EMOTIONAL DISTRESS AMONG CANCER PATIENTS IN THE HOSPICE SETTING: RECOMMENDATIONS FOR PRACTICE

by

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DEDICATION

In loving memory of Mina Pirastehfar

August 20, 1945 - March 7, 2009
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ABSTRACT

This is a summary of literature regarding emotional distress among cancer patients in the hospice setting with recommendations for nursing practice. An integrated literature review using Cooper’s framework was used to identify current literature regarding emotional distress among cancer patients in the hospice setting. Recommendations for practice are provided based on two IOM reports, *Cancer Care for the Whole Patient* and *Improving Palliative Care for Cancer*. Recommendations include a model for delivery of psychosocial care, suggestions for effective communication, an algorithm for distress management, NCCN guidelines for emotional distress, and a step by step process for implementing change.
CHAPTER ONE

There are more than 10.5 million people living in the United States with a diagnosis of cancer. Approximately, 41% of Americans will receive a diagnosis of cancer during their lifetime (ACS, 2008). In addition, more than half a million US residents have been predicted to die from cancer this year (ACS, 2008). Approximately 574,000 Americans with cancer were admitted to hospice last year (NHPCO, 2008). In 2007, 41.3% of all hospice patients were admitted with a cancer diagnosis (NHPCO, 2008, p. 7). Hospice is a resource that is increasingly embraced by terminally ill cancer patients and their families.

Psychosocial care of patients has traditionally been seen as divided from routine medical care and the effectiveness of supportive care has been questioned. This traditional perspective continues in many settings, despite the fact that patients and families report that emotional care is highly valued. Hospice agencies understand the need for psychosocial care and make this a prominent focus in their care models. Unfortunately, there is a considerable gap in the recognition and management of emotional distress among cancer patients in the hospice setting. Hospice care and psychosocial care for cancer patients go hand in hand. It is essential that the guidelines for emotional distress used in the hospice setting are consistent with evidence based research.

Purpose

The purpose of this report is to review evidence based literature regarding emotional distress among cancer patients in the hospice setting and to summarize current guidelines to develop steps for implementation in applicable clinical settings.
Background

History of Hospice

The term “hospice” is actually a historical term that was used to describe a place of refuge and recovery following a long expedition. The term was later applied to a specialty type of care for dying patients by physician Dame Cicely Saunders, the founder of the first modern hospice in London (NHPCO, 2008).

The idea of specific care for the dying patient was introduced in the US in 1963 at Yale University. Education was provided for chaplains, social workers, nurses, and medical students about the concept of holistic hospice care. Finally, in 1982, a provision to create a Medicare hospice benefit was enacted by Congress (NHPCO, 2008). Four years later, the Medicare Hospice Benefit was made permanent by Congress and hospice reimbursement rates were increased by ten percent. States now had the opportunity to add hospice services to Medicaid programs and nursing home residents were able to access hospice services (NHPCO, 2008).

The intention of hospice care agencies is to offer supportive and palliative care to people during the final stage of life. Hospice providers focus on comfort and quality of life, rather than the intent to cure. Hospice services are provided by an interdisciplinary team including: doctors, nurses, social workers, therapists, spiritual counselors, health assistants, and community volunteers (NHPCO, 2008). The interdisciplinary team is responsible for developing a plan of care specific for each unique patient and family.

Services provided by hospice agencies include medical, emotional, and spiritual care for terminally ill patients and their families. These services are designed to bring comfort, peace and
a sense of dignity in very trying circumstances. Unfortunately, the detection of emotional distress in hospice patients is not always recognized and subsequently left untreated.

The Hospice Patient

Hospice care is geared toward a group of people rather than a single individual. This group can be described as a patient unit and includes family members, caregivers, significant others, and children. Terminal illness affects the entire patient unit not only the terminally ill individual. All members of the patient unit are at risk for emotional distress. However, for the purpose of this review, the focus will remain on emotional distress in the terminally ill individual.

Emotional Distress

According to the NCCN, emotional distress is defined as “an unpleasant experience of an emotional, psychological, social, or spiritual nature that interferes with the ability to cope” (IOM, 2001, p. 212). The NCCN chose this term to describe the psychological, social, and spiritual (non physical) aspects of care because it is less stigmatizing than other terms (Holland & Bultz, 2006). I agree with this definition and the need for the adoption of a global term to increase the consistency of clinical practice guidelines and research. For the purpose of this report, the term “emotional distress” will be used as it has been suggested by the NCCN. Not all literature sources reviewed in this report use the term “emotional distress.” Although the identical term was not used in many of the literature sources, these articles are still relevant to this report. Terms that may be used synonymously with the term “emotional distress” include: psychosocial distress, psychological distress, and distress.
Symptoms of emotional distress may present as feeling of sadness, vulnerability, and fear, to more debilitating conditions including depression, anxiety, and panic (IOM, 2001). Little research has been done to understand how many cancer patients experience emotional distress in the hospice setting. However, “the incidence of psychological morbidity in oncology patients is high, with estimates ranging from 35 to 50 percent experiencing clinically significant psychological distress” (Zabora et al., 2001, p.20). The diagnosis of cancer creates a flood of new upsetting emotions and experiences resulting in increased stress for patients and their families (Segrin & Badger, 2007). Treatments are often associated with a variety of debilitating physical and emotional side effects. Anxiety, depression, and fear are common psychological impairments experienced by patients and their families. Physical stressors, that may present with a diagnosis of cancer, can create new obstacles and exacerbate existing emotional distress.

Cancer patients have been found to experience a wide variety of emotional distress including anxiety, depression, adjustment disorders, severe anxiety, PTSD or PTSS, and subclinical emotional distress (Katon, 2003). A comprehensive study conducted in the US found significant emotional distress in more than one third of cancer patients with the 14 most common types of cancer in a population on nearly 4,500 adult patients (Bucher et al., 2001). Emotional distress and poor mental health among cancer patients can lead to substantial physical and psychological disability. These problems are magnified in individuals with preexisting social stressors such as low economic status, lack of health insurance, or lack of family/social support.

If left untreated, emotional distress can influence and even provoke other coexisting symptoms. Emotional distress has been found to exacerbate physiological symptoms such as appetite loss, fatigue, and pain (IOM and NRC, 2006). In turn, the exacerbation of physiological
symptoms can lead to increased emotional distress. This can become a viscous cycle that is difficult to break.

