

Without objective assessments, healthcare professionals tend to underestimate psychological distress (Fallowfield, Ratcliffe, Jenkins, & Saul, 2001). Tavernier, Beck, and Dudley (2013) found that only

30% of oncology nurses used an assessment tool for distress in their clinical practices. Laugsand et al. (2010) found that healthcare providers underestimated the prevalence of symptoms when compared respectively to patients' ratings of the same symptoms, such as pain (67% versus 47%), poor sleep (32% versus 21%), depression (31% versus 17%), and fatigue (71% versus 54%). Therefore, the first step is implementing a consistent distress screening program.

Nurses have a unique opportunity to push toward more thorough distress assessment and care for patients along the cancer trajectory. The cancer medical team has been successful in assessing patients for symptoms related to cancer and its treatment. We are even far enough along in the research of symptom clusters to know that several symptoms occur simultaneously and often are related to each other (Kim, McGuire, Tulman, & Barsevick, 2005). Research has suggested that the symptoms of pain, fatigue, and sleep disturbance are commonly associated (Beck, Dudley, & Barsevick, 2005). Therefore, we know about symptoms and their relationships with each other; however, we know less about how and to what extent these symptoms cause psychological distress.

Reliable and valid tools are available for the assessment of psychological distress, such as the Hospital Anxiety and Depression Scale (14 questions) (Zigmond & Snaith, 1983), the National Comprehensive Cancer Network distress thermometer (one question) (Holland & Bultz, 2007), and the Psychological Distress Inventory (13 questions) (Morasso, Costantini, Baracco, Borreani, & Capelli, 1996). According to Mitchell (2011), if the choice of selecting a short screening tool for distress is based on acceptability

or cost-effectiveness, then the evidence supports the use of the distress thermometer, which has a single assessment question. The CoC requires that the patient be assessed a minimum of one time for distress, preferably during a pivotal medical appointment, such as the time of diagnosis or during discussions of treatment. However, it may be imperative to assess a patient for psychological distress

several times throughout their treatment and into survivorship.

Sixth Vital Sign

Some healthcare providers think that distress should become the sixth vital sign along with pulse, temperature, respirations, blood pressure, and pain. The International Psycho-Oncology Society (2013) is leading a charge to make screening for distress the sixth vital sign. Numerous cancer organizations, such as the Union of International Cancer Control and the Canadian Association of Nurses in Oncology, have joined the movement.

In keeping with the vision of the Oncology Nursing Society ([ONS], n.d.) of leading the transformation of cancer care, transformation can not happen for patients with cancer until we have a more robust assessment of psychological distress and be ultimately prepared with effective interventions to help them manage moderate and higher levels of distress. ONS, along with the American Psychosocial Oncology Society and the Association of Oncology Social Workers, developed a joint position statement on implementing psychosocial distress screening for patients undergoing cancer treatment (ONS, 2013). This position statement identifies numerous members of the oncology healthcare team who are willing to work together to identify psychological stress and do something about it.

It is the author's opinion that making distress the sixth vital sign is irrelevant. We should, instead, look at distress beyond a number and begin thinking about what we plan to do about patients' distress. The CoC requires that, for patients with moderate or severe distress, psychosocial services should be offered on site or by referral. Evidence-based interventions are available and should be used to help patients deal with psychological distress. What good will come from assessing patients for distress without being prepared to provide assistance through evidence-based interventions?

Supplement Direction

This section of the supplementary publication to the *Clinical Journal of Oncology Nursing (CJON)* was prepared to deliver information about how to implement a distress-screening tool. In the

first article, Susan Tavernier, PhD, APRN-CNS, AOCN®, provides a discussion of the validity of the distress thermometer along with evidence-based interventions for patients with distress. In the second article, Karen Hammelef, DNP, RN, and colleagues provide an article on their experience of implementing the distress thermometer throughout their organization. Hammelef's article is important because it shares the first-hand experience of implementing a screening tool for distress along with a discussion about the barriers and facilitators of the process.

The cancer community clearly is progressing toward understanding that patients with cancer experience distress that makes their journey even more difficult. We are now positioned at a precipice where we must find a tool that validly assesses patients with distress, and we must follow that assessment with interventions based in evidence. Oncology nurses have a responsibility to lead the journey beyond the precipice for our patients. This portion of the *CJON* supplement begins that conversation and invites you to make progress in identifying and managing psychological distress in the oncology population.

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Process Requirements

- **Timing of screening:** Patients with cancer are offered screening for distress a minimum of one time per patient at a pivotal medical visit to be determined by the program.
- **Method:** The mode of administration is to be determined by the program.
- **Tools:** Facilities select the tool to be administered to screen for current distress. Preference is given to standardized, validated instruments with established clinical cutoffs; however, facilities may use a measure of their choice. Facilities are encouraged to use established clinical cutoffs when possible; however, facilities may determine the cutoff score used to identify distressed patients.
- **Assessment and referral:** If there is clinical evidence of moderate or severe distress, the patient's oncology team (oncologist, nurse, social worker, and/or psychologist) is to "identify and examine the psychological, behavioral and social problems of patients that interfere with their ability to participate fully in their health care and manage their illness and its consequences." This evaluation will confirm the presence of physical, psychological, social, spiritual, and financial support needs and indicate the need to link patients with psychosocial services offered on-site or by referral.
- **Documentation:** Screening, referral or provision of care, and follow-up are documented in the patient medical record to facilitate integrated, high-quality care.

FIGURE 1. Commission on Cancer Standard 3.2 Psychosocial Distress Screening

Note. From "Cancer Program Standards 2012: Ensuring Patient-Centered Care (version 1.2) Standard 3.2," by the American College of Surgeons, 2012. Retrieved from <http://facs.org/cancer/coc/programstandards2012.pdf>. Copyright 2012 by American College of Surgeons. Reprinted with permission.

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Key words: distress; psychosocial aspects; quality improvement

Digital Object Identifier: 10.1188/14.CJON.S1.23-25