

**Analyzing Psychosocial Distress Screenings: A Quality Improvement Project that Modifies
the Frequency of Screenings**

Kady Conrad, BSN, RN-BC, DNP Student

Department of Nursing, Lenoir Rhyne University

Author Note

Kady Conrad, BSN, RN-BC  <https://orcid.org/0000-0002-9070-5578>

Judy Phillips, DNP, FNP-BC, AOCN  <https://orcid.org/0000-0002-0431-3229>

Kerry Thompson, PhD, MSN, RN  <https://orcid.org/0000-0001-7228-854X>

Len Hurst, MS DABR

We have no conflicts to disclose.

If you have any questions, please contact Kady Conrad at kady.conrad@my.lr.edu

**Analyzing Psychosocial Distress Screenings: A Quality Improvement Project that Modifies
the Frequency of Screenings**

Abstract

Background/Purpose: Distress is a multifactorial unpleasant experience that can interfere with the patients' ability to cope with cancer. Research has recognized the effectiveness of interventions in the ability to reduce distress and positively impact patient outcomes. Therefore, the American College of Surgeon's Commission on Cancer (ACSCoC) mandated that all cancer centers screen for distress to maintain and/or receive accreditation. The frequency of distress screening is up to the discretion of the cancer center; however, it is recommended to screen for distress at every medical visit. Due to this, cancer centers have implemented protocols that vary widely in their screening characteristics. This lack of consistency complicates the interpretation of research results that are intended to better understand and manage this issue. Therefore, more research is needed to determine the specific aspects of the distress screening process that need to be modified to achieve optimal patient outcomes.

Methods: This quality improvement project (QI) took place at a local radiation therapy office in western North Carolina, where the facility's protocol was to administer the National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List only at the initial visit. In this project, the nursing staff administered the NCCN Distress Thermometer and Problem List once a week for a three-month period, to see if there would be improvement in the facility's ability to recognize and address psychosocial distress among their patients. The results were then gathered from a retrospective chart review and compared to the existing documentation collected from a designated three-month period.

Findings: The results of the two-tailed Mann-Whitney U Test were significant and indicate that increasing the frequency of psychosocial distress screenings does provide a significant improvement in the recognition of psychosocial distress.

Conclusion: Despite the limitations, the study does provide evidence that increasing the frequency of psychosocial distress screenings can improve a facility's ability to recognize and address patient distress.

Research has shown that cancer diagnosis and treatment, whatever its prognosis, is a significantly stressful event that generates psychological distress in a large number of cancer patients (Grassi et al., 2017). Psychological distress is defined as a state of emotional anguish characterized by symptoms of depression and anxiety (Grassi et al., 2017). Distress in patients with cancer is correlated with negative physical and psychological consequences, which includes symptom severity, interference with daily life, fear, emotional distress, a sense of losing control, diminished quality of life, and decreased chance of survival. (Grassi et al., 2017). This distress may persist throughout the cancer care continuum, not only affecting patients' quality of life, but also their ability to adhere to treatment (Grassi et al., 2017).

Problem Statement

A diagnosis of cancer, its treatment, and surveillance are fraught with distress (Lazenby et al., 2018). The severity of the distress can range from feelings of vulnerability, sadness, and fear to issues that can become disabling such as depression, anxiety, panic, and social isolation (Lazenby et al., 2018). Most importantly the impact of distress has been associated with reduced quality of life and potentially reduced survival (Lazenby et al., 2018). One study investigated the prevalence rate of distress measured by various screening instruments such as the National Comprehensive Cancer Network (NCCN) Distress Thermometer or the Brief Symptom Inventory and discovered that the prevalence rate ranged from 22% to 58% (Lazenby et al., 2018). The pooled results from the study suggested that approximately 40% of cancer patients report significant distress (Lazenby et al., 2018). For this reason, the Institute of Medicine convened to discuss delivering psychosocial services to patients with cancer (Lazenby et al., 2018). The resulting report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, set the quality care standard that psychosocial care must be routinely integrated with

