2019

Clinical Practice Guideline: Posttraumatic Stress Disorder Screening Tool for Patients

Stephanie Lynn Smith
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Stephanie Lynn Smith

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Diane Whitehead, Committee Chairperson, Nursing Faculty
Dr. Barbara Barrett, Committee Member, Nursing Faculty
Dr. Dana Leach, University Reviewer, Nursing Faculty

The Office of the Provost

Walden University
2019

Abstract

Clinical Practice Guideline: Posttraumatic Stress Disorder Screening Tool for Patients with Cancer

by

Stephanie Lynn Smith

MS, University of Cincinnati, 2013

BS, College of St. Scholastica, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2019

Abstract

The National Institute of Health has estimated that over 1 million new cancer cases will occur yearly. Posttraumatic stress disorder (PTSD) is commonly associated with near death experiences or traumatic events, such as cancer diagnosis and treatment. There is a lack of knowledge and awareness by healthcare professionals in identifying PTSD in cancer patients. In this population, PTSD symptoms often contribute to anxiety, and there is no standardized protocol being used to screen these individuals for the trauma they are facing or have faced. The purpose of this project was to develop a clinical practice guideline for screening cancer patients for PTSD in a clinic population serving 20% cancer patients. The stress theory developed by Lazarus and Folkman guided this project. The project questions were to identify the most appropriate screening tool for PTSD in cancer patients and recommend a clinical practice guideline to the clinic healthcare providers. Five widely used PTSD screening tools were reviewed. Based on the project question the Clinician Administered PTSD Scale was identified as the most appropriate for this clinic setting and patient population. An expert panel consisting of 3 experienced psychiatric nurse practitioners reviewed the proposed guideline using the AGREE II tool. Using a scale of 1 (*strongly disagree*) to 7 (*strongly agree*), the team members agreed with a score of 5 or higher in each domain with the proposed guideline. Utilization of this guideline will promote a positive social change towards mental health awareness and improve the quality of life for these patients and their families.

Clinical Practice Guideline: Posttraumatic Stress Disorder Screening Tool for Patients with Cancer

by

Stephanie Lynn Smith

MS, University of Cincinnati, 2013

BS, College of St. Scholastica, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2019

Dedication

I dedicate this paper to all of those who have had, are currently going through treatments, or will be diagnosed with cancer. To those who have been directly impacted by this terrible disease. To my family, friends, and God who stood by me through this intense time while I completed my doctoral studies. To DJ, who has faced cancer, won, and yet still battles everyday with adversities. To Alexus and Henri who have listened to me say, “no, I can’t, I have to work on this paper.” I love you all.

Acknowledgments

Thank you to the Walden University, its faculty, my family members, and friends who have helped me, stood by me, and encouraged my every step to reach this point in my academic career. To Missy for her continued mentorship, expertise, knowledge, and encouragement in my academics. You have taught me all I know, sister.

Table of Contents

List of Tables

List of Figures

Section 1: Nature of the Project

Introduction

Cancer is the name given to a collection of related diseases in the body in which a person's own cells begin to divide without stopping and spread into surrounding tissues (National Institute of Health [NIH], 2019). About 1.2 million new cancer cases are diagnosed annually in the United States (National Cancer Institute, 2019). Cancer-related posttraumatic stress syndrome (PTSD) has been documented in patients with cancer. PTSD is characterized by the inability to relax for fear that a trauma will return as well as the avoidance of triggers associated with the trauma, such as certain part of town or a certain smell. PTSD can also include reliving a traumatic event in nightmares and/or flashbacks (NIH, 2019).

PTSD is positively associated with other indices of distress and reduced quality of life and is often associated with risk factors such as prior trauma history, preexisting psychiatric conditions, or poor social skills (Cardova et al., 2017). The *DSM-5* has included cancer-related stress as an implication for PTSD criteria (American Psychological Association, 2013). Research by the American Cancer Society (2019) supports psychosocial assessments on all cancer patients. Treatment of cancer-related PTSD should be approached with caution and be informed by existing evidence-based approaches for traumatic stress (CITE). Many patients are not referred for counseling or do not accept referrals to psychology-oncology services to be assessed and treated because high levels of sadness and anxiety are often perceived as "normal" reactions to cancer diagnosis and treatment; therefore, mood, anxiety, and other psychological

disorders are commonly mistaken for unexpected, “manageable” sadness and preoccupation with the disease (Grassi, Spiegel, & Riba, 2017). Emotional instability can cause these patients to question their spirituality, personal values, and existence as well as put strains on their personal relationships (CITE).

Mental health complications can occur at time of diagnosis, during and after cancer treatments, and at survivorship. The NIH (2019) reported that PTSD symptoms vary for each patient; however, symptoms will typically develop within 3 months of a traumatic event up to several months or even years later. Side effects of cancer and treatments can significantly influence a patient’s psychological state, potentially causing a patient to be more susceptible to developing PTSD during a traumatic event in the diagnosis, treatment, or survivorship (Caruso et al., 2017). Kirch (2019), director of quality of life and survivorship at the American Cancer Society, reported that screening for PTSD helps cancer centers identify patients early on who may be particularly vulnerable to lasting mental scars.

> We just don’t do a good job in general in oncology for screening for PTSD or even assessing anxiety and depression. Oncologists might have a hard time figuring this out because they treat a lot of people, and many don’t report psychiatric symptoms and screening needs to be one of the first steps. (Ganz, 2019, p. 5).

The accuracy of diagnosis requires the use of reliable and valid instruments. The development of a clinical practice guideline (CPG) at the project facility that screens for PTSD will help facilitate an appropriate treatment plan for these individuals, promoting

optimal patient care. The purpose of this project was to provide healthcare providers with a CPG that promotes the use of a reliable and valid PTSD screening tool for patients in a variety of cancer situations.