The most frequently reported symptom of cancer is fatigue and is identified as the greatest interference for activities of daily living. Fatigue is hypothesized to arise from a combination of extreme physical and psychological illness related experiences that may be different in each patient (Carr et al., 2002). Cancer patients commonly report that fatigue is associated with interfering in physical and mental functioning (Carr et al., 2002). An individual experiencing emotional distress may experience more fatigue than an individual who is not in distress.

Studies have shown that nine out of ten patients with advanced stages of cancer suffer from severe pain (Carr et al., 2002). Furthermore, pain is a common symptom that can be identified in thirty percent of all cancer patients in spite of the stage of the disease (Carr et al., 2002). Pain can occur as a result of the illness itself, treatment, or coexisting illnesses. Chronic pain that is left untreated can result in devastating effects such as loss of mobility, sleep disturbance, anxiety, and depression. Physical restrictions resulting from untreated pain include decreased mobility, functional impairments, inability to perform daily tasks. These restrictions can lead to loss of employment and create added stress for the individual and their family.

Patients may experience difficulty coping with role changes within their family and in other relationships. Anxiety and depression can develop as a result of physical stressors including persistent pain, onset of debility, weakness/fatigue (Holland & Bultz, 2006). Still, numerous social factors may contribute to anxiety and depression including financial obligations, inadequate health insurance, loss of employment, and changes within the family system (IOM
and NRC, 2006). Inadequate acknowledgement of psychosocial concerns may perpetuate the emotional distress and potentially complicate psychological symptoms.

Summary

Nearly half of the population is at risk for developing cancer. The majority of individuals receiving this diagnosis will experience some degree of psychosocial distress related to the disease process, treatment, or secondary infection. It has been well documented that emotional distress and poor mental health among cancer patients can lead to substantial physical and psychological disability (Zabora et al., 2001). Furthermore, cancer is one of the leading diagnoses for hospice admission (NHPCO, 2008). Hospice agencies utilize the expertise of interdisciplinary team to support the psychological well being of cancer patients. Unfortunately, emotional distress is still a significant problem for cancer patient in the hospice setting. Guidelines for emotional distress in the hospice setting must be consistent with current evidence based research and implemented in all applicable settings.
CHAPTER TWO

Chapter two consists of an integrated literature review using Cooper’s framework to organize current literature regarding emotional distress among cancer patients in the hospice setting (Whittemore & Knafl, 2005).

Problem Identification

Emotional distress is a significant problem among cancer patients in the hospice setting. Guidelines for emotional distress in the hospice setting must be consistent with current evidence based research and implemented in all applicable settings.

Literature Search

Literature was gathered using electronic search data bases including: CINAHL (EBSCO) and MEDLINE (Ovid). The initial search was conducted on EBSCO using the terms “emotional distress” and “hospice” with limitations for full text and humans. This search generated seven results. The second search conducted on EBSCO used the terms “hospice”, “distress”, and “cancer”. This search generated 82 results. The initial search conducted on Ovid included the search term “hospice” generating 4,529 results and the search term “distress” generating 35,950 results. The results of both searches were combined and limitations for “humans” and “full text” were applied. The final result was 17 articles. A second search conducted on Ovid included the search term “palliative” generating 26,522 results and the term “distress” generating 35,950 results. The results of both searches were combined and limitations for “humans” and “full text” were applied. The final result was 82 articles.

The limitation for “humans” was used to ensure literature involving human participants was collected. The limitation for “full text” was applied to discount search results that provided
incomplete articles (reference only articles, abstract only articles). Only articles that were available to review in full were examined. When combining the results from each of the four electronic searches (7+82+17+82) a total of 188 articles were produced.

Data Evaluation

Each of the abstracts/introductions for all 188 articles produced from the electronic search were reviewed. Based on the relevance of the article to the subject matter of this report, articles containing irrelevant information were discarded. Relevant information included one or more consistent terms regarding each of the following categories: participants, setting, topic (Table 1).

TABLE 1. Relevant Article Criteria

<table>
<thead>
<tr>
<th>Category</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Oncology patients, cancer patients, hospice patients, palliative care patients, caregivers, family members, health care professionals, nurses, nurse practitioners, advanced practice nurses, physicians, oncologists</td>
</tr>
<tr>
<td>Setting</td>
<td>All (outpatient, inpatient, skilled nursing facility, home health…etc.)</td>
</tr>
<tr>
<td>Topic</td>
<td>Hospice, palliative care, oncology, emotional distress, psychosocial distress, psychological distress, distress, psychosocial care, supportive care, quality of life, depression, anxiety, fatigue, stress, coping, unmet needs, screening, assessment, evaluation, education, communication, barriers, emotional support, psychosocial support, guidelines</td>
</tr>
</tbody>
</table>
From the 188 articles generated from the electronic search, 21 articles (See APPENDIX) were relevant to this report.

The final samples for this integrative review included research, review, and clinical literature. Research articles included a wide variety of methodology such as experimental, correlational, demonstrational, prospective, and case study.

Data Analysis

Data analysis was conducted by summarization of primary sources. Elements of data analysis involved identification of similar patterns and themes, contrasts and comparisons, and building a logical chain of evidence.

Presentation

In 1986, The National Hospice Study was the largest research project to explore the outcomes of hospice care using multiple measurement tools to assess multiple aspects of quality of life, including emotional distress (Bretscher et al., 1999). There was no evidence that hospice patients experienced any negative consequences as a result of hospice care (Greer & Mor, 1986). Still, the study was not able to determine a difference in the quality of life of hospice and non-hospice patients (Greer & Mor, 1986). From 1989 to 1994 the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) aimed to illustrate the needs of terminally ill patients and to evaluate how effectively those needs are communicated (Ferrell & Coyle, 2002). This was the most comprehensive effort to evaluate the unmet needs of terminally ill patients; involving more than 9,000 patient participants (Ferrell & Coyle, 2002). Results from Phase I of the study identified substantial deficiencies in patient care (Ferrell & Coyle, 2002). Phase II determined that physicians and healthcare providers displayed the same
lack of understanding for patient needs after intentional conversation than they did without any communication at all (Ferrell & Coyle, 2002).