biomedical cancer care for all patients (Lazenby et al., 2018). The panel found that the best way to integrate care is to screen patients early for psychosocial distress and to connect them with psychosocial healthcare services (Lazenby et al., 2018). Based off this, the American College of Surgeons Commission on Cancer mandated, in 2015, that every patient receiving treatment for cancer be screened for psychosocial distress at a pivotal medical visit, such as time of diagnosis, transition in cancer treatment, recurrence, completion of cancer treatment, or progression of disease in order to maintain accreditation (Lazenby et al., 2018). The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology for Distress Management reported that ideally, patients should be screened for distress at every medical visit as a hallmark of patient-centered care; however, the guideline currently recommends that all patients should be screened for distress at the initial visit, at appropriate intervals, and as clinically indicated (NCCN, 2018). These existing guidelines and accreditation standards are not consistent in their recommendations for how, when, or how often patients need to be screened for psychosocial distress (Deshields et al., 2021). As a result, cancer centers have implemented protocols that vary widely in their screening characteristics (Deshields et al., 2021). This lack of consistency complicates the interpretation of research results that are intended to better understand and manage this issue (Deshields et al., 2021). Therefore, more research is needed to determine the specific aspects of the distress screening process that are needed to achieve optimal patient outcomes.

A radiation therapy department in western North Carolina was one of the first cancer centers in the area to use the NCCN Distress Thermometer and Problem List (Appendix A) to screen their patients for distress. The current protocol is for the nurses to administer the screening tool to the patients at their initial visit. The physicians are informed of the results and

then they are entered into the electronic medical record (EMR). The physician will discuss the results with the patient and if the patient reports significant distress, then the social worker will set up the referrals or provide them with resources.

Purpose of Project

The main purpose of this quality improvement (QI) project is to implement a psychosocial distress screening tool once a week to determine if it improves the facility's recognition of psychosocial distress among its patients. The secondary purpose is to implement a system change if there is significant improvement in the recognition of psychosocial distress.

Literature Review

Understanding Distress

A cancer diagnosis can create a threat to an individual's sense of security and orderliness in life (NIH, 2012). This threat is often due to a deep-seated fear that any cancer represents pain, suffering, and death (NIH, 2012). This fear often leads to stress, which is a normal experience for an individual with cancer; however, individuals who experience high levels of stress or who experience it repeatedly over a long period of time may develop mental and/or physical health problems (NIH, 2012). This stress can eventually lead to distress when individuals have insufficient internal and external coping mechanisms to facilitate the accumulation of stressors derived from the disease, the treatment side effects, or other factors related to their diagnosis (NIH, 2012). Research has shown that extreme distress is associated with anxiety, depression, impaired social relationships, reduced quality of life, risk of suicide, poor treatment adherence, family dysfunction, and possibly shorter survival rate (Grassi et al., 2014). In addition to these outcomes, there is some evidence to suggest that stress can affect a tumor's ability to grow and metastasize. For example, one study found that tumors transplanted into the mammary fat pads

of mice had much higher rates of metastasis if the mice were chronically stressed compared to mice that were not stressed, due to norepinephrine promoting angiogenesis and metastasis (NIH, 2012). Another study discovered that women with triple-negative breast cancer, who were taking beta blockers while receiving chemotherapy, had a better chance of surviving their cancer treatment without a relapse, compared to women who were not taking beta blockers (Melhem-Bertrandt et al., 2011).