Problem Statement

The setting of this Doctor of Nursing Practice (DNP) project was a private, psychiatric clinic in the north central United States. This clinic provides psychological and psychiatric services to both children and adults. This facility was an appropriate setting for this project because it receives referrals for this population from primary care and oncology providers. Estimates from the facility administration are that 1 out of 5 (or 20%) of patients at this clinic currently have or have been diagnosed with cancer at some point in their life. This community has a large influx of cancer patients because it is centrally located and has an oncology center. Healthcare providers at this facility are expected to screen and manage patients with mental illness using the best evidence-based practices. This facility screens cancer patients for depression with use of the PHQ9 at every visit. The generalized anxiety tool, known as the GAD7, which screens for the four most common anxiety disorders, is utilized when a cancer patient presents to the clinic with a chief complaint of daily anxiety, panic episodes, and obsessive behaviors and/or thoughts.

Common symptoms of PTSD that a cancer patient may exhibit when they are unable to deal with trauma of having cancer include reminiscing about traumatic experiences over and over, intrusive thoughts, avoiding anything that could remind them of the traumatic event, difficulties with the control of their emotions, panic, intense

fear/anxiety, nightmares, and an overall difficulty with sleep (CITE). The earlier PTSD is diagnosed, the more successful treatment can be (CITE). If PTSD is left untreated for long periods of time, certain symptoms can be exacerbated, and many areas of a patient's life are severely affected (NIH, 2019). This doctoral project holds significance for social change by providing education, advances in nursing, and the practice goal of improving patient outcomes and promoting positive social change.

Purpose Statement

Lack of knowledge and awareness by health professionals contributes to the underdiagnosis of PTSD in cancer patients. Identification of cancer status and screening for PTSD at the initial psychiatric evaluation and subsequence visits is a proactive approach to ensure that this problem is addressed in this population. Chan et al. (2017) conducted a research study that involved 469 cancer patients who had been diagnosed with various types of cancer. All patients for their study were recruited within 1 month of their diagnosis at the same oncology referral clinic. The participants in their study were evaluated for PTSD symptoms first after 6 months following their cancer diagnosis, then again after 4 years. Chan et al. discovered that nearly one fifth of the participants experienced PTSD symptoms within a few months of their cancer diagnosis, and many of these people continued to display PTSD symptoms 4 years after their diagnosis.

Healthcare providers caring for cancer patients must understand and detect PTSD symptoms in their patients to provide optimal care. The project questions were:

1. Based on the current evidence, what is the most appropriate screening tool for PTSD in cancer patients?

2. Based on the evidence reviewed, what CPG recommendations should be made to the clinic healthcare providers?

Providing a CPG to healthcare providers for cancer patients suffering from PTSD will increase their confidence when caring for patients in this population. Early screening and detection can help promote various treatments used in treated PTSD, ultimately improving this population's quality of life.

Nature of the Doctoral Project

For this project, I reviewed evidence accessed through the Walden University Library, including from the CINAHL, Medline, ProQuest, Psych Info, PubMed, and Google Scholar databases. Inclusion criteria included English language only peer-reviewed resources published within the past 5 years. CPGs related to the topic were also reviewed. Keyword search terms included *PTSD, cancer and PTSD, psychological impact of cancer, cancer,* and *cancer screenings for mental health*. In this project, I followed the guidelines set forth in the Walden University *DNP Manual for Clinical Practice Guideline Development*. CPG development requires a systematic method with inclusion and exclusion criteria to search the literature and grade the strength of evidence (Moran, Burson, & Conrad, 2017). The Appraisal of Guidelines Research and Evaluation (AGREE) II instrument provided the framework for the development of this guideline. The AGREE II is both valid and reliable and consists of 23 key items organized within six domains (AGREE Research Trust, 2019).

Significance

The primary stakeholders for this doctoral project were the nursing staff and clinicians at this practicum site. Other stakeholders included family members, oncologists, and primary care clinicians. Early identification and management of PTSD will reduce the burden on insurance companies and third-party payers. This guideline will encourage early screening and interventions in this population in efforts to reduce costs of mental health and medical care across the lifespan (see Bellmore, 2016). The contributions of this doctoral project include recommendations from the review and initiation of a CPG that allows for nurses and clinicians to identify, screen, and treat for PTSD in this population. Ultimately, this guideline will promote social change by improving the patient's quality of life, family structure, and relationships as well as promote mental health awareness for communities, patients, nursing staff, and clinicians. "Mental illness-related stigma, including that which exists in the healthcare system and among healthcare providers, creates serious barriers to access and quality care" (Knaak, Mantler, & Szeto, 2017, p. 111).

I integrated scholarship into this project by conducting a thorough literature review in order to evaluate and apply up-to-date evidence focusing on the improvement of patient outcomes. The role of the DNP in scholarship, in relation to Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice, includes discovering and integrating knowledge through the examination and synthesis of academic literature, integrating knowledge from other disciplines by giving meaning to isolated facts, and applying new knowledge in the practice setting (American Association

of Colleges of Nursing [AACN], 2006). The project also aligned with DNP Essential VI: Clinical Prevention and Population Health for Improving the Nation's Health, which incorporates leadership from the DNP-prepared clinician to integrate evidence-based clinical prevention and population health services for individuals, such as those suffering from the psychological aspects of cancer (AACN, 2006).

