



ALLIANCE FOR QUALITY PSYCHOSOCIAL CANCER CARE

Selected Bibliography of Psychosocial Screening Literature

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- ◆ Stanton AL. **What Happens Now? Psychosocial Care for Cancer Survivors After Medical Treatment Completion.** *J Clin Oncol.* April 10, 2012, 30: 11, 1215-1220.

In this review article, Stanton documents the need for attention to psychosocial care after treatment and into longer-term survivorship, provides an overview of evidence on the efficacy of interventions, and offers suggestions for application and research on post-treatment psychosocial care. The author describes studies showing that individuals have distinct trajectories of psychological and physical adjustment over months or years after diagnosis, noting that the re-entry phase poses particular challenges for survivors. These include: 1) loss of the safety net of active medical treatment and accompanying support; 2) resuming or altering previous rolls inside and/or outside the home; 3) declines in interpersonal support; and 4) lingering physical and psychological effects from cancer and its treatment. While there is a strong need by survivors for information upon completion of treatment, health care professionals generally provide little preparation for this post-treatment phase. The author notes that “proactive psychosocial care can aim to prevent or assuage concerns during re-entry and set the stage for adaptive survivorship.” Evidence also shows that even as long-term survivors report a quality of life that meets or exceeds the norms, specific problems can persist -- fear of recurrence, fatigue, sexual health, and depressive symptoms. Younger adult survivors have a consistent predictor of poorer quality of life post-treatment among adult survivors. Research suggests that while a large proportion of survivors can expect “relatively stable, positive functioning or marked recovery over time in psychological and physical domains” others will experience chronic psychological or physical health issues that impact quality of life and would benefit from more intensive psychosocial care.

Among hundreds of studies demonstrating the efficacy of psychosocial and behavioral interventions for cancer patients, most research is focused on patients in the diagnostic or active treatment phases. There are randomized trials indicating the interventions provided at re-entry can be effective, but most of these trials have been limited to breast and prostate cancer survivors, and that the interventions “are not uniformly effective across outcomes.” More research is needed on other cancers, as well as research evaluating long-term effects of health behavior change programs, and ensuring translation into practice” by making such programs accessible and cost-effective.

The evidence calls for patients' psychological and physical concerns to be monitored, and that patients want physicians to ask about their emotional concerns. However, more research is needed to determine if "systematically screening for distress or systematically offering all patients a chance to raise any concerns is more effective and efficient requires study." The author notes that randomized controlled trials are needed to "develop and refine interventions for survivors evidencing clinically significant levels of the problem in question (e.g., depression, anxiety, fatigue)." Research is also needed to identify "for whom and under what conditions psychosocial and behavioral interventions are most effective" to be able to target and tailor care for those who need it most. This tailoring includes identifying interventions for more diverse populations. Finally, Stanton highlights the need to devote more attention to the most effective pathways for disseminating interventions, which maximize effectiveness and accessibility.

- ◆ Zebrack B, Isaacson S. **Psychosocial Care of Adolescent and Young Adult Patients with Cancer and Survivors.** *J Clin Oncol.* April 10, 2012, 30: 11, 1221-1226.

The authors discuss the unique characteristics of the adolescent and young adult cancer patients and survivors, which pose challenges in delivering quality care. The article is intended to enhance the understanding the psychosocial challenges faced by adolescent and young adults, reviews interventions to address those challenges, and offer recommendations for improving care. The article highlights five domains of stress and coping for cancer patients and survivors that occur throughout the continuum of care: informational; practical; emotional; interpersonal; and existential and spiritual. The particular issues or concerns within each of these domains are unique for adolescent and young adult population. The authors outline the existing psychosocial interventions to reduce stress and provide coping skills, including peer support, technology-based interventions, and skill-based interventions. Finally, the authors offer a number of recommendations as well as listings for resources to help adolescents and young adults with cancer-related psychosocial issues.

- ◆ Rohan E. **Removing The Stress From Selecting Instruments: Arming Social Workers To Take Leadership In Routine Distress Screening Implementation.** *Journal of Psychosocial Oncology* 2012, Vol. 30, 6 pp667-678.

