Differences in distress severity among oncology patients treated by a consultation–liaison service. A five-year survey in Germany

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Abstract
Background and objectives: Cancer diagnosis commonly causes distress. There are associations between distress levels and clinical and psychosocial variables, but they are not necessarily dependent on cancer type. We assessed whether distress in hospitalised oncology patients treated by a consultation–liaison service (CLS) varied with oncological diagnosis or sociodemographic, clinical and care variables.
Methods: A naturalistic, retrospective survey of all cancer patients (N=2864) treated by a CLS over a five-year period (2012–2016). Data were collected using standardised documents. Differences were analysed using bivariate regression. Multivariate linear regression and logistic regression respectively were used to assess associations between distress as a continuous (0–10) or dichotomous variable (0–4 vs. 5–10) and clinical and care variables.
Results: Bivariate tests showed that the following characteristics were associated with higher distress levels: female (68.5%); foreign (7.9%); psychiatric comorbidity (18.9%); electively referral (23.6%); two or more interventions (20.7%); psychotherapeutic (35.3%) or psychopharmacological (5.4%) interventions; post-discharge treatment recommendation (23.3%). Level of functioning (Eastern Cooperative Oncology Group Scale-ECOG), number of contacts and cumulative treatment time were positively associated with distress, unlike age. Patients with gynaecological, lung, otorhinolaryngological and brain cancers had higher distress levels. Multivariate linear regression largely confirmed the bivariate results. Logistic regression demonstrated that a dichotomous distress variable did not differentiate between cancer types.

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Introduction

General hospitals in the US began to recognise the importance of providing cancer patients with psychological and psychiatric treatment in the 1950s. Considerable effort has been devoted to assessing psychopathology and psychosocial comorbidity in this population, including developing screening instruments to identify patients in need of psycho-oncological care. It is well established that the specific patterns of distress and needs of oncology patients vary according to the type and stage of the disease. As time and staff resources are scarce there is a need for validated, short, highly sensitive and reasonably specific instruments for measuring distress.

An early approach to psycho-oncological care was outlined by Sutherland, who formulated certain principles governing the various types of adaptation displayed by cancer patients: adaptation of the self (i.e. to stress), functional adaptations that depend on the body organ affected and psychosocial adaptation to the environment. These principles were applied to single cancer subtypes, for instance in the case of radical mastectomy due to breast cancer. Bard and Sutherland described the psychological experience of radical mastectomy – a ‘terrifying experience for every woman’ – as consisting of three phases: an anticipatory phase, an operative phase and finally a reparative phase in which the patient attempts to re-establish her previous functioning level using a variety of techniques. They concluded that “during each phase a sequence of reality events and emotional reactions is constantly in process for each patient”.

The main target syndromes in psycho-oncology are distress, anxiety and depression. Distress is a dimensional concept meaning the subjective suffering level caused by a stressor such as a severe medical or psychosocial condition. Mood as well as anxiety disorders are categorical psychiatric constructs on the basis of inclusion as well as exclusion criteria. A meta-analysis of the results of 38 analyses of the accuracy of ultra-short methods of detecting cancer-related mood disorders found an overall sensitivity of 78.4% and an overall specificity of 66.8%, with a positive predictive value of 93.4%. The author concluded that ultra-short methods were modestly effective in screening for mood disorders but should not be used as diagnostic instruments, other than as a first-stage screen for ruling out depression. In a further investigation, the same author identified 45 potentially useful short and ultra-short tools, but only six which had been validated. These were the Hospital Anxiety and Depression Scale (HADS; 13 items), the Distress Thermometer (DT; 1 item), a single verbal question (1 item), the Psychological Distress Inventory (PDI; 13 items), combined DT and impact thermometer (2 items), and combination of two verbal questions (2 items). All these tools had similar accuracy, but their efficiency varied; the combination of two verbal questions plus the PDI was identified as the optimal short method of identifying distress.

The DT is the shortest screening instrument for assessing psychological distress in cancer patients, and the most widely investigated. Forty studies have examined the performance of the DT alone or in combination with the problem list, respectively other scales.

The DT is an eleven-point scale (range: 0–10) and can be used on its own (1 item), or combined with a ‘help’ question (2 items) or a problem list (5 categories: practical, family related, emotional, spiritual/religious and physical). The short version of the DT has been translated into 21 languages and there is a consensus that using a score around 4 as the threshold for clinical relevant distress optimises sensitivity and specificity. The reported optimal DT threshold for relevant distress varies between 2, in the case of patients newly diagnosed with advanced cancer and 7 in the case of patients newly diagnosed with breast cancer. The DT has been shown to be highly sensitive to distress and mood, anxiety and adjustment disorders (sensitivity = 100%), but lacks specificity (49–60%) i.e. was less effective at identifying non-distressed individuals.

The German version of the National Comprehensive Cancer Networks (NCCN) ‘Distress Thermometer’ has been validated using the HADS-D and the brief version of the Fear of Progression Questionnaire (PA-F 12). Using a threshold of 5 points the DT had a sensitivity of up to 84% and specificity of up to 47%. The discriminant power of the DT was particularly high with respect to more severe symptoms of anxiety or depression.

In the majority of studies, a threshold of 4 points was found to maximise sensitivity and specificity. However, a recent study using HADS reported that a threshold of 5 points produced the best balance between sensitivity and specificity. Studies in China have demonstrated that a threshold of ≥5 points discriminates well between demoralisation and depression. A Dutch study of 181 women who had recently received a breast cancer diagnosis reported that the optimal DT threshold score for detecting distress was 7 points (sensitivity = 0.75, specificity = 0.84, positive predictive value of 69% and negative predictive value of 87%). However Racklitis et al. found

Conclusions: Distress is less strongly related to cancer type than other clinical factors, e.g. psychiatric comorbidity, autonomy. Highly distressed patients should receive more intensive CLS care, irrespective of specific diagnosis. The positive association between elective referral and distress indicates that the CLS referral process works well.

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