Walden University's (2019) School of Nursing provided a rigorous and culturally relevant approach to educational programs, based on a scholar-practitioner model. This project influenced social change by supplying clinicians with evidence that will help them with the early identification of mental illness in cancer patients with the goal of enhancing the quality of life for their patients and families. The recommendations from this project supported providers with identifying, screening, and treating PTSD in this population.

Summary

In Section 1, I introduced the current gap in knowledge regarding which screening tools are the most effective for the early identification of mental illness amongst cancer patients. The nature of the project and the importance to stakeholders were explored. The significance of developing this CPG to nursing practice was also described. In Section 2, I provide an in-depth discussion of the background and context of the doctoral project as well as the role of the DNP student.

Section 2: Background and Context

Introduction

The current screening procedure at a private psychiatric clinic in the north central United States was to screen all cancer patients for depression with the PHQ9 tool as well as the GAD7 when anxiety symptoms were of concern. Currently, cancer patients are not screened for PTSD even though current literature indicates that PTSD in this population is extremely prevalent. The project questions were:

1. Based on the current evidence, what is the most appropriate screening tool for PTSD in cancer patients?
2. Based on the evidence reviewed, what CPG recommendations should be made to the clinic healthcare providers?

In this section, I explored the concepts and model that framed the project. The relevance to nursing practice are synthesized. I also described the local background and context for the project and discussed my role in developing and presenting the CPG to stakeholders.

Concepts, Models, and Theories

In this project, I used the stress theory, developed by Lazarus and Folkman, for the development of this CPG. The framework of the stress theory integrates stress, appraisal, and coping as they relate to how individuals react to psychologically stressful situations and/or environments (CITE). This clinical assessment of an individual's coping reaction facilitates enhanced clinical decision-making on how best to intervene as well as provide one possible clinical indication of who will engage in maladaptive or adaptive

coping (Folkman & Moskowitz, 2000). In clinical practice, this theoretical framework has been utilized in the assessment, intervention, and evaluation of an individual's psychological stress and coping responses (CITE). Stress theories provide nursing with a framework through which to understand the effects that stress has on individual and how the individual responds to stressful situations and life events (McEwen & Will, 2011).

For this project, the theory of stress, coping, and adaptation, created by Lazarus and Folkman (1984), was used to help healthcare providers understand the effects of stress and how a person responds to stress. Kato (2014) indicated the importance for healthcare providers to understand the role of coping for optimal healthcare provider and patient communication, interactions, and the ability to help patients learn and adapt to their traumatic events. Lazarus (1984) stated that cognitive appraisal occurred when a person considers two major factors that contribute to their response to stress: (a) the threatening tendency of the stress to the individual and the assessment of resources required to minimize, tolerate, or eradicate the stressor and the stress it produces (see Figure 1).

. In general, cognitive appraisal is divided into two types or stages: primary and secondary appraisal (Kato, 2014).

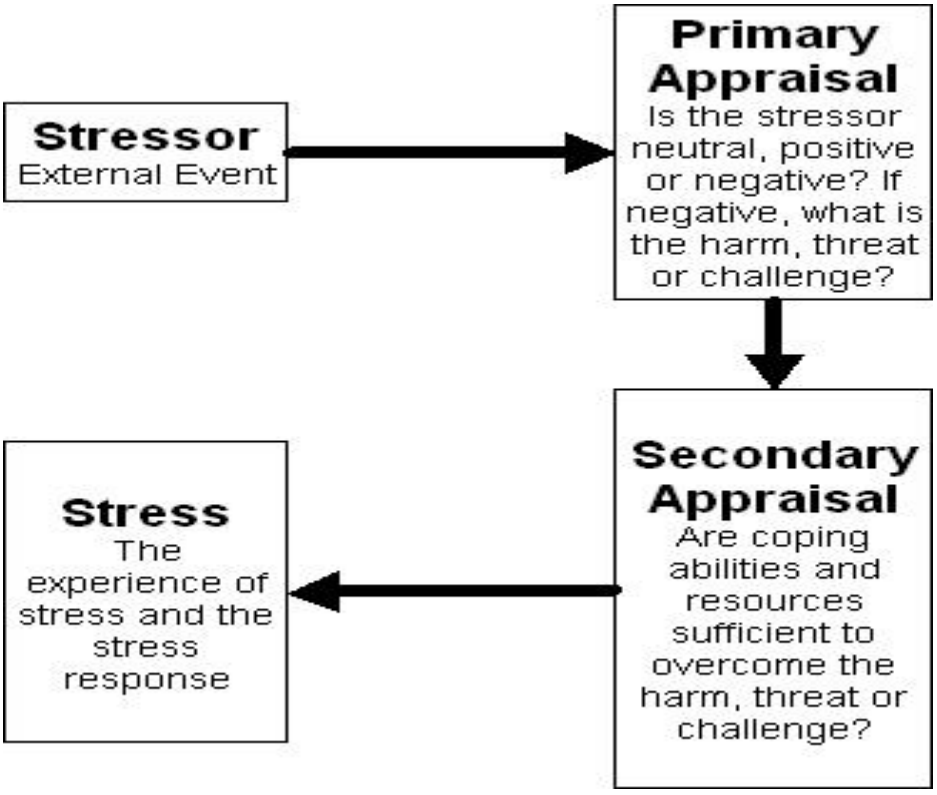

Figure 1. Lazarus and Folkman's theory of stress and coping.

Lazarus (1984) provided the following definitions for terms important for understanding the theory of stress and coping:

- *Stress*: The physiological response to threatening or challenging events in the environment.
- *Coping*: The process of spending conscious effort and energy to solve personal and interpersonal problems.
- *Adaption*: The change that takes place as a result of the response to a stressor.