The Institute of Medicine (I.O.M. 2007) and the American College of Surgeons (ACoS) Commission on Cancer have brought the need for screening related to psychosocial distress to the forefront. In order to continue to receive accreditation from ACoS, facilities must comply with the mandate to screen for distress; the choice of screening tools is left to the discretion of each institution. This article provides a discussion of the scientific criteria which screening instruments must have in order to accurately measure distress. Reliability, which refers to an instruments ability to measure a concept over time with varied populations and contexts and validity which refers to the degree to which an instrument actually measures what it intends to measure and sensitivity and specificity were explored. The article described three instruments commonly used in hospital settings: the Hospital Anxiety and Depression Scale (HADS), the Brief Symptom Inventory-18 (BSI-18) and the Distress Thermometer (DT). Strengths and weaknesses

of each were explored. Considerations related to resources, cost and racial and cultural concerns were discussed. The article provides useful information for clinicians evaluating which tool would best meet the needs of their individual institution or work setting.

- ◆ Clark P, Bolte S, Buzaglo J, Golant M, Daratsos L, Loscalzo M. **From Distress Guidelines to Developing Models of Psychosocial Care: Current Best Practices.** *Journal of Psychosocial Oncology* 2012, Vol. 30, 6 pp 694-714.

Given that addressing distress in cancer patients is widely accepted as a necessary step in facilitating adjustment to illness, institutions and community centers are looking at screening tools and practices to meet the American College of Surgeons commission on Cancer mandate for screening. Evidence based guidelines for managing distress include screening, assessment, treatment and follow-up. This article looks at four different settings to examine the challenges, barriers and successes encountered in implementing a thorough and thoughtful approach to patient distress. A summary of key points reflects the following themes. Challenges related to resistance reflected staff concerns that they would not have sufficient manpower and or time to incorporate distress screening into already busy practices. The importance of communication and engaging all stakeholders early in the process was highlighted as a key element to ensuring success, as was sharing results each step along the way. One author described this as a comprehensive strategy of inclusion. Lessons learned and successes included the perception that biopsychosocial screening helped create better patient/professional partnerships through enhanced communication and that new programs could be and were developed in response to the data collected about patient needs.

- ◆ Kayser K, Acquati C, Tran,T. **No Patients Left Behind: A Systematic Review of the Cultural Equivalence of Distress Screening Instruments.** *Journal of Psychosocial Oncology* 2012, Vol. 30, 6 pp 679-693.

This article examines the issue of cultural sensitivity in distress screening instruments and the importance of considering if a particular measure or tool truly captures the level of distress in patients from culturally diverse backgrounds. Dr. Kayser et al make the point that sample populations upon which instruments were tested too often did not include data related to race or ethnicity. The article goes on to question why researchers, especially in Europe and Asia, were satisfied with having a homogeneous sample and made little effort to recruit patients from culturally diverse backgrounds. The point is made that given changing patterns of immigration we need screening instruments that address cultural dimensions in order to meet the needs of cancer patients for diverse ethnic and racial backgrounds. It is important to look at the possibility that current screening tools may carry some inherent and unintended bias. The constructs of conceptual equivalence and statistical equivalence were discussed. The article concluded with four recommendations related to screening for distress in a culturally sensitive manner: determine the cultural composition of patients; locate instruments validated in the patients native language; make the instrument available to providers; follow-up with those patients indicating distress to assess the validity of the instrument in identifying patients in need of services.

- ◆ Zabora J, MacMurray L. **The History of Psychosocial Screening Among Cancer Patients.** *Journal of Psychosocial Oncology* 2012, Vol. 30, 6. Pp. 625-635.

This overview of the history of psychosocial screening would be of interest to anyone looking at where we have been and how we have gotten to this point in terms of psychosocial screening. The authors share that the roots of screening stem from the work done in developing triage protocols for combat and natural disasters. Credit is given to early pioneers in the field of oncology i.e. Worden and Weisman, for their efforts to adapt the concept of battlefield and disaster triage for the population of people dealing with cancer. The theoretical basis for psychosocial screening is explored with mention of appraisal, meaning, internal and external resources as concepts that influence patient adjustment. The authors then move on to discuss the Distress Management Guidelines issued by the National Comprehensive Cancer Network (NCCN) in 1997; the 2007 IOM report which calls for screening linked to provision of services and periodic assessment; the Alliance for Quality Psychosocial Cancer Care, formed as a consortium of cancer organizations to integrate the recommendations of the IOM report into medical standard of care and The American College of Surgeons Commission on Cancer which among other recommendations mandates that accredited programs have a process to monitor psychosocial distress. This article is a succinct and well written overview of the history of screening and concludes with important considerations for the future.

