Nursing Expertise and the Evaluation of Psychosocial Distress in Patients With Cancer and Survivors

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The number of cancer survivors in the United States will continue to grow because of improved screening, early detection practices, and advances in treatment. The cancer experience has a significant impact on the patient and his or her family, which increases the risk for psychosocial distress. Untreated distress experienced by a patient with cancer contributes to poorer treatment adherence, medical outcomes, and quality of life. To provide high-quality, safe patient care, oncology nurses must increase clinical expertise and knowledge. The current article provides an overview of clinical tools available for nurses to use when screening for distress in patients throughout the cancer care continuum.

About 35%–43% of patients with cancer experience psychological distress, depending on the cancer site or stage of disease (Holland & Alici, 2010). Evidence also suggests that a large percentage of this group are not referred or treated for the distress (Cohen, 2013). The lack of treatment for distress may undermine patients' coping abilities, compromise treatment decisions, and result in poor quality of life for patients and their families. In addition, untreated distress can contribute to decreased treatment adherence, poorer medical outcomes, prolonged rehabilitation, and higher healthcare costs (Abrahamson, 2010; Mitchell, Vahabzadeh, & Magruder, 2011).

Psychological distress, as defined by the National Comprehensive Cancer Network ([NCCN], 2013), is an emotionally unpleasant experience of a cognitive, behavioral, emotional, social, or spiritual nature, which may inhibit a person’s ability to manage a cancer diagnosis, its physical symptoms, and its treatment. Symptoms experienced by cancer survivors include increased levels of global psychological distress, difficulty returning to work, psychosexual concerns, and increased psychiatric morbidity (Alter et al., 1996). Research indicates the patient’s ability, willingness, and opportunity to express concerns may influence his or her adjustment to stressors associated with cancer (Jensen-Johansen et al., 2013).

Accurate assessment of distress in patients with cancer is challenging because symptoms of distress may be hard to distinguish from disease symptoms and treatment side effects (Ryan et al., 2005). The importance of screening for distress is supported by the campaign to view it as the sixth vital sign (in addition to pulse, respiration, blood pressure, temperature, and pain), which must be monitored throughout the cancer trajectory (Bultz & Carlson, 2006; Bultz & Johansen, 2011).

Several professional oncology organizations (i.e., American Psychosocial Oncology Society, Association of Oncology Social Work, and Oncology Nursing Society) have banded together to support implementation of the Commission on Cancer’s (COC’s) new accreditation criterion for cancer centers to implement screening programs for psychosocial distress (Pirl et al., 2014). The joint task force has identified critical aspects necessary to effectively meet the COC mandate, such as timing, method, tools, assessment or referral, and documentation of screening. Despite the growing recognition of the significant impact cancer has on the emotional health of patients and their families, integration of distress screening into routine practice continues to be a challenge. For example, patients or their families are often reluctant to discuss psychological issues with healthcare providers. This reluctance may stem from concerns about bothering the provider or being stigmatized for having an emotional problem (Graves et al., 2007). Psychological symptoms may be missed or ignored because of lack of time for assessment, providers’ inexperience in dealing with psychosocial concerns, or inadequate knowledge of resources for patients (Graves et al., 2007).

Distress Screening Tools

Various stress-measurement screening tools are available to identify patients who can benefit from intervention for distress (see Figure 1). The Distress Thermometer is a tool currently recommended by the NCCN for its effectiveness in identifying distress and efficiency of use (Holland et
The tool is user friendly and consists of a vertical thermometer diagram on which patients rate their level of distress on a scale ranging from 0–10, with 0 indicating no distress and 10 indicating extreme distress. It also includes a short problem list for patients to identify areas of concern, such as child care, housing, spiritual concerns, or physical symptoms (e.g., insomnia, fatigue, appetite or weight changes, headaches). When using the single-item Distress Thermometer, a score of 4 or greater has been established as the cutoff point, indicating moderate to severe distress that would suggest the need for referral to appropriate interventions (Jacobsen, 2007). Limitations associated with the brief tool include lack of specificity, ceiling effects (particularly in patients with end-stage disease or poor prognosis), and a lack of sensitivity to incremental increases in distress in patients who start at a high level (Jacobsen, 2007; Skoan et al., 2006). In addition, once a numerical stress score is established, nurses have difficulty equating the numerical score to the warranted level and timing of the intervention. Distress levels also fluctuate over the course of cancer care. Levels are generally high at the beginning of treatment and can climb again at the end of therapy, contributing to less diagnosis of distress and lack of intervention (Abrahamson, 2010).