The Standards for Distress Screening

Since 2015, cancer distress screenings have been mandated for continued cancer center accreditation by the American College of Surgeons Commission on Cancer (CoC) (CoC, 2020). CoC accreditation is granted to facilities that are committed to providing the best care possible and demonstrating compliance with the CoC standards (CoC, 2020). Each cancer center must undergo rigorous evaluation every three years to review its performance and compliance with these standards to maintain accreditation (CoC, 2020). The American College of Surgeons revised the format of the 2016 CoC standards in 2020 to align with their other quality programs (CoC, 2020). The updated standards state all patients must be screened for distress at least once during the patient's first course of treatment (CoC, 2020). However, additional screenings can be provided and are up to the discretion of the cancer center (CoC, 2020). The center must have a policy that details their specific process for assessing and treating patients with distress (CoC, 2020). The center can select any psychosocial distress screening tool, but preference is given to standardized, validated instruments with established clinical cutoffs (CoC, 2020). Finally, if moderate to severe distress is identified in a patient, then a member of the oncology team needs to discuss the results with that patient face-to-face and provide or refer resources based on their needs (CoC, 2020).

Distress Screening Tools

In the United States, neither the Commission on Cancer nor other cancer organizations specify which screening tool should be used to identify patients with distress. As a result, there is a wide variety of tools being used in cancer centers today. The most frequently used instrument is the National Comprehensive Cancer Network (NCCN) Distress Thermometer and Problem List (NCCN, 2018). Other instruments include Patient Health Questionnaire (PHQ-9), Brief Symptom Inventory-53, Beck Depression Inventory, and Beck Anxiety Inventory. The Distress Thermometer is a one-item, 11-point Likert scale represented on a visual graphic of a thermometer that ranges from zero (no distress) to ten (extreme distress), in which patients indicate their level of distress (NCCN, 2018). Originally, a cut off score of five was used to identify patients experiencing significant distress; however, the most recent version of the NCCN practice guidelines recommends that a score of four or higher indicates moderate to severe distress (NCCN, 2018). Patients who report high levels of distress are administered the accompanying 40-item problem list, which lists common problems related to the cancer experience (NCCN, 2018). This problem list helps providers identify whether the patient is experiencing practical, emotional, family, spiritual-religious, or physical problems (NCCN, 2018). NCCN states the goal is to have the patients' distress score rating become as common as the pain scale rating (NCCN, 2018).

Challenges to Distress Screening and Recommendations

Existing guidelines, recommendations, and accreditation standards do not state how, when, or how often to screen patients for distress (Deshields et al., 2021). As a result, cancer centers have implemented protocols that vary widely, which contributes to variations observed in clinical practice outcomes, related to the implementation of distress protocols, and complicates

the interpretation of research results that are geared toward understanding this issue (Deshields et al., 2021).

The frequency of distress screenings is one point that contributes to the variability observed in clinical practice (Deshields et al., 2021). The CoC guidelines specify that patients must be screened at least once during the patient's first course of treatment (CoC, 2020). While the NCCN guidelines have specified the aspirational goal of screening every patient at every visit as a part of patient-centered care (NCCN, 2018). However, research has shown that many centers struggle to implement a screening process at every visit, due to lack of resources or logistics (Deshields et al., 2021). Therefore, one study recommended screening patients with advanced disease more frequently due to the high prevalence and severity of disease symptoms and distress (Deshields et al., 2021). Another study discovered that screening patients every other week optimized efficiency and frequency, by identifying nearly 90% of distressed patients with 12% of the screening events compared with daily screening.

Theoretical Framework

The Neuman Systems Model was used for this project to achieve optimal wellness through a holistic system-based approach. This middle-range nursing model is based on the theory that living organisms interact with each other and with the environment (*Neuman's Systems Model*, 2020). It focuses on the response of the patient system (physiological, psychological, sociocultural, developmental, and spiritual) to actual or potential environmental stressors and uses primary, secondary, and tertiary interventions to assist the individual in retaining, attaining, or maintaining stability (*Neuman's Systems Model*, 2020). This project used this model to provide primary prevention by having the staff educate the patients about distress, secondary prevention by using the NCCN Distress thermometer and problem list to identify

patients that are distressed, and tertiary prevention by referring patients for further assessment and supportive resources.