- ◆ Traeger L, Greer J, Fernandez-Rubles C, Temel J, Pirl W. **Evidence Based Treatment of Anxiety in Patients With Cancer.** *J Clin Oncol* 2012 Vol. 30, 11, pp. 1197-1205.

Adjustment and anxiety disorders may be present in up to one third of adult outpatients being treated at oncology centers. Often this anxiety represents a reactivation of an underlying anxiety disorder brought to the foreground by the diagnosis of cancer. This article examines the evidence for choosing which instrument rates highest on detection of anxiety (Hospital Anxiety and Depression Scale or HADS), looked at disease and treatment factors that may mimic anxiety (pulmonary embolism, brain lesions) or exacerbate symptoms (use of steroids, insomnia, pleural effusions) and looked at how poorly controlled anxiety negatively affects cancer care. Psychosocial interventions which may include new patient orientation, psychotherapy, stress-management techniques, cognitive-behavioral therapy, supportive-expressive therapy, mind-body approaches, and pharmacologic interventions were explored for evidence of treatment efficacy. Pros and cons and contra-indications for psychosocial and pharmacologic interventions were discussed along with evidence based recommendations for which to use or avoid in specific situations.

- ◆ Giese-Davis G, Collie K, Rancourt K, Neri E, Kraemer HC, Spiegel D. **Decrease in Depression Symptoms Is Associated with Longer Survival in Patients With Metastatic Breast Cancer: A Secondary Analysis.** *J Clin Oncol* 29: 413-420.

In a secondary analysis of a randomized trial of supportive-expressive group therapy, 125 women with metastatic breast cancer completed a depression symptom measure (the Center for Epidemiologic Studies-Depression Scale [CES-D]) at baseline and were randomly assigned to a treatment group or to a control group that received educational materials. At baseline and 4, 8, and 12 months, 101 of 125 women completed a depression symptom measure. The treatment group received one year of supportive-expressive group therapy (SET). The authors examined whether decreasing depression symptoms over the first year of the study (the length of the intervention) would be associated with longer survival.

The secondary analysis in this study found that “decreases in depression symptoms over the first year of an RCT predicted longer survival times over the ensuing 14 years for a sample of 101 women with metastatic or recurrent breast cancer.” The study also found that “a decrease in depression over the initial intervention year of this randomized intervention trial predicted survival many years later.” This is one of only a few studies to test the process of change in depression as it relates to cancer survival. The study demonstrates that decreasing depression, with or without formal intervention, may improve quality as well as quantity of life for women with advanced breast cancer.

- ◆ American College of Surgeons Commission on Cancer. **Cancer Program Standards 2012: Ensuring Patient-Centered Care.** 2011.

These standards include a provision that CoC-accredited programs have a policy or procedure in place to ensure patient access to psychosocial services either on-site or by referral. The new standards are available at <http://www.facs.org/cancer/coc/cps2011.html>.

- ◆ Baken DM, Wooley C. **Validation of the Distress Thermometer, Impact Thermometer and combinations of these in screening for distress.** *Psycho-Oncology* 2011; 20 609-614

This study looked at options for screening patients for anxiety, depression and distress. Specifically four options were considered: using the Distress Thermometer (DT) alone, the Impact Thermometer (IT), the Distress Thermometer and Impact Thermometer paired and the Distress Thermometer and the Impact Thermometer summed. The HADS (Hospital Anxiety and Depression Scale) was used to validate the two brief screening tools. The study conclusion revealed that more accurate results may be obtained by using a combination of the D.T. and the I.T. albeit the complexity of the scoring produced a drawback to doing this as the ease of screening with the D.T. was lost when combined with the I.T.

- ◆ Barry D. Bultz, Christoffer Johansen. **Screening for Distress, the 6th Vital Sign: where are we, and where are we going?** Article first published online: 29 MAY 2011 DOI: [10.1002/pon.1986](https://doi.org/10.1002/pon.1986)

Abstract: *Our current ability to identify all patients feeling distress is not possible. Limitations in our screening tools and constrained financial resources may lead to one-time clinic screening procedures rather than routine screening. Likewise, we cannot be sure that we will identify clinically relevant and measurable effects of the screening activity if we do not have access to a system of referral and treatment for patients screened positive for distress 34. This all demonstrates the growing need for more trials investigating the effects of screening and treatments for distress. With the endorsement of distress as the 6th Vital Sign we are at a new threshold of comprehensive cancer care. The current challenge for Psycho-Oncology is how to use our science to improve patient care.*

◆ Palmer SC, Coyne JC. **Clinical Trial Did Not Demonstrate Benefits of Screening Patients With Cancer for Distress.** Editorial, *J Clin Oncol*, April 1, 2011, 29: 10, e277-78.