In 1999, Bretscher et al. evaluated newly admitted hospice patients for measures of physical and emotional distress associated with serious illness using standardized questionnaires. The study involved a total of 121 inpatient participants. Unfortunately, only 16 participants survived to the completion of the study, of which, 14 had a diagnosis of cancer. Results indicate that study participants “had much lower vigor/activity scores and slightly lower fatigue scores, indicating less vigor and more fatigue” in the hospice patients compared with average score for an individual receiving outpatient care (Bretscher et al., 1999, p. 311). Score for hospice patients evaluating confusion/bewilderment, tension/anxiety, and depression/dejection were found to be comparable and somewhat less than outpatient averages (Bretscher et al., 1999). Bretscher et al. went on to establish “that it is possible to obtain information about one’s QOL (quality of life) in terminal phases of life” and most of “the dimensions of QOL are preserved until the very end” (1999, p. 312).

Screening for Emotional Distress

The goal of hospice care is to provide patients with the highest level of quality of life by preventing of all forms of suffering, including emotional distress (Thekkumpurath et al., 2008). This can be accomplished through routine screening and early treatment of identifiable distress. Emotional distress is not routinely assessed in the hospice settings. It has been reported that over half of these problems are never identified (Thekkumpurath et al., 2008).

Many tools exist for the assessment of emotional distress and these tools are relatively easy to administer in the majority of clinical settings (Holland & Bultz, 2006). Screening tools
used for the assessment of emotional distress include: The Hospital Anxiety and Depression Scale (HADS), Center for Epidemiological Studies Depression Scale (CES-D), Functional Assessment of Chronic Illness Therapy (FACIT), Fatigue Symptom Inventory (FSI), and Distress Thermometer (APOS, 2009).

The Distress Thermometer (Figure 1) is a quick and simple visual screening tool that uses the picture of thermometer and number scale to evaluate emotional distress (NCCN, 2005). Patients are asked to identify a number 0 to 10 (absent distress, severe distress) that represents their level of distress during the past week (NCCN, 2005). The very simple single-item evaluation done with paper and pencil can be self administered in less than 60 seconds. The screening assessment can be used for individuals with any type of illness in variety of settings. The scoring system for this assessment is simple. A patient indicating a distress level of 4 or greater indicates a referral. This screening tool has been shown to offer good sensitivity and specificity (Jacobsen et al., 2005). Results from this screening tool have also found to be comparable to the HADS and Brief Symptom Inventory (BSI) methods of screening (Jacobsen et al., 2005).
Another screening tool, used to evaluate more specific aspects of emotional distress is the HADS which allows patients to honestly self-identify symptoms of distress. This assessment tool consists of 14 items each with a four point Likert scale. This study consisted of approximately 3,035 cancer patient participants. From the total participants, 781 individuals scored above the cut off qualifying for triage (some type of intervention) and 83.7% chose to participate in psychosocial counseling. Of the individuals who did not score above the cut off, 37.7% requested to participate in psychosocial counseling. The use of this screening tool makes it possible for cancer patients to quickly and easily communicate their current mental state and provide a self-reported level of distress.

Routine screening, opposed to a one time initial screening, is critical given that individuals diagnosed with cancer suffer from prolonged, undetected distress resulting from...
multiple unmet needs that may vary throughout the disease process (Carlson & Bultz, 2003). Furthermore, evidence of the variability in symptom presentation associated with the trauma of a cancer diagnosis suggests that emotional distress screening should be completed at various points throughout the illness trajectory (Figure 2).

![Cancer Care Trajectories](image)

**FIGURE 2.** Cancer Care Trajectories (IOM and NRC, 2006)

It is the responsibility of the healthcare system and healthcare professionals to identify patients who are in need of psychosocial intervention. Unfortunately, significant emotional distress usually remains undetected until the resulting adverse impact on quality of life is severe. Untreated psychological symptoms can be as equally debilitating as the physiological illness. Routine administration of screening tools in patients with oncology related emotional distress will allow healthcare professionals to quickly assess, identify, and manage patient needs.
Unmet Needs and Symptoms of Distress

Cancer patients display a variety of symptoms of distress which may result from multiple unmet needs. In 2007, Pigott et al. developed a Supportive Needs Screening Tool (SNST) to assess unmet needs in a sample of oncology patients. For the 87 patients, a total of 1,052 needs were identified by the SNST, with an average of 12 needs per patient. All patients who completed the SNST reported at least one unmet need, with 89% of patients reporting five or more needs, and 54% reporting ten or more needs, indicating that the majority of cancer patients have multiple and often complex needs (Figure 3).

![Figure 3: Needs per Patient Identified by the SNST (Pigott et al., 2007)](image)

Sixty two percent of patients reported at least one psychological need. Unmet psychological needs included feeling of distress/worry, unhappiness/depression, and coping frustration (Figure 4).
Forty four percent of patients identified one or more informational needs relating to their diagnosis or treatment. Results of the study indicated that patients desired written information, with follow up discussions to address questions regarding the written material. This tool was administered in an outpatient setting; however, assessing these needs in hospice patients and individuals receiving palliative care would be beneficial in evaluating and monitoring for emotional distress.

McMillan & Small (2002) conducted a study to examine the relationship between symptoms of distress and quality of life (QOL) among individuals with advanced cancer in the hospice setting. Participants included 178 adult hospice patients with a primary diagnosis of cancer. Participants completed a number of questionnaires including the QOL index and a distress scale. Common symptoms of distress identified by the questionnaires included, “lack of energy, pain, dry mouth, and shortness of breath” (McMillan & Small, 2002, p. 1426). A regresional analysis indicated a univariate level of relationship between that total distress scores
and QOL. The study determined that symptoms of distress affect QOL in hospice patients with cancer (McMillan & Small, 2002).

**Barriers to Psychosocial Care**

The identification of barriers that prevent the implementation of guidelines for emotional distress and psychosocial care is necessary to understand how these obstacles can be overcome. Descriptive methods including surveys, focus groups, and interviews have been used to identify medical professionals’ perceptions of potential barriers to psychosocial care. Schofield et al. (2006) have identified three categories for the classification of barrier to psychosocial care for hospice: predisposing, enabling, and reinforcing factors. The first classification describes influential factors such as knowledge, personal beliefs, and self efficacy that can influence healthcare professionals’ behavior. Enabling factors like time, assessment skills, and resources can facilitate or inhibit the providers’ performance. Finally, reinforcing factors such as feedback, rewards, or negative consequences support or oppose the maintenance of the behavior over time.