The facility is a five-time magnet recipient; therefore, it was important to address the Magnet Model for the theoretical development of this project. The Magnet Model is designed to provide a framework for nursing practice and research in the future (ANCC, 2020). It encourages facilities to strive for discovery and innovation, while leading the reformation of healthcare. The five components of this model are transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and empirical quality results (ANCC, 2020). Each of these components was addressed in the formulation of this project.

Methodology

Design

This was a three-month quality improvement (QI) project implementing the psychosocial distress screening tool weekly, using a descriptive, quasi-experimental design to obtain the primary outcome.

Setting and Resources

The implementation of this QI project was at a radiation therapy department in Western North Carolina. It is accredited by the ACSCoC as a comprehensive community cancer center and treats adult patients with various cancer diagnoses. The staff is composed of radiation oncologists, radiation therapists, dosimetrist, medical physicist, and registered nurses. The medical physicist, who is also the medical director of the radiation therapy department, is the stakeholder for this project.

The radiation therapy department has been utilizing the NCCN Distress Thermometer and Problem List (Appendix A) for their distress screening tool since 2015 to comply with the ACSCoC requirement. Their current protocol is for the nursing staff to distribute the screening tool to all patients at their initial visit. The completed screening tool is then reviewed and scanned into the medical record. If moderate to severe distress (score ≥ 4) is reported, then the staff uses the associated problem list to identify key issues of concern and ask further questions to determine the best resources (psychiatry, social work, chaplain, etc.) to address the concerns.

Intervention

The radiation therapy staff was educated about the QI project and their role. The registered nurses provided all patients with the NCCN Distress Thermometer and Problem list once a week for three months. The staff then followed the existing protocol, for assessing and managing patient distress. After the three-month period, the reported distress scores were collected via the EMR and compared with the reported distress scores from a three-month period prior to the initiation of the study. The data was only accessible by the private investigator (PI) and the stakeholder. The data was deidentified and stored on an encrypted jump drive. The deidentified data was then entered into Intellectus © for analysis.

Sample

A convenience sample was used in this project. The sample size included all participants that meet the criteria for the control group and for the experimental group. The inclusion criteria for the control group included patients that were scheduled to receive their initial radiation treatment prior to the initiation of the study in a designated three-month period. The inclusion criteria for the experimental group included all patients that are scheduled to receive radiation treatment after the implementation of the study in a designated three-month period. The exclusion criteria

for both groups were patients 17 years or younger, prisoners, wards of the state, mentally disabled person, and cognitively impaired persons. The information that was collected from each group was the reported distress score and if the staff provided resources to patients reporting moderate to severe distress (score ≥ 4).

Analysis

Statistical analysis was performed using the program Intellectus Statistics ©. Clinical data was analyzed using descriptive statistics. The relationship of the distress scores between the control group and the experimental group were investigated with the two-tailed Mann-Whitney U Test.

Ethical Consideration

The QI project was approved by the Institutional Review Board (IRB) at Lenoir-Rhyne University and Catawba Valley Medical Center. The collected data was de-identified via alphanumeric coding and stored on a secure private drive with two levels of password protection at the site of implementation, prior to being entered into Intellectus © for analysis. Following the completion of the project, all the data was secured on the private drive and will be deleted, according to hospital policy, in three years.

Data Analysis

Descriptive Statistics

A total of 52 distress scores were reported prior to the initiation of the project, with an average score of 1.19 ($SD = 2.33$, $SE_M = 0.32$, $Min = 0.00$, $Max = 10.00$, $Skewness = 2.18$, $Kurtosis = 4.08$). There were 35 patients (67.3%) that reported no distress (score 0), 11 patients (21.2%) that reported mild distress (<4), and 6 patients (11.5%) that reported moderate

to severe distress (score ≥ 4). One hundred percent of the patients that reported moderate to severe distress were offered resources by the staff to address their distress.