This letter to the editor discusses the study by Carlson et al (see above) regarding routine distress screening for breast and lung cancer patients. The letter states that the study did not demonstrate that screening cancer patients for distress reduced their distress, but this result was not reported in the article.

According to Palmer and Coyne, “there was no difference in mean distress at 3 months between patients with cancer who were simply screened for distress, those whose screening results generated a personalized report that was provided to them and placed in an electronic medical record, and those who, in addition to the report, received an offer to discuss any issues with psychosocial staff regardless of their level of distress.” The authors note that this raises potentially important clinical and policy questions. They suggest that instead of screening, patients could be asked if they would like to discuss any psychosocial concerns that they might have with oncologic or psychosocial staff regardless of level of distress. This would allow the additional resources and staffing required for screening to be directed to facilitating better patient-staff communication.

The authors acknowledge that screening for distress is widely advocated, but there is a lack of evidence that screening actually leads to reduced distress. They state that screening proponents of screening often “do not cite evidence, mis-cite null findings as supportive, or cite post hoc secondary and subgroup analyses as though they carry the same weight as primary outcomes, without noting that these are null findings.” The letter notes that those who advocate universal routine screening for distress of cancer patients should look at evaluations of evidence for the efficacy of screening for depression in general as well as in specialty medical settings. For instance, the US Preventive Services Task Force Recommendation Statement recommends against screening in settings in which staff-assisted depression care is not in place, a situation that characterizes most oncology care settings.

The authors encourage advocates (and they count themselves as such) to “look beyond the simple solution that screening offers and has yet to demonstrate, and to focus on the message that offering patients the chance to discuss their concerns, regardless of screening, may make a more substantial contribution to their well-being.”

- ◆ Loscalzo MJ, Clark KL, Holland J. **Commentary: Successful Strategies for Implementing Biopsychosocial Screening.** *Psycho-Oncology* 2011;20 455-462

This commentary discusses strategies to utilize in setting up a screening program. It begins with a review of why screening is important and goes on to explore the need to engage key stakeholders at the outset with policies that meet their needs and that avoid control and turf issues. The commentary highlights the importance of providing information as to the value of screening for stakeholders i.e. physicians, nurses, administrators. Implementing screening involves understanding the culture of the clinic and then providing in-service education complete with food and thank you notes to ensure staff feel appreciated as they undertake the process. The importance of securing physician champions was stressed as was the value of having a member of the screening team present during all screenings for the first week of the roll-out. The article concludes with a reminder that to ensure success key stakeholders must perceive the direct benefits to them as well as to patients and families.

- ◆ Linda E. Carlson, Shannon L. Groff, Olga Maciejewski, and Barry D. Bultz. **Screening for Distress in Lung and Breast Cancer Outpatients: A Randomized Controlled Trial.** *J Clin Oncol.* 28: Nov. 20, 2010. 4884-4891.

High levels of distress have been detected in patients in many countries, and recommendations to routinely screen for and treat distress have been published by a number of agencies, including the National Comprehensive Cancer Network. The primary objective of this study was to compare the efficacy of three versions of screening on subsequent distress (using the distress thermometer [DT]) in a population-based cohort of outpatients with breast and lung cancer. Other objectives were: to assess the impact of the three conditions on measures of anxiety and depression; and to assess the impact of receiving referrals to resources on changes in distress, anxiety, and depression across conditions.

High prevalence of distress was detected in these patients with lung and breast cancer, with almost two thirds of the patients with lung and half of the patients with breast cancer scoring over the cutoff for high distress at baseline. The authors noted that these levels are higher than previous reports of general outpatients using other assessment tools, but similar to results in a lung patient clinic that also used the DT. The authors primary hypotheses were partially confirmed in each tumor group. Mean distress scores for patients with breast cancer were lower at follow-up for those in both the full screening and triage groups compared to minimal screening, but the proportions in the high distress category did not differ across groups. In patients with lung cancer, although mean distress scores did not differ at follow-up, the proportion of patients with lung cancer with high distress was 20% lower in the triage condition than the other two. This indicates that those patients with lung cancer with the highest levels of initial distress benefited most from personalized triage, while those with low or moderate levels to begin with may have slightly increased. This randomized controlled trial found that routine online screening is feasible in a large cancer center and that intensive screening including feedback to patients and care providers followed by personalized triage may help to reduce future distress levels, particularly when coupled with the uptake of appropriate resources.