CPG development requires a systematic method with inclusion and exclusion criteria to search the literature and grade the strength of evidence (Moran et al., 2017). The AGREE II tool provided the framework for the development of this guideline.

Relevance to Nursing Practice

The development of an evidenced-based CPG that addresses PTSD in cancer patients in a psychiatric care setting advances the field of nursing practice because it addresses a clinical problem using current evidence and increases healthcare providers' confidence when caring for patients in this population. Early screening and detection can help promote varied treatments for PTSD, ultimately improving this population's quality of life. The lack of knowledge and awareness of healthcare professionals contributes to the underdiagnosis of PTSD in cancer patients (Knaap et al., 2014). In the following subsections, I review existing research on this practice problem.

PTSD

About 70% of people worldwide will experience a traumatic event; yet, the lifetime prevalence of PTSD is only at 5% (Atwoli et al., 2015). Other researchers have shown that 4%–55% of this population should have a cancer-related PTSD diagnosis (Cordova, Riba, & Spiegal, 2017). Chan et al. (2018) reported a strong prevalence of PTSD in cancer patients at both 6 months and 4 years following cancer diagnosis. Chan et al. also reported that the overall rate of PTSD decreased with time from 21.7% incidence at 6 months to 6.1% incidence at 4 years. Over one third of participants who were initially diagnosed with PTSD had persisting or worsening PTSD symptoms within 4 years of cancer treatments (Chan et al., 2018). The greater social awareness and understanding along with reduced mental health stigma associated with cancer will act as

a protective factor against PTSD, with this effect lessening as the patient has more years in treatment and follow up (Chan et al., 2018).

PTSD affects all aspects of a patient's life, including self-image, relationships with family and friends, spirituality, ability to work, etc. (Gold et al., 2012). Emotional instability can cause patients to question their spirituality, personal values, and the meaning of their existence, which can strain patient relationships with loved ones (Grassi et al., 2017). Multiple studies have revealed that psychological distress, including cancer-related PTSD, negatively impact patients' health, treatment, and quality of life (CITE). Because of these factors, it is important for healthcare providers to recognize the signs and symptoms of PTSD in this population, including avoidant behaviors that may exhibit themselves as missed appointments, failing to complete treatment, or withdrawing from friends to avoid speaking about the cancer. Increased psychological distress is further correlated with decreased radiation treatment compliance and overall survival (Chen et al., 2017).

PTSD and Cancer Patients

Abbey et al. (2017) indicated an increase in the prevalence rates of cancer-related PTSD and that prevalence rates seemed to vary widely based on the method of assessment. This study revealed that self-report PTSD symptom measures yielded prevalence estimates of clinically significant symptom levels ranging from 7.3% to 13.8%, depending on screening scoring method used. Investigations using more stringent, clinician-administered structured diagnostic interviews for PTSD yielded a lifetime

prevalence estimate of 12.6% and a current prevalence estimate of 6.4% (Abbey et al., 2017).

In a nationwide cohort study that included all Danish-born residents of Denmark from 1995–2011, Gradus et al. reported that

> Standardized incidence ratios (SIR) were calculated, null associations were found between PTSD and nearly all cancer diagnoses examined, both overall (SIR for all cancers = 1.0, 95% confidence interval (CI) = 0.88, 1.2) and in analyses stratified by gender, age, substance abuse history and time since PTSD diagnosis. (p. 568)

Although research has shown that cancer-related PTSD often has a chronic course, researchers have also demonstrated that mental health services are grossly underutilized by this population (Kadan-Lottick et al., 2015). Vachon (2006) stated that only 10% of cancer patients reporting levels of distress received any type of psychosocial therapy. Kadan-Lottick et al. (2015) interviewed 251 patients with advanced cancer and found that 55% of those with a major psychiatric disorder did not receive a psychiatric referral; yet, 90% of all participants said they would seek psychiatric help if they were aware they had an emotional problem.

Screening Tools for PTSD

The mental health screening tool that formed the basis of the CPG developed in this DNP project was the patient questionnaire instrument used for screening of PTSD. Selecting a screening tool and establishing a screening process are essential first steps, but they are only the beginning of developing a distress-screening program (Kendall et

al., 2012). Many positive screens will require an assessment by the appropriate psychosocial professional to determine the frequency, intensity, duration, and functional impact of the distress (CITE). The assessment may reveal the need for intervention and/or referral, so after intervention, follow up and further evaluation are needed ensure that the patient's distress is minimized or eliminated (Kendall et al., 2012).

Zebrack et al. (2015) suggested that screening tools for psychosocial distress should yield reliable and valid results and recommended that institutions adopt screening tools that align with the needs of their patient population. The VA (2019) identified the CAPS screening tool as the gold standard in PTSD assessments. Their rationale for this statement was that the tool, with its structured interview, provided a categorical diagnosis as well as a measure of the severity of PTSD symptoms as defined by *DSM-IV*. Table 1 depicts a description of the most widely used PTSD screening tools.