Table 1*Control Distress Scores*

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max	Skewness	Kurtosis
Distress_Score	1.19	2.33	52	0.32	0.00	10.00	2.18	4.08

Note. '-' indicates the statistic is undefined due to constant data or an insufficient sample size.

Table 2*Control Frequency Table*

Variable	<i>n</i>	%
Distress_Score		
0	35	67.31
1	6	11.54
3	5	9.62
5	2	3.85
6	1	1.92
7	1	1.92
8	1	1.92
10	1	1.92
Missing	0	0.00
Resources_Provided		
No	46	88.46
Yes	6	11.54
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

A total of 180 distress scores were reported after the initiation of the project, with an average score of 2.01 ($SD = 2.12$, $SE_M = 0.16$, $Min = 0.00$, $Max = 9.00$, $Skewness = 1.14$, $Kurtosis = 0.80$). There were 57 patients (31.7%) that reported no distress (score 0), 83 patients (46.1%) that reported mild distress (<4), and 40 patients (22.2%) that reported moderate

to severe distress (score ≥ 4). One hundred percent of the patients that reported moderate to severe distress were offered resources by the staff to address their distress.

Table 3*Experimental Distress Score*

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max	Skewness	Kurtosis
Distress_Score	2.01	2.12	180	0.16	0.00	9.00	1.14	0.80

Note. '-' indicates the statistic is undefined due to constant data or an insufficient sample size.

Table 4*Experimental Frequency Table*

Variable	<i>n</i>	%
Distress_Score		
0	57	31.67
1	36	20.00
2	27	15.00
3	20	11.11
4	17	9.44
5	10	5.56
6	4	2.22
7	5	2.78
8	2	1.11
9	2	1.11
Missing	0	0.00
Resources_Provided		
No	140	77.78
Yes	40	22.22
Missing	0	0.00

Note. Due to rounding errors, percentages may not equal 100%.

Two-Tailed Mann-Whitney *U* Test

A two-tailed Mann-Whitney two-sample rank-sum test was conducted to examine whether there were significant differences in Time_1 between the levels of Treatment. The two-

tailed Mann-Whitney two-sample rank-sum test is an alternative to the independent samples *t*-test, but does not share the same assumptions (Conover & Iman, 1981). There were 52 observations in group Control and 81 observations in group Experimental.

Results

The result of the two-tailed Mann-Whitney *U* test was significant based on an alpha value of .05, $U = 1492.5$, $z = -3.01$, $p = .003$. The mean rank for group Control was 55.20 and the mean rank for group Experimental was 74.57. This suggests that the distribution of time 1 for the control group was significantly different from the distribution of time 1 for the Experimental group. The median for Control ($Mdn = 0.00$) was significantly lower than the median for Experimental ($Mdn = 1.00$). Table 5 presents the result of the two-tailed Mann-Whitney *U* test.

Table 5

Two-Tailed Mann-Whitney Test

Variable	Mean Rank		<i>U</i>	<i>z</i>	<i>p</i>
	Control	Experimental			
Time_1	55.20	74.57	1,492.50	-3.01	.003

Discussion

Distress from cancer, whether that be from the diagnosis or the side effects of the treatment, can cause emotional, spiritual, social, financial, and psychological challenges that can lead to coping difficulties, poor quality of life, and possibly poor physiologic cancer outcomes if left unaddressed (Deshields et al., 2021). By screening for distress, it provides a way to identify patient stressors and allow further assessment or referral for psychosocial care. Due to this, the ACSCoC mandated cancer centers to screen for psychosocial distress at a pivotal medical visit; however, the lack of consistent recommendations for how, when, or how often patients need to be screened for psychosocial distress has led to a wide variety of distress screening protocols

being implemented (Deshields et al., 2021). Therefore, this QI project's intention was to determine whether increasing the frequency of distress screenings improved the recognition of psychosocial distress.