A licensed, evidence-based psychosocial distress screening program, CancerSupportSourceSM (CSS), is also a resource for patients under stress. This affordable electronic system, originally developed by the Cancer Support Community, integrates screening, referral, and follow-up care. Patients complete an electronic assessment questionnaire to identify their needs, and the program automatically scores their responses. This instrument includes a validated four-item depression subscale that alerts clinicians to the need for a clinical follow-up assessment (Buzaglo et al., 2014). Patient and clinician reports are generated based on the individual's needs. The clinician summary report includes a summary of the patient’s results, red flags indicating that follow-up is warranted. The summary is automatically emailed directly to the healthcare team and, when applicable, is included in the electronic medical record. Patients are provided tailored, automated referrals to support resources and follow-up care. The CSS has been validated with survivors living in community settings (Miller, Mullins, Onukwugha, Golant, & Buzaglo, 2014). The Cancer Support Community also offers free screening assessments for patients.

**Therapeutic Presence**

Nurses spend more time with patients than any other member of the healthcare team. The scope and standards of oncology nursing practice prepare nurses to collect in-depth data regarding the “physical, psychosocial, social, spiritual, and cultural health status of patients” (Brant & Wickham, 2013, p. 21). Through academic preparation and clinical training, oncology nurses possess the specialized skills and knowledge needed to assess a patient’s distress and to form a tailored plan of care to alleviate distress (Kwekkeboom & Seng, 2002). In addition, research suggests barriers related to patients’ reluctance in reporting distress include the perception that physicians are too busy or do not have the skills needed to address emotional concerns (Mosher et al., 2014). Empirical evidence suggests physicians often do not recognize nonverbal distress signals, which contributes to ineffective management of distress (Abrahamson, 2010; Ryan et al., 2005).

Margaret Newman’s Theory of Nursing Presence emphasizes the transformative nature of the nurse and patient relationship by “helping people recognize the meaning of their lives when disease occurs” (Newman, 2008, p. 2). In the patient and nurse relationship, the nurse can choose to become involved in the patient’s cancer experience when the patient allows the nurse to share in the experience. The nurse can then be focused and involved with the patient. This shared experience can lead to growth, transformation, and healing in the patient and the nurse (Koerner, 2011; Newman, 2008). A nurse’s initial response to a patient’s report of distress and anxiety will help to guide a more detailed assessment of his or her concerns and initiate appropriate management to address his or her needs (Sheldon, Swanson, Dolce, Marsh, & Summers, 2008).

**Implications for Practice and Conclusions**

Nurses can use the screening tools and guideline presented in the current article to identify and initiate further assessment of psychosocial symptoms. The Distress Thermometer and the problem checklist can be used by nurses to gather information and assess the severity of distress. Nurses can intervene by enhancing their professional knowledge of appropriate interventions to alleviate stress. Nurses can share information on the most common symptoms associated with cancer treatment and medications; discuss benefits of interventions such as relaxation, meditation, or exercise; and make referrals to community-based resources, such as support groups or other psychosocial services (Vitek, Rosenzweig, & Stollings, 2007). For patients who have been identified as having a moderate to high level of distress, nurses should notify the healthcare team and request appropriate referrals within the institution (e.g., social work, chaplaincy, psycho-oncology). If patients are unable to access institutional services, nurses can locate psychosocial services in the patient’s community using online services from professional organizations.
organizations, such as the American Psychosocial Oncology Society and the American Psychological Association. Nurses can also educate patients and their families on how to use adaptive coping mechanisms, such as deep breathing, mindfulness, and other self-management exercises, to decrease distress (Chase, 2013).

Nurses are challenged with caring for more patients in an outpatient setting as advances in medicine and technology improve early diagnosis and increase the number of cancer survivors. The prevalence of psychosocial distress in patients with cancer has been shown to be greater than 50% (Holland & Alici, 2010). This percentage may be underestimated, given the current lack of screening for distress at the time of diagnosis and during the cancer experience. Distress screening is an evidence-based approach to assess patients and families for psychosocial distress and need for intervention. As part of professional practice, oncology nurses must increase their skills and knowledge in screening for psychosocial distress in patients, survivors, and their families. Nurses who understand and acknowledge the trauma of a cancer diagnosis can help improve a patient's quality of life.

References

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