- ◆ International Pscho-Oncology Society. **International Psycho-Oncology Statement on Standards and Clinical Practice Guidelines in Cancer Care.** July 2010. http://www.ipos-society.org/about/news/standards_news.aspx

In July 2010, IPOS adopted a statement on the standards and clinical practice for oncology care:

- Quality cancer care must integrate the psychosocial domain into routine care
 - Distress should be measured as the 6th Vital Sign after temperature, blood pressure, pulse, respiratory rate and pain.
- ◆ Paul B. Jacobsen, David Shibata, Erin M. Siegel, Ji-Hyun Lee, William J. Fulp, Carlos Alemany, Guillermo Abesada-Terk, Jr., Richard Brown, Thomas Cartwright, Douglas Faig, George Kim, Richard Levine, Merry-Jennifer Markham, Fred Schreiber, Philip Sharp and Mokenge Malafa. **Evaluating the quality of psychosocial care in outpatient medical oncology settings using performance indicators.** *Psycho-Oncology*. DOI: 10.1002/pon.1849

An American Psychosocial Oncology Society workgroup developed indicators of quality of psychosocial care that may be measured through medical records review. This article describes the first large-scale use of these indicators to evaluate psychosocial care in outpatient medical oncology settings. The medical records of 1660 colorectal, breast and non-small cell cancer patients first seen by a medical oncologist in 2006 at 11 practice sites in Florida were reviewed for performance on indicators of the quality of psychosocial care.

Medical records were abstracted for numerous indicators of the quality of cancer care; however, this report focuses on two indicators of the quality of psychosocial care: (1) there should be evidence in the medical record that the patient's current emotional well-being was assessed within 1 month of the patient's first visit with a medical oncologist; and (2) if a problem with emotional wellbeing was identified, there should be evidence in the patient's medical record that action was taken to address the problem or an explanation provided for why no action was taken.

The findings showed that assessment of emotional well-being was significantly less likely to be documented than assessment of pain. A problem with emotional well-being was documented in 13% of records and evidence of action taken was documented in 58% of these records. Ten of eleven practice sites performed below an 85% threshold on each indicator of psychosocial care. Variability in assessment of emotional-well being was associated with practice site, and patient gender and age, while variability in assessment of pain was associated with practice site and cancer type.

This illustrates how use of the psychosocial care indicators allows identification of specific practice sites and processes of care that should be targeted for quality improvement efforts. Additionally, findings demonstrate the extent to which routine assessment of emotional well-being lags behind routine assessment of pain in cancer patients.

- ◆ Paul Jacobsen. **Improving Psychosocial Care in Outpatient Oncology Settings.** *Journal of the National Comprehensive Cancer Network.* 8: No. 4. April 2010. 368-370.

Clinical Practice Guidelines in Oncology: Distress Management were first issued by the NCCN in 1994 and are updated annually. These guidelines were developed based on the recognized need for better management of distress and with the intent of promoting best practices for the psychosocial care of patients with cancer. NCCN guidelines recommend that all patients undergo screening routinely to identify the level and source of their distress. The specific services and resources recommended are intended to be appropriate to the nature and severity of the problems identified through screening and, if indicated, further evaluation.

This article describes the efforts of the APOS work group to develop quality indicators and their testing as part of the Florida Initiative for Quality Cancer Care (FIQCC) and the Quality Oncology Practice Initiative of ASCO. The findings from these evaluations consistently indicate that, to date, efforts to promote routine symptom assessment have been more successful for pain than for emotional well-being. In addition, findings show considerable variability in quality of psychosocial care across practices. Most importantly, findings provide information that can be used by individual practices to make decisions about the need to improve the quality of psychosocial care they provide.

Practices participating in these evaluations were provided feedback showing how its performance compared with the average of all practices and to every practice individually. Evidence suggests that providing feedback in this manner can yield improvements in the quality of psychosocial care provided to patients. Although provision of feedback alone may yield improvements in the quality of psychosocial care, a more deliberate approach seems more likely to achieve the desired results. Dr. Jacobsen offers potential strategies for more deliberate approaches.