Key Findings

The results of the two-tailed Mann-Whitney U Test were significant and indicate that the observed difference between the control and experimental are not likely due to random variation. Thus, it can be assumed that increasing the frequency of psychosocial distress screenings does provide a significant improvement in the recognition of psychosocial distress.

The results of the descriptive statistics indicate that one hundred percent of the patients reporting moderate to severe distress were offered resources by the staff to address their distress. This finding is extremely important, because successful distress screening programs must review and acknowledge the scores in an effective and timely manner, while providing appropriate interventions.

Implications for Practice

In clinical practice, it is important to identify psychosocial distress in cancer patients as soon as possible. By increasing the frequency of distress screenings, it can become a part of the routine assessment and allow for earlier recognition of psychosocial distress. This increased frequency will not only improve the patients' quality of life, but also positively impact the healthcare system by improving patient satisfaction.

Limitations

In this project, there were some limitations that need to be noted. First, the project sample was small, and the results of the study may not be generalizable to other cancer facilities. Secondly, the patients were in various phases of a treatment plan, which resulted in some

patients only completing two to three distress screening tools. Finally, the response rate towards the end of the study was lower than expected, which is thought to be due to patient burnout.

Conclusion

Individuals who are diagnosed with cancer, especially those with advanced disease or limited life expectancy, are particularly vulnerable to distress. Due to this distress, the NCCN guidelines suggest the need for more frequent screenings; however, there is limited research to determine if increasing the frequency of screenings actually improves the recognition of distress. Therefore, this project's intentions were to provide additional research and ultimately improve the facility's ability to recognize psychosocial distress. Despite the limitations, this project does provide evidence that increasing the frequency can improve a facility's ability to recognize and address patient distress. However, additional projects are needed to confirm optimal distress screening frequencies.

References

- ANCC. (2020). *Magnet Model- Creating a Magnet Culture*
[<https://www.nursingworld.org/organizational-programs/magnet/magnet-model/>].
American Nurses Association.
- Chiang, A., Amport, S., Corjulo, D., Harvey, K., & McCorkle, R. (2015). Incorporating patient-reported outcomes to improve emotional distress screening and assessment in an ambulatory oncology clinic. *Journal of Oncology Practice, 11*(3).
- CoC. (2020). *Optimal Resources for Cancer Care: 2020 Standards*. American College of Surgeons. https://www.facs.org/-/media/files/quality-programs/cancer/coc/optimal_resources_for_cancer_care_2020_standards.ashx
- Conover, W. J., & Iman, R. L. (1981). Rank transformations as a bridge between parametric and nonparametric statistics. *The American Statistician, 35*(3), 124–129.
<https://doi.org/10.1080/00031305.1981.10479327>
- Cuttillo, A., O'Hea, E., Person, S., Lessard, D., Harralson, T., & Boudreaux, E. (2017). NCCN Distress Thermometer: cut off points and clinical utility. *Oncology Nursing Forum, 44*(3), 329–336.
- Deshields, T. L., Wells-Di Gregorio, S., Flowers, S. R., Irwin, K. E., Nipp, R., Padgett, L., & Zebrack, B. (2021). Addressing distress management challenges: Recommendations from the consensus panel of the American Psychosocial Oncology Society and the Association of Oncology Social Work. *A Cancer Journal for Clinicians*.
- Grassi, L., Caruso, R., Sabato, S., Massarenti, S., & Nanni, M. G. (2014). Psychosocial screening and assessment in oncology and palliative care settings. *Frontiers in Psychology, 5*.

Grassi, L., Spiegel, D., & Riba, M. (2017). *Advancing Psychosocial Care in Cancer Patients*.

PMC. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5717468/>

Hess, C. B., Singer, M., Khaku, A., Malinou, J., Juliano, J., & Varlotto, J. M. (2015). Optimal frequency of psychosocial distress screening in radiation oncology. *Journal of Oncology Practice, 11*(4).

Intellectus Statistics (Online computer software). (2021). Intellectus Statistics.