Table 1

Screening Tools

Screening tools	Description	Pros	Cons
PCL-5	20-item self-report measure that assesses the 20 *DSM-5* symptoms of PTSD. Monitors symptom change during and after treatment, Screens individuals for PTSD, and make a provisional PTSD diagnosis (VA, 2019)	The PCL-5 is part of a national effort to establish PTSD outcome measures. It is well validated, and much include one Checklist for DSM-5. (PCL-5) is one of the most commonly used self-report measures of PTSD (VA, 2019)	The PCL-5 can be completed in five to seven minutes. Self-survey, patients may not be honest. can be scored in different ways

PCL-S	The PCL-S (specific) asks about symptoms in relation to an identified "stressful experience." The PCL-S aims to link symptom endorsements to a specified event (VA, 2019).	This screening tool asks specific questions geared to a specific traumatic event.	It is only related to a specific event. Patients may not be honest.
PCL-C	The PCL-C (civilian) asks about symptoms in relation to generic “stressful experiences” and can be used with any population. This version simplifies assessment based on multiple traumas because symptom endorsements are not attributed to a specific event. In many circumstances it is advisable to also assess traumatic event exposure to ensure that a respondent has experienced at least one event that meets DSM-IV Criterion A (VA, 2019).	The PCL-C is a **shortened version of the PTSD Checklist Civilian version (PCL-C)** (VA, 2019). This tool was designed for the primary care settings.	Professional judgment is needed when it is utilized while generalizing it in other clinical settings or with military members. Patients may not be honest.
PC-PTSD	The PC-PTSD is a screening tool for Posttraumatic Stress Disorder. This tool has four questions and is designed for clinical use. It is not designed to give a definitive diagnosis of PTSD, rather it assesses whether a clinical interview should be carried out for PTSD, thus further screening.	The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to	The screen does not include a list of potentially traumatic events. This does not diagnosis PTSD.

		traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answer "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD.	
CAPS	CAPS ask respondents to endorse up to three traumatic events to keep in mind during the interview. CAPS-5 requires the identification of a single index trauma to serve as the basis of symptom inquiry. Symptom severity ratings are based on symptom frequency and intensity.	CAPS-5 is a 30-item questionnaire, corresponding to the *DSM-5* diagnosis for PTSD. The language of the CAPS-5 reflects both changes to existing symptoms and the addition of new symptoms in *DSM-5* (VA, 2019). CAPS-5 asks questions relevant to assessing the dissociative subtype of PTSD (depersonalization and derealization), but no longer includes other associated symptoms (e.g., gaps in awareness).	CAPS-5 items are rated with a single severity score. Patient not being honest, though since this is administered by a trained professional this becomes less likely.

Local Background and Context

The setting of this DNP project was private, psychiatric clinic in north central United States. This clinic receives referrals for this population from primary care and oncology providers. One out 5 patients at this clinic currently have or have been diagnosed with cancer at some point in their life. Healthcare providers at this facility currently screen cancer patients for depression with use of the PHQ9 at every visit. The generalized anxiety tool known as the GAD-7, which screens for the four most common anxiety disorders, was administered when a cancer patient presents to the clinic with a chief complaint of daily anxiety, panic episodes, and obsessive behaviors and/or thoughts. The use of a CPG at this project site will promote identifying, screening, and treating mental illness in this population. Using a CPG will increase the awareness of PTSD for their cancer patients, community, nursing staff, and clinicians.

Role of the DNP Student

The DNP nurse is often involved in the development of CPGs within a nursing specialty (Walden University, 2019). Practice guidelines within a healthcare organization or system provide a method to translate evidence into practice and improve outcomes (CITE). The assessment of patient needs or scientific advances may generate the development of practice guidelines that are informed by a systematic process of review of evidence (CITE). In situations where the demand for practice change is quicker than the pace of national guideline development, the dissonance may result in a need to develop guidelines at the local healthcare organization (White, Dudley-Brown, & Terhaar, 2016). The DNP nurse is a future leader of the professional team for evaluation of evidence and

development of a new CPG to meet the needs of this practice site and patients. My role in this project was to explore current evidence on PTSD screening tools and develop a CPG for recommendation to the facility.

Summary

In Section 2, I discussed the clinical site's needs and how this project was developed to meet them. Lazarus and Folkman's (1984) stress theory and AGREE II were discussed as the methodology and framework used for development of this guideline. PTSD screening tools were also identified and evaluated. I identified my role in this project as well. In Section 3, I discuss the collection and analysis of the gathered evidence and my process for developing the guideline.

Section 3: Collection and Analysis of Evidence

Introduction

Cancer is the name given to a collection of related diseases in the body in which cells begin to divide without stopping and spread into surrounding tissues (NIH, 2019). Cancer-related PTSD has been documented in many patients at various stages of cancer (Cordova et al., 2017). The current screening procedure at private psychiatric clinic in the north central United States was to screen all cancer patients for depression with the PHQ9 tool. When anxiety symptoms are of concern, the GAD7 tool was also administered. Based on my experience at the clinic and reports from other providers, cancer patients were not screened for PTSD even though evidence indicated that PTSD in this population was extremely prevalent.

Practice-Focused Questions

The project questions were:

1. Based on the current evidence, what is the most appropriate screening tool for PTSD in cancer patients?
2. Based on the evidence reviewed, what CPG recommendations should be made to the clinic healthcare providers?

Sources of Evidence

The goal of this project was to review current evidence and guidelines to develop a CPG to recommend to a private, psychiatric facility. To complete the literature review for this project, I searched for evidence using the following keywords: *PTSD, cancer and PTSD, psychological impact of cancer*, *cancer screenings for mental health*, and *clinical*

practice guidelines and PTSD. The Walden University Library was accessed to explore the following databases: CINAHL, Medline, ProQuest, Psych Info, PubMed, and Google Scholar. Inclusion criteria included English language articles that were from peer-reviewed sources and published within the past 5 years.