Frost et al. (1997) found that health professionals perceive time to be the greatest barrier to providing psychosocial care. A lack of time is the most commonly cited reason for omitting psychological evaluation. However, studies suggest that psychosocial distress found in cancer patients can often be recognized in under one minute of conversation (Schofield et al., 2005). Furthermore, evidence has shown that appropriate identification and response to emotional cues may actually reduce provider consultations by several minutes (Butow et al., 2002).

Another substantial barrier is the lack of skills and training to properly identify psychosocial needs. Providers tend to more readily respond to physical symptoms and informational cues (72%) than psychological symptoms and emotional cues (28%) (Butow et al.
In addition to identifying psychosocial distress, providers must also possess the skills to intervene. Inadequate skills to manage psychosocial concerns may discourage providers from exploring this topic in fear that they will be unable to deal with the issues presented. This complex perpetuates the avoidance of patients’ psychosocial concerns and needs.

Not all clinical environments are especially conducive to best practice psychosocial care. A lack of resources including consultation space, informational resources, and allied professionals for referrals may present barriers to identification and management of psychosocial symptoms (Frost et al. 1997). Many healthcare professionals find the requirements associated with psychosocial care to be stressful and emotionally draining. The lack of support for providers can result in burn out and further discourage psychosocial evaluation and management from routine practice.

Reinforcing factors are particularly important in the success of psychosocial care. A lack of reinforcing factors can be a potential barrier to the achieving best practice psychosocial care. Detailed feedback was reported as an effective and valuable component for communication skills training by oncologists (Schofield et al., 2005). Feedback regarding performance can be motivating for providers and help inspire confidence in practice. In addition, reward systems are another recommended strategy in achieving high quality psychosocial care. Rewards may be intangible such as peer support, patient approval, and reputation or they may be tangible such as salary increase or promotion.

Lastly, there are not currently any negative consequences for providers who fail to meet the psychosocial needs of patients. Providers who fail to perform adequate psychosocial assessments may suffer from damage to their reputation, delays in professional advancement,
and even legal action (Schofield et al., 2005). However, none of these consequences are necessarily going to educate the provider about acceptable practice. In cases where the provider consistently fails to provide adequate psychosocial care, the individual could be subject to a training program to target the lack in knowledge. The goal must be to influence the provider to adopt best evidence practice techniques and apply these techniques to practice.

The inability to deliver high quality healthcare is the result of numerous barriers within the health care systems that affect the clinicians’ role and structure their practice and performance (IOM, 2008). These barriers occur at the level of the patient’s interaction with the clinician (poor communication, time restraints), the level of interactions among multiple clinicians (miscommunication, poor continuity of care), within the organization in which care is delivered (lack of resources and personnel) and in the external environment beyond the delivery of care (lack of reimbursement) (IOM, 2008). Barriers at all levels can be identified as potentially causative to the failure of healthcare providers to respond appropriately to cancer patients’ psychosocial needs.

Barriers to providing psychosocial care will vary and are specific to each specialized environment. Identifying the barriers that exist within each specific healthcare system is a time consuming process. Establishing a plan to eliminate barriers to quality care will demand even more time and energy. Although this may be a complex process it is essential for ensuring high quality psychosocial health care.

Summary

Screening for emotional distress is a critically important evidence-based best practice measure that may be overlooked. Failing to acknowledge this discrepancy could result in a
number of poor patient outcomes. Several psychosocial concerns have been identified for cancer patients including depression, fatigue, anger, financial matters. The presence of unmet needs is related to the development and exacerbation of emotional distress. Furthermore, there are multiple barriers associated with psychosocial care. Barriers are related to predisposing, enabling, and reinforcing factors and exist on multiple levels within the healthcare system. Barriers at any level of the healthcare system can lead to the failure of the healthcare provider to adequately respond to cancer patients’ psychosocial needs.
CHAPTER THREE

Chapter three provides a summary of two IOM reports *Cancer Care for the Whole Patient* and *Improving Palliative Care for Cancer* (IOM, 2001 & IOM, 2008). In an effort to address the unmet needs of cancer patients, the National Institutes of Health suggested that the IOM study the delivery of psychosocial and palliative care required by cancer patients. This literature is the source of information for the recommendations discussed in chapter four.

Report #1: Cancer Care for the Whole Patient

In 2005, the IOM was asked to reexamine the important role of psychological, behavioral, and social factors in the design and delivery of the healthcare system for patients with cancer. Although this review was not specifically directed at hospice, it is important to review because it addresses psychosocial needs of cancer patients and standards for psychosocial care. The IOM expert committee reported that cancer patients identified their healthcare providers were unsuccessful at understanding and addressing their psychosocial needs (IOM, 2008). Patients reported that their providers seemed to be unaware of available resources for support and failed to make appropriate referrals (IOM, 2008). The expert committee found that health care providers did not identify psychosocial support to be an essential element of high quality care for cancer patients.

The committee also identified a high level of patient dissatisfaction for the type/amount of information they receive from health care providers (IOM, 2008). Research confirms that providers typically have a lack of understanding for patients’ informational needs and concerns (IOM, 2008). In addition, providers often fail to communicate at a level that patients can
understand. The IOM acknowledges that education and training for health care professionals is necessary to overcome the communication barriers.

In addition, the committee recognized a prominent lack of sharing and collaboration between provider and patient in the decisions making process. Studies show that health care providers significantly underestimate patients’ desire for an active or shared role in their care (IOM, 2008). Communication and patient involvement in decision making processes has been linked to the reduction of anxiety and depression, increased satisfaction with treatment choices, and more appropriate treatment choices (IOM, 2008). A considerable amount of evidence indicates that effective communication between provider and patient is positively related to health outcomes (IOM, 2008).

Based on the above findings, the committee agreed that the establishment of a standard of care is of primary importance. The committee recommends that key participants and leaders in the oncology community should take part in promotion and adherence of these standards (IOM, 2008). In addition, there must be a system to guarantee that all oncology patients receive individualized care that follows the standards for psychosocial healthcare (IOM, 2008). Education and assistance for healthcare providers should be available to ensure the implementation of these standards of care by the National Cancer Institute (IOM, 2008).

Report #2: Improving Palliative Care for Cancer

Improvements in the development and delivery of palliative care required by terminally ill patients are not on par with advances seen in other fields of health care. *Improving Palliative Care for Cancer* is an addition to the IOM report, *Approaching Death: Improving Care at the End of Life* from 1997. This was one of the first evidence-based reports to focus on aspects of
care for the dying. *Improving Palliative Care for Cancer*, focuses on specific areas of palliative care for cancer patients in which the National Cancer Policy Board (NCPB) believes action in required. This report is the most current literature for palliative care offered by the IOM.

