Detecting Distress

Introducing routine screening in a gynecologic cancer setting

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BACKGROUND: Cancer results in a wide range of challenges that contribute to patient distress. Detecting distress in patients can result in improved patient outcomes, and early intervention can avoid patients having unmet needs.

OBJECTIVES: The aims were to determine the prevalence of distress in patients with gynecologic cancers, identify specific problems, and explore staff perceptions of distress screening.

METHODS: A mixed-methods design was used. Quantitative data were collected on distress levels and problems. Qualitative interviews were conducted with healthcare professionals.

FINDINGS: Sixty-six percent of women scored 4 or greater on the Distress Thermometer, which was used as the indicator for follow-up or referral. A third reported low distress, and the same proportion was highly distressed. The top five problems identified by participants were nervousness, worry, fears, fatigue, and sleep problems.

KEYWORDS
gynecologic cancer; oncology; distress screening; Distress Thermometer

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ALONGSIDE PHYSICAL SYMPTOMS AND SIDE EFFECTS of treatment, cancer results in psychological, social, and practical challenges, which can contribute to patient distress (Carlson, Waller, Groff, Giese-Davis, & Bultz, 2013). The International Psycho-Oncology Society highlights distress as a critical factor affecting patients' well-being and recommends that distress be named the sixth vital sign in oncology (Holland, Watson, & Dunn, 2011). The reported prevalence rates of psychological distress in patients with cancer range from 35%–49% (Carlson, Groff, Maciejewski, & Bultz, 2010). However, the actual rates of distress are thought to be much higher because of underdetection. Clinician assessments have been shown to be inferior to gold-standard methods, such as validated screening tools and clinical interviews (Werner, Stenner, & Schüz, 2012), and distress is often missed by clinicians (Mitchell, Vahabzadeh, & Magruder, 2011).

Distress encompasses a range of issues, including psychological, spiritual, and existential distress, as well as juggling roles and having financial concerns and practical problems, such as needing help with accommodation or travel. Distress is associated with poorer physical and psychological quality of life (Carlson et al., 2010). Detecting distress in patients with cancer can result in early intervention, which helps avoid patients struggling with unmet or complex needs (Faller et al., 2013). Identifying distress early could also reduce the financial burden on health services (Han et al., 2015). Healthcare professionals (HCPs) must recognize distress so it can be adequately managed (Werner et al., 2012); to do this, HCPs need to screen all patients systematically.

Several organizations and professional bodies state in their standards for quality cancer care that psychosocial support should include routine screening for distress, followed by appropriate referrals targeted to the needs identified by patients (Holland et al., 2011; Werner et al., 2012). Despite this, uptake of routine distress screening in clinical oncology settings has been suboptimal (Mitchell, Lord, Slattery, Grainger, & Symonds, 2012). Many barriers exist to the successful implementation of routine distress screening in clinical settings, including a lack of training, clinicians' perception of limited skills and confidence in identifying distress, and inadequate referral resources (Absolom et al., 2011). A shortage of private space has also been identified (Ristevski et al., 2013). Many HCPs believe that addressing distress will take too much time. However, appropriate recognition and discussion of emotions can reduce consultation times (Butow, Brown, Cogar, Tattersall, & Dunn, 2002).

Roth et al. (1998) developed a single-item Distress Thermometer (DT), which the National Comprehensive Cancer Network (Vitek, Rosenzweig, &