Analysis and Synthesis

Step 1: Critically Appraise the Evidence

A critical appraisal of the literature on the topic led to 18 current articles. I reviewed each article to determine if it was pertinent to this topic and came from a peer-reviewed source. My analysis of each article included reviewing the background information, study objectives, research method, limitations, conclusions, and references. The search results included experimental studies, systematic reviews, peer-reviewed articles by content experts, guideline development manuals, and two international CPGs. Various authors indicated the need for effective screening and identification of mental illness in cancer patients in all situations (CITE). The articles were reviewed using the following criteria:

1. Author, date, and title,
2. Level of evidence
3. Analysis,
4. Conclusions, and
5. Implications for practice.

I also reviewed CPGs related to the topic. These guidelines were previously discussed in Table 1.

Step 2: Synthesize the Evidence from the Literature

I synthesized the evidence according to the levels of evidence indicated in Table 2.

Table 2

Hierarchy of Evidence Table

Type of Evidence	Level of Evidence	Description
SR or meta-analysis	I	Synthesis of evidence from relevant RCTs
RCT	II	Experiments where subjects are randomized
Controlled trial without randomization	III	Experiments where subjects are nonrandomly assigned to a group
Case-control or cohort study	IV	Comparison groups or observations of groups to predict or determine outcomes
SR of qualitative or descriptive studies	V	SR of Gathering data on human behavior or describing background on an area of interest
Qualitative or descriptive study	VI	Gathering data on human behavior or describing background on an area of interest
Expert opinion or consensus	VII	Opinions of experts or consensus of experts

Adapted from: Fineout Overhold, E., Melnyk, B., Stillwell, S., & Williamson, K. (2010). Critical Appraisal of the Evidence: Part 1. American Journal of Nursing, 110(7) pg. 48.

Level I. Abbey et al (2015) conducted a systematic review that provided a synthesis of evidence that justified the need the further investigating of traumatic related events associated to cancer. Zebrack, Kayser, Sundstrom, et al. (2015) addressed cancer patients' emotional and psychosocial needs. Vodermaier, Linden, and Siu (2009) conducted a literature search that yielded 106 validation studies that described a total of 33 screening measures, particularly newly developed cancer-specific scales, for assessing a patient for mental illness.

Level II. Cordova et al. (2017) focused on the screening options and treatment of

cancer-related PTSD by reviewing existing evidence-based approaches for traumatic stress.

Level III. Knaak et al. (2017) revealed that both patient and staff well-being and is committed to combating stigma in patient care to promote mental health screenings.

Level IV. Monson et al, (2008) reported a significant need to screen cancer patients for PTSD. Chan et al. (2017) indicated that one third of patients (i.e., 34.1%) who were initially diagnosed had persistent or worsening PTSD 4 years later. The authors also indicated that there is a need for early identification of this subset of patients who have cancer with PTSD to design risk-targeted interventions.

Level V. Katzman & John (2018), revealed that screening for PTSD in cancer patients should be identified and treated appropriately based on age, diagnosis, treatment, and by comorbid symptoms. Grassi et al. (2017) examined some of the most significant related mental health issues in cancer patients while focusing on recent advances in psychosocial and psychopharmacological interventions as a part of a mandatory, integrated, and comprehensive approach to psychiatric cancer care. DeSantis et al. (2014) reported that it is important for clinicians to understand the unique medical and psychosocial needs of cancer survivors and to proactively assess and manage these issues. There are a growing number of resources that can assist patients, caregivers, and healthcare providers in navigating the various phases of cancer survivorship (DeSantis et al., 2014).

Level VI. Allen et al. (2018) conducted a cohort study that revealed that most cancer survivors report negative consequences related to their cancer experience. Allen et

al. emphasized that clinicians need the skills to recognize and treat PTSD and other psychiatric disorders in this patient population. Caruso et al. (2017) examined some of the most significant issues related to screening and the assessments of psychosocial morbidity in cancer patients. Gradus et al. (2015) displayed evidence showing an association between PTSD diagnoses and various forms of cancer in a nationwide study. While French-Rosa, Moye, & Nail (2015) reported that mental health interventions that specifically address cancer-related PTSD may improve the cancer patient's recovery and adaptation over time.

Level VII. Vachon (2006) focused primarily on the psychosocial distress and the coping of cancer survivors who have completed their initial treatment and are now disease free. Researchers continue to debate the value of such interventions. Staton, Rowland, and Ganz (2015) described major psychosocial and physical sequelae facing adults during periods of cancer and highlighted the need for PTSD screening. Kimerling, Prins, Yeager, and Magruder (2010) recommended using a five-point screening system when determining whether the improvement is clinically meaningful using the PCL from the *DSM-IV* for PTSD screening.

Step 4: Develop Clinical Practice Guideline

The proposed CPG was:

1. Cancer patient referral from oncology and/or primary care provider.

   Initial visit scheduled.

2. Initial psychiatric evaluation at clinic to include screening of all cancer patients regardless of stages/situations with the PHQ9 (i.e., depression scale) and the GAD7 (i.e., anxiety scale)
3. Patient scores above 0 on PHQ9 even though GAD7 is normal: complete PHQ9 and GAD7 each visit.
4. Any abnormal GAD7 results would require PTSD screening with the CAPS screening tool.
5. Patient scores under 4 on PHQ9 and under 3 on the GAD7. Conduct yearly PTSD screening with the CAPS screening tool unless there is a change in status at subsequent visits.
6. Initiate guideline per facility protocol for treatment.

Step 5: Identify an Expert Panel

The expert panel included three, board-certified, psychiatric nurse practitioners. All of the expert panel participants were currently working in the mental health field. All panelists evaluated and treated patients with PTSD and had over 10 years of experience in this field.

Step 6: Obtain Institutional Review Board Approval

The facility signed the site approval form for the CPG development project.

Step 7: Obtain Expert Panelists' Signatures

Upon Walden Institutional Review Board approval# 09-27-19-0662380, the expert panelists signed the form for anonymous questionnaires.