The majority of cancer research is highly focused on curative treatments. The IOM and many other key health care foundations have agreed that “patients should not have to choose between treatment with curative intent or comfort care” (IOM, 2001, p. 9). Throughout the course of cancer patients require curative treatment and comfort care in varying degrees. The goal is to achieve the highest quality of life despite the outcome of the treatment being provided. The IOM reports that this is achieved by allowing patients to choose treatments that fit their individual situation, in addition to providing symptom control for individuals with advanced stages of illness (2001). Patient involvement in their own plan of care is a topic shared by the later 2008 report.

Lack of effective communication is another topic found in this IOM report. Even before the publication of *Cancer Care for the Whole Patient*, there was a need for improved communication in the health care system. This report acknowledges a lack of effective patient-provider communication in palliative care. Similar to the 2008 report, in 2001, the IOM suggested enhancing patient-provider communication through education. The IOM acknowledges that effective communication is an essential part of palliative care (2001).

**Summary**

Both IOM reports, discussed above, have identified a lack of psychological and spiritual care provided to cancer patients (IOM, 2001 & IOM, 2008). Advancements in the delivery and development of psychosocial and palliative care have fallen behind other fields within the health
care system. Lack of adequate patient-provider collaboration and effective communication are common findings shared in both reports and a key element necessary to improve psychosocial and palliative care.
CHAPTER FOUR

Chapter four provides recommendations for practice based on the IOM reports discussed in chapter three. A model for delivery, suggestions for effective communication, an algorithm for distress management, NCCN guidelines for emotional distress, and a step by step process for implementing change are provided.

Recommendations

After reviewing the literature I recommend the following plan for the care of emotional distress in hospice patients:

1. I believe the Model for Delivery Psychosocial Health Services should guide the delivery of psychosocial health services.

2. I believe the NCCN Algorithm for Distress Management should be implemented and followed by all health care providers in the management of patient distress.

3. I believe an educational program for effective patient-provider communication, follow the six important aspects of communication provided by the NCI, should be mandatory for all health care professionals.

4. I believe the eight NCCN guidelines discussed in the IOM report Palliative Care for Cancer should be examined and implemented into all setting providing hospice/palliative care.

A Model for Delivery

The IOM expert committee conducted a search for effective psychosocial health service delivery models. The investigation generated several models that have been tested and identified
as proficient for the delivery of psychosocial services (Figure 5). The IOM found components similar to the majority of the models include:

(1) identifying patients with psychosocial health needs that are likely to affect their ability to receive healthcare and manage their illness, and developing with patients appropriate plans for (2) linking patients to appropriate psychosocial health services, (3) supporting them in managing their illness, (4) coordinating psychosocial with biomedical health care, and (5) following up on care delivery to monitor the effectiveness of services and determine whether any changes are needed (IOM, 2008).

Evidence derived from the models implies all aspects of the model (screening, referrals, follow up) must be incorporate into patient care in order to prove affective (IOM, 2008).
FIGURE 5. Model for the Delivery of Psychosocial Health Services. (IOM, 2008)

The core of the model is effective communication; necessary to unite the interdisciplinary team and the patient/family. Effective communication allows the patient to obtain and comprehend information their health status and plan of care. The patient is able to express their needs and freely ask questions. Similarly, the provider must be comfortable providing detailed information regarding the illness, assessing patient needs, and responding to questions. The establishment of a good interpersonal relationship is essential to facilitate successful communication.
Suggestions for Effective Communication

The NCI acknowledges six important aspects of effective patient-provider communication: foster a healing relationship, exchange information, respond to emotions, manage uncertainty, make decisions, and enable patient self management (2007). Evidence-based research suggests effective patient-provider communication and patient involvement in the decision making process results in better health care outcomes. Unfortunately, patient involvement in the decision making processes is remains minimal and this open form of communication is not routinely practiced. Patients are typically inadequately prepared to communicate successfully with their health care providers (IOM, 2008). On the other hand, health care providers are equally unprepared to gather valid information regarding patient needs and concerns (IOM, 2008). There is a need for interventions aimed at enhancing patient–provider communication in order to recognize and support patient preferences.

Algorithm for Distress Management

The National Comprehensive Cancer Network (NCCN) has developed an algorithm (Figure 6) for the identification of patients experiencing moderate to severe distress resulting in a referral to the appropriate services when distress is identified.
Clinical guidelines for distress management must incorporate the “human” aspects of care. Standards of care must include psychological, spiritual, social, and existential patient concerns. In 1998, the NCCN gathered a panel of multidisciplinary members to address the current status and need for clinical practice guidelines in psychosocial care (NCCN, 2005). At this time, guidelines for psychosocial and spiritual care incorporating all supportive care disciplines were established (NCCN, 2005). The principles developed by the NCCN panel have been transformed into guidelines for palliative care.

**NCCN Guidelines**

The NCCN identifies eight standards/guidelines that are relevant to the management of emotional distress among cancer patients in hospice care.

1.) Define the term *emotional distress*. Emotional distress is a broad term intended to represent normal emotions such as sadness, worry, or fear (IOM, 2001). The term has been chosen to describe psychosocial problems because it carries less of a stigma than labels such as depression or anxiety. Emotional distress is defined as, “an unpleasant
experience of an emotional, psychological, social, or spiritual nature that interferes with the ability to cope” (IOM, 2001, p. 212). Defining this term allows patients to comfortably and confidently identify symptoms of emotional distress without feeling uncomfortable.

2.) Routine screening for emotional distress using a standardized tool. This assessment may occur in the home, clinic, office, nursing home or hospital setting. There are several methods and tools used to assess levels of emotional distress. The NCCN recommends a quick, simple, and not threatening approach such as a verbal 1-10 scale or a visual tool such as a distress thermometer (IOM, 2001). Routine assessment should be conducted on a weekly basis by qualified health care professional in order to thoroughly assess changes psychosocial health that may occur throughout the cancer trajectory.

3.) Management of identified emotional distress. After identifying the severity of the emotional distress level, a list of physical symptoms accompanying this rating should be collected. Patients have identified the combinations of theses assessments as an acceptable method for evaluation. The indication of a distress level of five or higher prompts a referral to the appropriate supportive care service (psychiatry, psychology, nursing, social work, chaplain service, patient advocacy, etc.). A distress level of five or above has been identified as comparable to the Hospital Anxiety and Depression Scale rating of significant distress (Roth et al., 1998) and always warrants action on behalf of the health care provider.