<https://analyze.intellectusstatistics.com/>

Lazenby, M., Ercolano, E., Knies, A., Pasacreta, N., Grant, M., Holland, J., Jacobsen, P., Badger, T., Jutagir, D., & McCorkle, R. (2018). Psychosocial distress screening. *Clinical Journal of Oncology Nursing, 22*(3).

Melhem-Bertrandt, A., Chavez-Macgregor, M., Lei, X., Brown, E. N., Lee, R. T., Meric-Bernstam, F., Sood, A. K., Conzen, S. D., Hortobagyi, G. N., & Gonzalez-Angulo, A. (2011). Beta-blocker use is associated with improved relapse-free survival in patients with triple-negative breast cancer. *Journal of Clinical Oncology, 29*(19).

Mishel, M., & Braden, C. (1988). Finding meaning: antecedents of uncertainty in illness. *Nursing Research, 37*, 98–103.

NCCN. (2018). *Distress Management*. NCCN Clinical Practice Guidelines in Oncology.

https://oncolife.com.ua/doc/nccn/Distress_Management.pdf

Neuman's Systems Model. (2020). Nursing Theory. <https://nursing-theory.org/theories-and-models/neuman-systems-model.php>

NIH. (2012). *Psychological Stress and Cancer*. National Cancer Institute.

<https://www.cancer.gov/about-cancer/coping/feelings/stress-fact-sheet>

Razali, N. M., & Wah, Y. B. (2011). Power comparisons of Shapiro-Wilk, Kolmogorov-Smirnov, Lilliefors and Anderson-Darling tests. *Journal of Statistical Modeling and Analytics*, 2(1), 21–33.

WHO. (2018). *International Agency for Research on Cancer*. World Health Organization.

<https://www.who.int/cancer/PRGlobocanFinal.pdf>

Zebrack, B., Kayser, K., Bybee, D., Padgett, L., Sundstrom, L., Jobin, C., & Oktay, J. (2017). A practice-based evaluation of distress screening protocol adherence and medical service utilization. *Journal of the National Comprehensive Cancer Network*, 15(7), 903–912.

Appendix A



National
Comprehensive
Cancer
Network*

NCCN Guidelines Version 1.2022 Distress Management

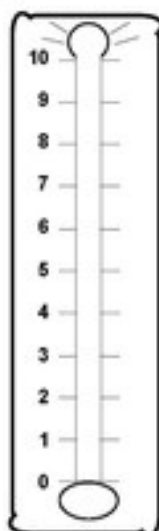
[NCCN Guidelines Index](#)
[Table of Contents](#)
[Discussion](#)

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress



No distress

PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns

- Pain
- Sleep
- Fatigue
- Tobacco use
- Substance use
- Memory or concentration
- Sexual health
- Changes in eating
- Loss or change of physical abilities

Emotional Concerns

- Worry or anxiety
- Sadness or depression
- Loss of interest or enjoyment
- Grief or loss
- Fear
- Loneliness
- Anger
- Changes in appearance
- Feelings of worthlessness or being a burden

Social Concerns

- Relationship with spouse or partner
- Relationship with children
- Relationship with family members
- Relationship with friends or coworkers
- Communication with health care team
- Ability to have children

Practical Concerns

- Taking care of myself
- Taking care of others
- Work
- School
- Housing
- Finances
- Insurance
- Transportation
- Child care
- Having enough food
- Access to medicine
- Treatment decisions

Spiritual or Religious Concerns

- Sense of meaning or purpose
- Changes in faith or beliefs
- Death, dying or afterlife
- Conflict between beliefs and cancer treatments
- Relationship with the sacred
- Ritual or dietary needs

Other Concerns:

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

Version 1.2022, 12/09/2021 © 2021 National Comprehensive Cancer Network® (NCCN). All rights reserved. NCCN Guidelines® and this illustration may not be reproduced in any form without the express written permission of NCCN.

DIS-A