- ◆ Barbara L. Andersen, Lisa M. Thornton, Charles L. Shapiro, William B. Farrar, Bethany L. Mundy, Hae-Chung Yang, and William E. Carson, III. **Biobehavioral, Immune, and Health Benefits following Recurrence for Psychological Intervention Participants.** *Clin Cancer Res* 16(12) June 15, 2010.

A clinical trial was designed to test the hypothesis that a psychological intervention could reduce the risk of cancer recurrence. Newly diagnosed regional breast cancer patients (n = 227) were randomized to the intervention-with-assessment or the assessment-only arm. The intervention had positive psychological, social, immune, and health benefits, and after a median of 11 years the intervention arm was found to have reduced the risk of recurrence (hazard ratio, 0.55; P = 0.034). In follow-up, we hypothesized that the intervention arm might also show longer survival after recurrence. If observed, we then would examine potential biobehavioral mechanisms. Hazards analyses augment previous findings in showing improved survival for the intervention arm after recurrence. Follow-up analyses showing biobehavioral

advantages for the intervention arm contribute to our understanding of how improved survival was achieved.

- ◆ Beesley V, Eakin E, Steginga S, Aitken J, Dunn J, Battistutta D. **Unmet needs of gynaecological cancer survivors: implications for developing community support services.** *Psycho-Oncology*. 2008;17(4):392–400.

Abstract: *Eight hundred and two women participated in a population-based mail survey in 2004 (56% response rate). The questionnaire included a validated instrument to assess 45 need items across multiple supportive care domains, and a range of measures to evaluate related correlates consistent with a social–ecological perspective. Forty-three per cent of respondents reported having at least one moderate- or high-level unmet need. The five highest included needing help with fear about the cancer spreading (17%), concerns about the worries of those close to them (15%), uncertainty about the future (14%), lack of energy/tiredness (14%), and not being able to do things they used to do (14%).*

- ◆ Espie C, Fleming L, Cassidy J, Samuel L, Taylor L, White C, Douglas N, Engleman H, Kelly H, Paul J. **Randomized Controlled Effectiveness Trial of Cognitive Behavior Therapy Compared With Treatment As Usual for Persistent Insomnia in Patients With Cancer.** *J Clin Oncol*. Oct. 2008, Vol. 26 (28).

Sleep disturbance is well documented as a distressing problem for oncology patients. This article compared a cognitive behavioral intervention which consisted of 5 weekly sessions focused on standard CBT techniques i.e. stimulus control, sleep restriction, and cognitive therapy strategies to treatment as usual (TAU) in which physicians were free to prescribe, maintain, or discontinue prescriptions. Subjects in both groups were selected after having met criteria for chronic insomnia and were randomly assigned to either the intervention or the control group. Results indicated that patients receiving CBT for insomnia had a mean reduction of almost 1 hour in insomnia symptoms compared with no change in the TAU group. Results held at 6 months following intervention.

- ◆ Mehnert A, Koch U. **Psychological comorbidity and health-related quality of life and its association with awareness, utilization, and need for psychosocial support in a cancer registerbased sample of long-term breast cancer survivors.** *J Psychosom Res*. 2008; 64(4):383–391.

Abstract: *One thousand eighty-three patients were recruited through a population-based cancer registry an average of 47 months following diagnosis (66% response rate). Self-report measures including the Hospital Anxiety and Depression Scale, Posttraumatic Stress Disorder Checklist—Civilian Version, and Short-Form Health Survey were used.*

Thirty-eight percent of patients had moderate to high anxiety, and 22% had moderate to high depression; posttraumatic stress disorder was observed in 12%. The overall psychological comorbidity was 43% and 26% for a possible and probable psychiatric disorder. Disease

progress, detrimental interactions, less social support, a lower educational level, and younger age were predictors of psychological comorbidity. Lower QOL and higher levels of anxiety were observed in cancer survivors compared to age-adjusted normative comparison groups. Time since diagnosis had no significant impact on psychological comorbidity as well as QOL. Forty-six percent of women felt insufficiently informed about support offers. Insufficient knowledge was associated with older age and lower education. Since diagnosis, 57% had participated in cancer rehabilitation and 24% in other psychosocial support programs. Fifteen percent of all patients and 23% of those with a possible psychiatric disorder expressed their need for psychosocial support. Women with distress and perceived support needs who did not participate in past support programs were older, less educated, and less informed.

Findings show the long-term impact of breast cancer and indicate need for patient education, screening for psychosocial distress, and implementation of psychological interventions tailored in particular for older women.