4.) Standards for health care professionals. Education and training in palliative care must include competencies for health care providers and nurses, as well as social workers,
mental health professionals (psychiatry, psychology), and spiritual counselors (IOM, 2001). All providers must be able to conduct a thorough and timely psychosocial assessment using rapid screening methods. Health care professionals must be able to utilize algorithms to expedite appropriate referrals so that patients may access community resources.

5.) Education for effective communication. Health care providers must be taught to communicate with patients using compassion and empathy (IOM, 2001). Patients need to understand that psychosocial and spiritual wellbeing are a key focus in their care. Patients must feel comfortable identifying unmet needs and communicating those needs to the interdisciplinary team.

6.) Standards to ensure reimbursement of supportive services. Adequate reimbursement for supportive services is critical. This is necessary to guarantee these services are readily accessible to patients and their families.

7.) Standards to assess the quality of care and patient satisfaction.

8.) Research is necessary to ensure appropriate measures for evaluating quality of care.

The initial step to implementing the NCCN guidelines into the hospice setting begins with the formation of a multidisciplinary consensus panel comprised of individuals who provide supportive care services (IOM, 2001). The panel should develop a classification system to organize the services (psychological, social, spiritual, psychiatric, etc.) and define each service in specific terms so that there is no overlapping or confusion between each specific domain (IOM, 2001). It is suggested that the word “emotional distress” be used to encompass all psychosocial components when speaking in general terms.
The comprised panel should be responsible for examining the existing standards of care within the organization and the guidelines for palliative care developed by the NCCN. The guidelines should be broken down and tested for feasibility within the organization (IOM, 2001). Substantial efforts will need to be made to ensure the implementation of the clinical practice guidelines. The NCCN guidelines for communication in palliative should also be examined, adapted, and implemented into the organization at this time (IOM, 2001). The panel will be responsible for identifying and overcoming barriers associated with the proposed practice guidelines.

Specific barriers to distress management have already been identified and should be anticipated and addressed by the panel. There is a known lack of minimum standards for psychosocial needs in addition to the lack of oversight by regulatory bodies to reinforce staff performance (IOM, 2001). Standards of care must be established and a regulatory body must be appointed to uphold these standards. Negative attitudes carried by health care professionals may discourage the integration of psychosocial guidelines into total care. Health care professionals need specific education for assessment, diagnosis, and management of distress (IOM, 2001). Training must be mandatory for all health care professionals to ensure adequate delivery of psychosocial care. Furthermore, algorithms, such as the NCCN Algorithm for Distress Management, should be used to expedite referrals to supportive services have not been put in place impeding distress management.

The absence of reimbursement for mental health professionals, spiritual counselors, and pastoral services decreases the availability of these valuable interdisciplinary team members and their services (IOM, 2001). Identifying funding and making these essential resources accessible
to the patient population is imperative. The panel must outline the standards for psychosocial care and acquire funding from professional organizations to implement the established standards (IOM, 2001). For example, distress must be evaluated on a verbal 0-10 scale during every visit. The patient response must be documented in the patient chart (or specified location) by the health care professional and an algorithm should be used to expedite the need for a referral. Patients in need of supportive services should have access to those services within 24 hours (IOM, 2001).

Educational standards for health care providers must include the recognition of distress and appropriate management (IOM, 2001). In addition, mental health professionals must be taught to modify their existing knowledge to incorporate end of life care. Pastoral services must be included as a psychosocial service and taught to be a valuable aspect of palliative care. Patients and family members should be educated to comprehend that psychosocial and spiritual well being are important elements of palliative care and should be viewed as an integral part of medicine not as a separate domain.

Governmental and managed care organizations must be informed that the lack of reimbursement for psychosocial services in palliative care is having a negative impact on the quality of care provided to patients (IOM, 2001). Funding for supportive services is essential in reducing the suffering and distress experienced by patients during end of life care. Professional organizations in the fields of psychology, oncology, psychiatry, nursing, social work, and chaplaincy should be familiar and competent in the current clinical practice guidelines. The appropriate regulatory bodies within these fields must include performance standards for professionals in regards to their communication and delivery of care (IOM, 2001).
A patients’ bill of rights must include the right to distress management equal to that of any physical symptom management (IOM, 2001). Patients have the right to prompt and competent care of psychosocial and spiritual concerns. Research in the recognition and treatment of distress through controlled trials will be necessary to improve care standards. Research should be pursued when examining the feasibility and implementation of distress management guidelines in each discipline in which supportive services are provided (IOM, 2001). Finally, research should be conducted to evaluate the effectiveness of the implemented guidelines to ensure quality of care (IOM, 2001).

Evaluation of Recommendations

In order to evaluate the results of these recommendations, I propose that all hospice/palliative care organizations be required to document the of percentage of the cancer patient population screened annually for emotional distress per site. Each site must also document the percentage of the cancer patient population diagnosed with emotional distress each year. Documentation of percentage of the cancer patient population treated annually for emotional distress per site must also be a requirement. Lastly, in order to document our national effort, I believe a global system in necessary to organize and compare statistics and ensure that our advancements and improvements are comparable to other countries.

Strengths and Limitations of Recommendations

I want to point out the strengths of the above recommendations. As a whole, these are all evidence based recommendations formulated by the IOM expert committee. The recommendations address nationally recognized areas of concern for the management of emotional distress as reported by the IOM. In addition, there are also limitations to these
recommendations. Consistent application of these recommendations to individual organizations will be difficult as hospice and palliative care settings and structures will vary. Actual implementation of these recommendations by health care providers may prove challenging as research shows people have a tendency to resist change.

Report Limitations

This report is limited in the fact that Cooper’s Framework was not applied in full. Full application of Cooper’s Framework would include multiple literature search methods including: ancestry searching, journal hand searching, networking, and searching research registries. For the purpose of this report, computerized database search was the only search method applied (Whittemore & Knafl, 2005). “Computerized database searches are efficient and effective; however, limitations associated with inconsistent search terminology and indexing problems may yield only 50% of eligible studies” (Whittemore & Knafl, 2005, p. 548). As a result, multiple studies that were not reviewed in this report may exist.