Step 8: The Expert Panelists Will Review the Guidelines

The panelists used the AGREE II instrument and made recommendations for revisions. Each panel member reviewed the proposed guidelines using the following domains:

1. Scope and purpose,
2. Stakeholder involvement,
3. Rigor of development,
4. Clarity of presentation,
5. Applicability, and
6. Editorial independence (AGREE Research Trust, 2019).

Step 9: Identify Key Stakeholders and/or End Users

I presented the revised guideline to end users, stakeholders, and other experts for further discussion on content and usability.

Step 10: Develop a Final Report

Step 11: Disseminate Final Report to Key Stakeholders

Summary

To address the gap-in-practice at a local psychiatric clinic, I formulated practice-focused questions regarding the use of PTSD screening tools and a CPG to help identify, screen, and treat PTSD patients from the psychological trauma of cancer. In this project, I followed the *Walden University DNP Manual for Clinical Practice Guideline Development*. Through an exhaustive literature search, I identified that the early screening for PTSD in cancer patients is needed to improve their quality of life and give

them the necessary support to cope with this traumatic event. In the next section, I describe the reviews and recommendations made by the expert panel as well as the development of the final new practice guideline.

Section 4: Findings and Recommendations

Introduction

The setting for this DNP project was a private, psychiatric clinic in the north central United States providing psychological and psychiatric services to both children and adults. This facility has a large influx of cancer patients because it is centrally located and has an oncology center. Healthcare providers at this facility are expected to screen and manage patients with mental illness using the best evidence-based practices.

The purpose of this project was to provide healthcare providers with a CPG that would promote treatment for PTSD for patients in a variety of cancer situations. Developing a CPG addressed the gap in practice at the site and screening this population for PTSD will help healthcare providers treat this population with evidence-based practices. In Section 4, I describe the findings and recommendations from the expert panel development of the new practice guideline. The project questions were:

1. Based on the current evidence, what is the most appropriate screening tool for PTSD in cancer patients?
2. Based on the evidence reviewed, what CPG recommendations should be made to the clinic healthcare providers?

Findings and Implications

In order to evaluate the validity of the created guideline, the recommended CPG was appraised by an expert panel using the AGREE II tool. The expert panel consisted of three psychiatric nurse practitioners working in mental health clinics. All panel members had experience treating patients with PTSD. As previously mentioned, the AGREE II tool

includes 23 criteria measures to appraise six domains as well as two, overall, global rating assessment questions. Each question is rated on 7-point scale with 1 equating to *strongly disagree* and 7 equating to *strongly agree*. Each domain score is summed by totaling the scores of the individual items and dividing by the maximum possible score (AGREE II Instrument, 2013). Table 4 describes the results of the expert panel AGREE II tool reviews.

Table 4

AGREE II Expert Panel Results

Criteria	Review 1	Review 2	Review 3	Comments
1. The overall objectives of the guidelines were specifically described.	5	7	7	Improve quality of life through accurate screening and diagnosis for the best evidence-based practice treatment.
2.Health questions read the guideline are specifically described.	5	7	7	Appropriate, based on current evidence with best patient outcomes.
3. The population to whom the guideline is meant to apply is specifically described.	6	7	7	Children and adults, define ages.
4. The guideline development group includes individuals from all relevant professional groups.	6	7	7	
5. The views and preferences of the	6	7	7	CAPS is lengthy and may need to be limited to

target population have been sought.				older adolescents and adults. Without core morbidities and or cognitive or intellectual disorders.
6. The target users of the guideline are clearly defined.	6	7	7	Adults, defined his age to age without neurocognitive disorders? Ability to accurately respond to screening?
7. Systemic methods were used to search for evidence.	6	7	7	
8. The criteria for selecting evidence are clearly described.	6	7	7	
9. The strength and limitations of the body of evidence are clearly described.	4	7	7	Strength assist with treatment; I know into current evidence-based practice limitations or length of time. Provide accurate screening, adapt by other professionals.
10. The methods for formulating the recommendations are clearly described.	5	7	7	
11. The health benefits, side effects, and risks have been considered in formulating the recommendations.	5	7	7	Risk with screening, no risk patient information, IRB approved, health benefit, yes.
12. There is an explicit link between the recommendations	6	7	7	Fix your general audience, it may be helpful to explain further why you selected the

and supporting evidence.				CAPS tool over other screening tools.
13. The guideline has been externally reviewed by experts prior to its publications.	4	7	7	Yes, currently occurring.
14. A procedure for updating the guideline is provided.	5	4	7	Utilizing expert panel and clinic. Patient's been screened for feedback. Could you provide more detail and how you would or when you would update the clinical practice guideline?
15. The recommendations are specific and unambiguous.	5	7	7	Yes, however consider how this may be different with previous history of anxiety/depression versus new diagnostic assessment and new onset of symptoms during, before, or after cancer diagnoses and treatment.
16. The different options for management of the condition or health issue are clearly presented.	4	Not answered	7	Therapy, EMDR, SSRIs, first, second, third, mind treatment?
17. T recommendations are easily identifiable.	4	7	7	Specific to screening, yes.
18. The guideline describes facilitators and barriers to its application.	5	7	7	Length of time to follow clinical practice guideline, barrier/cognitive

				status/previous mental health diagnoses.
19. The guideline provides advice and/or tools and how the recommendations can be put into practice.	6	6	7	Yes, does the clinic need to this weekly? Or allow for extra time? The CAPS take between 30 to 60 minutes to complete could you expand on who would be trained to conduct this assessment and how it would fit in the daily workload at the clinic.
20. The potential resource implications of applying the recommendations have been considered.	4	7	7	Consider time to administer screening, this patient has time does the provider have time?
21. The guideline presents monitoring and/or auditing criteria.	6	7	7	Specific scoring provided, more to consider to be specific.
22. The views of the funding body have not influenced the content of the guideline.	7	7	7	
23. Competing interests of guideline development group members have been recorded and addressed.	7	7	7	
Overall client assessment	-	-	-	-

1. Rate the overall quality of this guideline.	5	6	7	
I would recommend this guideline for use.	Yes, with modifications.	Yes	Yes	There needs to be inclusion and exclusion criteria including age, health literacy/cognitive ability and if prior history depression anxiety and personality disorder are influencing factors or if it will have different screening criteria. Will you be different treatment approaches depending on screening/results?