- ◆ Garssen B, de Kok E. **How useful is a screening instrument.** *Psycho-Oncology*. 2008; 17(7):726–728. Letter to the Editor

Bert Garssen and Els de Kok raise issues about the effectiveness of screening instruments in this letter to the editor. They refer to several studies which reveal that while patients may be screened and referred for counseling many refuse help. Their point is that there is a discrepancy between detection of a problem and successful treatment. The authors of this letter mention another study that showed patients who had not scored high on a scale for anxiety and depression still none-the-less wanted counseling and sought that help out. A point was made that while the literature has studies examining the psychometrics of different tools there is a paucity of studies demonstrating actual benefit in clinical practice. One benefit of screening which they did identify is that screening can facilitate communication between patients and physicians and may lead to higher patient satisfaction because of the attention the oncology staff are paying to psychosocial issues.

- ◆ Ahna L. H. Pai, Anna Maria Patin-Fernandez, Mary McSherry, David Beele, Melissa A. Alderfer, Anne T. Reilly, Wei-Ting Hwang, Anne E. Kazak. **The Psychosocial Assessment Tool (PAT2.0): Psychometric Properties of a Screener for Psychosocial Distress in Families of Children Newly Diagnosed with Cancer.** *Journal of Pediatric Psychology*. July 3, 2007.

This study examines the validity and reliability of the Psychosocial Assessment Tool 2.0 (PAT2.0), a brief screener for psychosocial risk in families of children with cancer. The original PAT was a 20-item screening questionnaire that assessed a range of risk and resource factors including family structure, family resources, social support, child knowledge, school attendance, child emotional, and behavioral concerns, child maturity for age, marital/family problems, family beliefs, and other stressors (Kazak et al., 2001). The new PAT2.0 was shortened to 15 item sets, modified to improve question clarity, reformatted to be more user-friendly, and expanded in item content based on new knowledge and data from the original PAT study. The response format for the items was designed to be brief and simple (e.g., yes/no, categorical

responses, Likert-type scales), and takes approximately 10 minutes to complete. The study engaged 132 female and 72 male caregivers of 141 children newly diagnosed with cancer. The authors conclude that the study shows good internal consistency and test-retest reliability and support the PAT2.0 as a useful screening tool for newly diagnosed pediatric oncology patients and their families. The article also states that the data in this study support the use of the PAT2.0 to categorize families based on their level of risk where higher scores are indicative of greater levels of risk. Further research is needed to test larger sample sizes, to refine the measure further to evaluate the sensitivity and specificity of the PAT2.0 to fully understand its clinical utility in predicting distress. In addition, future research is needed to determine if the PAT2.0 could identify specific areas of risk and directly inform the multidisciplinary treatment teams on targeted psychosocial interventions and care, as well as understanding the ability of the tool to predict the “costs” associated with elevated risk.

- ◆ Palmer SC, Coyne JC. **Screening for depression in medical care—pitfalls, alternatives, and revised priorities.** *J Psychosom Res.* 2003;54(4): 279–287.

This study reviews the literature regarding screening in medical settings. The authors suggest that screening in itself is unlikely to improve patient outcomes, and that unapparent costs of screening may affect patient outcomes and health delivery systems negatively. The article offers suggestions for how screening instruments might be used to improve outcomes while minimizing negative effects on health care. The authors review evidence questioning the assumption that routine screening is an efficient and dependable means of improving patient outcomes and highlights some of the unintended consequences of screening. Based on existing research, the evidence suggests that routine screening in the primary care setting and increasing the identification of patients and initiating treatment is unlikely to reduce the prevalence of MDD. Research suggests that there would be a greater impact by improving treatment for those with already identified MDD, i.e., treating MDD as a chronic long-term illness and providing long-term management. In addition, improving the quality of routine screening would require substantial resources to reach even modest improvement. This paper does not address screening for distress in patients with cancer.

- ◆ Sollner W, Maislinger S, König A, Devries A, Lukas P. **Providing psychosocial support for breast cancer patients based on screening for distress within a Consultation-Liaison service.** *Psycho-Oncology.* 2004;13(12):893–897.