Conclusion

After reviewing the literature, regarding emotional distress among cancer patient in hospice/palliative care settings I believe the Model for Delivery Psychosocial Health Services discussed in the IOM report Cancer Care for the Whole Patient should guide the delivery psychosocial health care (2008). This use of this model is proficient for the delivery of psychosocial services as it has been derived from multiple valid sources including: Building Health Systems for People with Chronic Illnesses (Palmer & Somers, 2005), Chronic Care Model (ICIC, 2007), Clinical Practice Guidelines for Distress Management, (NCCN, 2008), Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer (NBCC & NCCI,
2003), Improving Supportive and Palliative Care for Adults with Cancer (NICE, 2004), and Partners in Care (Wells et al., 2004). The NCCN Algorithm for Distress Management should be implemented and followed by all health care providers in the management of patient distress (2005). An educational program for effective patient-provider communication should be mandatory for all health care professionals and follow the six important aspects of communication provided by the NCI (2007). Lastly, the eight NCCN guidelines discussed in the IOM report Palliative Care for Cancer should be examined and implemented into all setting providing hospice/palliative care (2001).

Evaluation of the recommendations through statistics documenting national screening, diagnosis and treatment efforts of emotional distress is necessary. This report is limited by the incomplete application of Cooper’s Framework. Further research may be necessary to collect a more complete list of eligible literature for review.
APPENDIX A

