Due to early detection and improvements in treatment, cancer is considered chronic. Patients may experience long periods of remission intermingled with periods of metastatic disease. It is not uncommon for patients with chronic disease to experience distress. This “multifactorial, unpleasant emotional experience of psychological (cognitive, behavioral, emotional) social and or spiritual nature may interfere with the ability to cope effectively with cancer, its symptoms and treatment” (National Comprehensive Cancer Network [NCCN], 2014, p. 2).

Distress is nonselective and occurs at any point along the disease trajectory. Prevalence varies by the type of cancer, but the risk for distress is greatest with advanced disease and poor prognosis. Comorbidities of cancer (diabetes, congestive heart disease, chronic obstructive pulmonary disease, and cerebrovascular disease) can exacerbate distress and create challenges for treatment (Petty & Lester, 2014). Untreated distress has been linked to poor decision making, decreased coping and quality of life, nonadherence with treatment, poor clinical outcomes, and increased length of stay and health care costs (Mitchell, Vahabzadeh, & Magruder, 2011). However, distress assessment of cancer patients admitted to both dedicated oncology and general medical surgical units is not a common practice.

In a sample of 4,500 patients diagnosed with the most common cancers, researchers estimated that 35% to 43% experienced psychosocial distress (Holland et al., 2013). Despite these findings, others report that a large portion of patients are not screened, referred, or treated for distress (Holland et al., 2013). Holland et al. (2013) reported that barriers to distress screening have been attributed to both patients and providers. Patients frequently do not disclose distress due to the stigmas associated with emotional illness and the diagnosis of cancer. In contrast, oncology clinicians, including nurses, tend to focus on the physical aspects of patient care and may be unfamiliar with valid and reliable tools to screen and assess patient distress. Although the NCCN guidelines (2014) advocate that all patients with cancer have a multidisciplinary distress assessment, integration of such assessment into routine practice remains a challenge. Specific to this challenge is the lack of comprehensive, yet pragmatic, assessment tools. Instruments used in research are not always amendable to use in daily practice, and those that are available may not assess the global constructs associated with distress. Therefore, distress measurement tools need to be valid, reliable, evidence based, easy to complete, and cost effective to implement and sustain as a component of the standard of care (Tavernier, 2014).

THE DISTRESS THERMOMETER FOR PATIENTS

The NCCN clinical practice guidelines (2014) in oncology recommend assessing distress in cancer patients using the Distress Thermometer for Patients. The NCCN Distress Thermometer for Patients is a screening tool with
two components—visual analog and problem list—that can easily be used for serial assessment at any point during the disease trajectory. The Distress Thermometer for Patients visual analog scale and problem list (http://www.nccn.org/patients/resources/life_with_cancer/pdf/nccn_distress_thermometer.pdf) are part of the copyrighted NCCN clinical practice guidelines in oncology. Express written permission for use, without cost, can be obtained from http://www.nccn.org/guidelines (NCCN, 2014).

The visual analog scale component of the Distress Thermometer uses a familiar image of a thermometer and is similar to those used to measure pain. Descriptive points for the 10-point visual analog scale include no distress (0 to 4) and moderate to severe distress (≥5).

The problem list component of the Distress Thermometer consists of 35 items, which prompts the patient to identify potential sources of distress for each of the problem categories. The five categories of problems include (a) practical (housing, insurance, transportation), (b) physical (pain, nausea, fatigue), (c) emotional (worry, sadness, depression, anger), (d) spiritual/religious (God, loss of faith), and (e) other. Although the Distress Thermometer is a validated screening instrument to detect indicators of cancer-related distress in the adult patient population, it is important to point out that it is not a diagnostic tool (NCCN, 2014).

ASSessing DIsstress and iDentifying iNterventions

Nurses are usually the first provider a patient encounters. Therefore, they are in a position to lead the implementation of screenings and identify interventions for illness-related distress early. Given that nurses routinely collect data regarding physical, psychosocial, social, spiritual, and cultural health status of patients during patient encounters, they can easily integrate this information into a distress assessment. In addition, assessment-related activities serve as an opportunity to both assess knowledge deficits and reassure patients that distress is not uncommon and can be treated. Enhancing patients’ knowledge regarding treatment-related expectations is helpful in decreasing their stress and anxiety associated with complicated illness. Hence, patients who have a better understanding of distress may be more likely to disclose what they are feeling rather than keeping their distress unspoken and unresolved (Chase, 2013).

Use of information from the Distress Thermometer and problem list equips nurses to formulate a customized holistic plan of care that includes emotional support. Using patients’ self-report of their level of distress and specific problems they selected as being the most relevant on the day of the screening and in the past week (NCCN, 2014), nurses can identify and implement appropriate interventions. Regardless of the patient’s self-reported level of distress, it is critical to individualize the interventions making sure they are age, education, gender, and culturally appropriate. Patients and families with any level of distress (mild and moderate) should receive information regarding community resources and support groups, and facilitating consultation with social workers and other health care providers as indicated. However, patients identified with severe distress should be referred to mental health professionals (Chase, 2013).

SUMmary

Distress screening using the NCCN Distress Thermometer for Patients is a valid, evidence-based approach to assess and facilitate the identification of interventions for patients and families experiencing cancer-related distress and should become a component of the standard of care for cancer patients across all health care settings (NCCN, 2014).

references