This article reported on results of a study conducted with women with breast cancer undergoing radiation therapy who were evaluated for anxiety and depression as well as evaluated for the need for assistance with social and financial problems and their interest in receiving supportive counseling. The instruments used were the Hospital Anxiety and Depression Scale (HADS) and the Questionnaire to Assess the Need for Psychosocial Support. The Distress Thermometer was not mentioned in this article; pros and cons of using the HADS were explored. The study’s authors concluded that short screening instruments like the HADS were useful for identifying patients with high distress albeit fails to take into account specific problems and fails to take into account the social support patients receive from their network

which for this article includes not only family and friends but refers to the support provided by their physicians and nurses. Issues of economic feasibility of using screening questionnaires were raised. Discussion included findings that women expressed the wish for supportive counseling from mental health professionals and that clinicians require more sophisticated screening procedures assessing different aspects of patient distress, maladaptive coping, compliance with treatment and perceived social support.

- ◆ Galina Velikova, Cancer Research UK Centre, University of Leeds, Leeds Institute for Molecular Medicine, St James's Institute of Oncology, Leeds, United Kingdom. **Patient Benefits From Psychosocial Care: Screening for Distress and Models of Care.** Editorial. *Journal of Clinical Oncology*. 28: Nov. 20, 2010. 4871-4873.

This editorial on the Carson article referenced above notes that the Carlson study reported positive results in terms of alleviating generalized distress in the triage patients with lung cancer, and patients who had referrals to the psycho-oncology team showed improvement in anxiety and depression. The editorial notes that after screening more than 1,000 patients new to cancer clinics, approximately 30% of them generated referrals to psycho-oncology services. Thus, the fear of raising expectations and overwhelming services is not supported by the Carlson study.

Carlson et al illustrates the conceptual issues in differentiating between distress and depression/anxiety. Alleviation of general distress (measured by DT) was limited to patients with lung cancer, whereas significant benefits were seen for patients with high depression/anxiety scores who received referrals to service. Velikova states that these results support a model where serious cases of psychiatric morbidity should be promptly identified and referred, as they would clearly benefit from specialist psycho-oncology interventions and treatments.

The editorial also points out that the study has not explored (or not provided information) on the role of the oncology team in detecting and managing distress. A summary of patient reports was provided to the team via the electronic medical record, but it is not clear whether the oncology team addressed any of the issues. It could be that the reasonable referral rate was a result of the oncology team dealing with the problems.

Velikova states that large-scale screening for distress is feasible and acceptable with good patient recruitment and retention rates; however, extra resources (1.5 additional staff positions) were necessary to run the screening. Thus, the cost of generated referrals should be estimated for implementing screening in routine clinical practice – i.e., health economic evaluation is essential. According to Velikova, this randomized clinical trial supports screening, detection, and appropriate management of distress and depression/anxiety in patients with cancer as beneficial, but it is likely that different models of psychosocial care will work in different health care settings. Thus, community practices and hospitals should look at different models to assess what would work best in their setting before implementing screening.

- ◆ Andrea Vodermaier, Wolfgang Linden , Christopher Siu. **Screening for Emotional Distress in Cancer Patients: A Systematic Review of Assessment Instruments.** *J Natl Cancer Inst* 2009; 101: 1464 – 1488.

As screening for emotional distress is becoming increasingly common in cancer care, this systematic review examines the psychometric properties of the existing tools used to screen patients for emotional distress, with the goal of encouraging screening programs to use standardized tools that have strong psychometrics. Systematic searches of MEDLINE and PsycINFO databases for English-language studies in cancer patients were performed using a uniform set of key words (eg, depression , anxiety , screening , validation , and scale), and the retrieved studies were independently evaluated by two reviewers. Evaluation criteria included the number of validation studies, the number of participants, generalizability, reliability, the quality of the criterion measure, sensitivity, and specificity. The literature search yielded 106 validation studies that described a total of 33 screening measures. Many generic and cancer-specific scales satisfied a fairly high threshold of quality in terms of their psychometric properties and generalizability. Among the ultrashort measures (ie, those containing one to four items), the Combined Depression Questions performed best in patients receiving palliative care. Among the short measures (ie, those containing five to 20 items), the Center for Epidemiologic Studies – Depression Scale and the Hospital Anxiety and Depression Scale demonstrated adequate psychometric properties. Among the long measures (ie, those containing 21 – 50 items), the Beck Depression Inventory and the General Health Questionnaire – 28 met all evaluation criteria. The PsychoSocial Screen for Cancer, the Questionnaire on Stress in Cancer Patients – Revised, and the Rotterdam Symptom Checklist are long measures that can also be recommended for routine screening. In addition, other measures may be considered for specific indications or disease types. Some measures, particularly newly developed cancer-specific scales, require further validation against structured clinical interviews (the criterion standard for validation measures) before they can be recommended.