RELEVANT ARTICLES
### Relevant Articles

<table>
<thead>
<tr>
<th>Article</th>
<th>Author</th>
<th>Purpose</th>
<th>Conclusions</th>
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<tr>
<td>Quality of life in hospice patients: A pilot study</td>
<td>Bretscher, M., Rummans, T., Sloan, J., Kaur, J., Bartlett, A., Borkenhagen, L., Loprinzi, C. (1999)</td>
<td>The purpose of this pilot study was to use objective data to identify the true experience of dying from the point of view of the patient and determine quality of life in the hospice setting.</td>
<td>Patient, caregivers, and staff from a hospice program completed questionnaires evaluating the patient’s QOL every 2 weeks until the patient’s death. This pilot study found that patients’ QOL was relatively high and stable over time.</td>
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<td>Problem-solving cancer care education for patients and caregivers</td>
<td>Bucher, J., Loscalzo, M., Zabora, J., Houts, P. (2001)</td>
<td>A program evaluation was conducted to explore the potential effects of a 90-minute problem-solving education session for persons with advanced cancer and their families.</td>
<td>Most educational sessions for cancer patients focus on delivering information, not on building skills. These findings suggest that one-on-one educational sessions that teach problem-solving skills can be successfully delivered in a busy clinic setting.</td>
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<td>Oncologists’ reactions to cancer patients’ verbal cues</td>
<td>Butow, P., Brown, R., Cogar, S. (2002)</td>
<td>This study investigated patients' attempts to gain informational and emotional support through the use of verbal cues.</td>
<td>Overall, results showed that doctors effectively identify and respond to the majority of informational cues; however, they are less observant of and able to address cues for emotional support. Cues can be addressed without lengthening the consultation or increasing patient anxiety.</td>
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<td>Cancer distress screening: needs, models, and methods</td>
<td>Carlson, L. &amp; Bultz, B. (2003)</td>
<td>This review summarizes literature documenting the levels of distress commonly found in cancer patients, followed by discussion of recommended standards for routine distress screening, and a summary of various programs that have attempted to establish clinical screening programs.</td>
<td>Distress screening is useful and has become an ethical imperative in identifying patient need. Screening should be considered necessary for the provision of truly adequate psychosocial care.</td>
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<td>Management of cancer symptoms: pain, depression, and fatigue</td>
<td>Carr, D., Goudas, L., Lawrence, D., Pirl, W., Lau, J., DeVine, D. (2002)</td>
<td>This is an Evidence-Based report regarding the management of pain, depression, and fatigue symptoms in cancer</td>
<td>Despite numerous instruments having been developed to assess these symptoms, optimal and standardized methods for the assessment of these symptoms in</td>
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<td>An overview of palliative nursing care</td>
<td>Ferrell, B. &amp; Coyle, N. (2002)</td>
<td>Overview of palliative care and barriers to providing quality end of life care.</td>
<td>Obstacles to providing high-quality care at the end of life include a lack of adequate end-of-life training of providers, delayed referral to hospice and palliative care services, and inadequate insurance coverage or benefits for palliative care in managed care organizations.</td>
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<td>Intervening with the psychosocial needs of patients and families:</td>
<td>Frost, M., Brueggen, C., Mangan, M. (1997)</td>
<td>Evaluates the question as to whether gaps in psychosocial care for cancer patients exist between the theoretical literature and what is occurring at the bedside.</td>
<td>Nurses identified meeting psychosocial needs as extremely important in this study. However, nurses either lack the skills or are not confident with their skills when intervening with psychosocial needs. Efforts must be made to close the gap between the theoretical importance of meeting psychosocial needs and the actual delivery of these interventions in the clinical setting.</td>
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<td>An overview of the national hospice study findings</td>
<td>Greer, D. &amp; Mor, V. (1986)</td>
<td>Summary of the major findings and implications for medical practice and health policy based on the National Hospice Study findings.</td>
<td>There appear to be few strong patient quality of life advantages associated with hospice, and while the home care model reduces costs, the hospital based model may not. Findings reveal that hospice has no negative effects and may be a viable option for terminal care.</td>
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<td>Depression in advanced disease: a systematic review. Part 1.</td>
<td>Hotopf, M., Chidgey, J., Addington-Hall, J., Ly, K. (2002)</td>
<td>To identify all literature regarding depression in patients with advanced cancer and among mixed hospice</td>
<td>Depression is a common problem in palliative care settings. The quality of much of the available research is poor, based on small samples of patients with very high</td>
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<td>Study Title</td>
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<td>Improving palliative care for cancer patients</td>
<td>Institute of Medicine (2001)</td>
<td>The report focuses on addressing not only what can be done for people nearing the end of life, but also setting a course for the development of better treatments and better ways of delivering and paying for them.</td>
<td>The report provides recommendations for future directions, clinical practice guidelines for management of psychosocial and physical symptoms of cancer, a research agenda for reducing distress of patients with cancer, and an educational plan in palliative and end of life care for health care professionals.</td>
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<td>Cancer care for the whole patient: meeting psychosocial health needs</td>
<td>Institute of Medicine (2008)</td>
<td>This report describes barriers to accessing to psychosocial services and ways in which these services can best be provided, analyzes the capacity of the current mental health and cancer treatment system to deliver such care, identifies associated resource and training requirements, and offers recommendations and an action plan for overcoming the identified barriers.</td>
<td>The report provides a model for delivery of psychosocial health services, steps for implementing the standard of care, options for public and private sector policy support, a plan for preparing health care professionals, and a research agenda.</td>
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<td>From cancer patient to cancer survivor: Lost in transition</td>
<td>Institute of Medicine and National Research Council (2006)</td>
<td>This report is meant to serve as an important vehicle to raise awareness, fill gaps that have existed in cancer patients’ long-term care, and chart a course for quality care for cancer survivors and their families.</td>
<td>Recommendations include: implementing a cancer survivorship care plan, building bridges between oncology and primary care providers, developing and testing models of survivorship care, developing guidelines, instituting quality improvement, and strengthening professional education programs, and making better use of psychosocial and community support services.</td>
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<td>Screening for psychologic distress in ambulatory cancer patients</td>
<td>Jacobsen, P., Donovan, K., Trask, P., Fleishman, S., Zabora, J., Baker, F., Holland, J. (2005)</td>
<td>Research was conducted to determine whether the single-item Distress Thermometer compared</td>
<td>Findings confirm that the single-item Distress Thermometer compares favorably with longer measures used to screen for</td>
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<td>Posttraumatic stress disorder following cancer: A conceptual and empirical review</td>
<td>Katon, W. J. (2003)</td>
<td>Investigates whether or not a PTSD diagnosis is applicable to the psychological reaction to being diagnosed with cancer. This review highlights that there are many unanswered questions pertaining to cancer-related PTSD. The initial data suggest that a significant proportion of cancer patients suffer PTSD symptoms, and this points to the need for more systematic study of this form of PTSD.</td>
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<td>Symptoms distress and quality of life in patients with cancer newly admitted to hospice home care</td>
<td>McMillan, S. &amp; Small, B. (2002)</td>
<td>To evaluate the relationships between quality of life and symptom distress, pain intensity, dyspnea intensity, and constipation intensity in people with advanced cancer who were newly admitted to hospice home care. Quality of life was affected by symptom distress in people with advanced cancer near the end of life. The symptoms most commonly reported and those that cause the greatest patient distress should be addressed first by hospice nurses. Continued effort is needed in the important area of symptom management.</td>
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<td>Clinical practice guidelines for the psychosocial care of adults with cancer</td>
<td>National Breast Cancer Coalition &amp; National Cancer Control Initiative (2003)</td>
<td>The development of Clinical practice guidelines for the psychosocial care of patients with medical illness is a newer initiative, and more complex as the target audience includes health care professionals from diverse backgrounds. This report outlines the development of psychosocial care guidelines in the international context, gives an overview of their content, and describes strategies for their implementation and evaluation.</td>
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<td>Unmet needs in cancer patients: development of a supportive needs screening tool (SNST)</td>
<td>Pigott, C., Pollard, A., Thomson, K., Aranda, S. (2007)</td>
<td>This article reports the first steps in the development of a supportive needs screening tool appropriate for use in an oncology outpatient setting. The routine use of systematic screening processes for unmet needs in a tertiary clinical cancer setting does not occur. The results of the current study provide support for the face validity; however, further psychometric testing is required to examine the construct validity and reliability of the supportive needs screening tool.</td>
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<td>Barriers to the provisions of evidence</td>
<td>Schofield, P., Carey, M., Bonevski, B., Sanson-</td>
<td>To determine whether the precede-proceed</td>
<td>The precede-proceed model is a useful framework to direct the</td>
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<td>Based psychosocial care in oncology</td>
<td>Fisher, R. (2006)</td>
<td>Model an effective framework for elevating the gap between recommended best evidence psychosocial and supportive care and actual practice.</td>
<td>Design of implementation research, which is critical to achieving the ultimate goal of elevating the suffering associated with a cancer diagnosis.</td>
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<td>Screening new cancer patients for psychological distress using the hospital anxiety and depression scale</td>
<td>Sellick, S. &amp; Edwardson, A. (2007)</td>
<td>To determine whether or not it is possible to collect information about the psychological distress of a patient population and to use that information in order to: (1) identify those most in need at a particular point in time; and (2) use that information to inform and direct the practice of a group of clinicians charged with working with those individuals.</td>
<td>Having a protocol that makes it possible for cancer patients to quickly and easily convey something of their present mental state and provide a self-report of their level of distress has been helpful to individuals who have been asked to provide supportive care or psychosocial counseling to individuals in need.</td>
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<td>The cancer communication assessment tool for patient and families (CCAT-PF): A new measure</td>
<td>Siminoff, L., Zyzanski, S., Rose J., Zhand, A. (2008)</td>
<td>To examine the validity and reliability of the CCAT-PF as a new instrument in the assessment of congruence in patient–family caregiver communication for both research and clinical purposes.</td>
<td>The CCAT-PF had convergent and divergent validity across a spectrum of well-validated social and physical status instruments. Although administering both family and patient versions is optimal, administering it to a patient or family caregiver only can produce reliable information.</td>
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<td>Screening for psychological distress in palliative care: A systemic review</td>
<td>Thekkumpurath, P., Venkateswaran, C., Kumar, M., Bennett, M. (2008)</td>
<td>This is a systematic review that summarizes the evidence for screening for psychological distress in a palliative care setting.</td>
<td>The usefulness of psychiatric questionnaires depends on changes in professional behavior, such as using them in routine practice to produce action on the results by clinicians. Screening programs in palliative care settings are most effective when coupled with an educational program to raise awareness among non psychiatric staff and the presence of a dedicated and responsible specialist psychiatric input.</td>
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<td>The prevalence of psychological distress by cancer site</td>
<td>Zabora, J., Brintzenhofeszoc, K., Curbow, B. (2001)</td>
<td>The goal of this project was to determine the prevalence of</td>
<td>These results offer vital support for the need to identify high risk patients through psychosocial</td>
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psychological distress among a large sample of cancer patients.

...screening in order to provide early intervention. To simply perceive cancer patients as a homogeneous group is an inaccurate assumption. Failure to detect and treat elevated levels of distress jeopardizes the outcomes of cancer therapies, decreases patients’ quality of life, and increases health care costs.
REFERENCES


Greer, D. & Mor, V. (1986). An overview of the national hospice study findings. Journal of Chronic Disease, 39(1), 5-7.