Domain 1

Domain 1 of the AGREE II tool addressed the scope and purpose of the guideline with three questions that focused on guideline objectives and the target population the guideline will serve. The overall score for this domain was 91%, which reflects that the objectives of the guideline were met. There were no questions or suggestions for improvement in this domain from the expert panel. The purpose of the guideline was specifically attained and the aim of the guideline, target population, and clinical concerns were clearly identified.

Domain 2

Domain 2 of the AGREE II tool addressed stakeholder involvement with three questions that focused on guideline creation participants, target users of the guideline, and whether views and preferences of the target population were taken into consideration.

The overall score for this domain was 91%, which reflects stakeholder involvement was appropriate.

Domain 3

Domain 3 of the AGREE II tool addressed the rigor of development with eight questions that focused on the search for evidence and the process used to formulate the guideline recommendations. The overall score for this domain was 95%, reflecting that the expert panel agreed to develop this guideline. No suggestions were offered in this domain.

Domain 4

Domain 4 of the AGREE II tool addressed the clarity of presentation with three questions that focused on guideline recommendations being specific and identifiable. The overall score for this domain was 95%, reflecting a consensus that the guideline presentation was easily understood.

Domain 5

Domain 5 of the AGREE II tool addressed the applicability of the guideline with four questions that focused on barriers to implementing the guideline, guidance for integrating it into practice, and the process for monitoring and auditing the guideline in the future. The overall score for this domain was 95%, which reflects a consensus from the expert panel. There were no suggestions offered.

Domain 6

Domain 6 of the AGREE II tool addressed the editorial independence with two questions that focused on the competing interests. The overall score for this domain was 91%, which was the highest scoring domain. No suggestions were offered.

Recommendations

All three experts completed a guideline assessment. The final overall score for the quality of the guideline was 92.7% with all experts stating they would recommend the guideline. One panelist recommended a modification related to length of provider appointments for this screening; however, specific treatments for positive PTSD are not necessarily addressed in this CPG because it is used to screen patients for PTSD. Again, all expert panels agreed that they would use this guideline as recommended. My recommended final CPGs are:

Step 1: Initial psychiatric evaluation at clinic to include screening of all cancer patients regardless of stages/situations with the PHQ9 (i.e., depression scale) and the GAD7 (i.e., anxiety scale).

Step 2: If patient scores above 0 on PHQ9, even though GAD7 is normal, complete PHQ9 and GAD7 each visit.

Step 3: If any abnormal GAD7 results, require PTSD screening with the CAPS screening tool.

Step 4: If patient scores under 4 on PHQ9 and under 3 on the GAD7, conduct yearly PTSD screening with the CAPS screening tool unless there is a change in status at subsequent visits.

Step 5: Initiate the guideline per facility protocol for treatment. All providers should to be culturally competent.

Strengths and Limitations of the Project

Having a CPG for PTSD screening will ensure that PTSD symptoms do not go undiagnosed or treated. With early screening and detection of PTSD, healthcare providers I developed this CPG specifically for the project site, so it may not be applicable to other sites or specialties. Patients may not be honest when answering screening tools, which may impact diagnosis and treatment. This CPG did not specify age recommendations for the tool. Children and adolescent patients as well as patients with limited English-speaking ability might need different screening tools. Prior mental health diagnoses would be taken into consideration but not necessarily guide this guideline. Clinicians would be completing this guideline with patients. As mentioned by one of the panelists, appointment times would need to be revised.

Section 5: Dissemination Plan

For this scholarly project, I developed a CPG for PTSD screening specific to the project site. An expert panel was created to evaluate the guideline. They used the AGREE II tool and found it to be appropriate for implementation at the project site. Upon receiving their positive evaluation, I presented the guideline to facility administrators. If the project site decides to implement the guideline, I will assist with the education of staff and implementation of the CPG. Another opportunity to disseminate the information would be submitting it to other healthcare systems' quality improvement teams. This would allow the information to be disseminated to other local facilities in the area. A final approach would be submitting the project manuscript for publication to an appropriate nursing journal, which would broaden the audience to nationwide.

Scholar

I experienced personal and professional growth during the process of this project. Completing this project allowed me the opportunity to work with a team member, both on and off the project site. I learned that it is necessary to conduct an extensive literature review to ensure that the most current evidence-based practices and data are reviewed before developing a CPG. This experience has also provided me with the knowledge of how to create a guideline and evidence of the positive effects it will have on this population. As a DNP-prepared scholar, moving forward, I plan to participate in the further development of CPGs.

Practitioner

My growth as a practitioner has continued to increase throughout the journey of completing my DNP degree. My own morals and values helped shape my desire to learn more for my patients and ultimately provide optimal care. This care is based on scholarship and research I have completed and the knowledge I have attained along the way. My DNP project has helped me align my knowledge and skills with existing theoretical frameworks to implement a new CPG and help develop better practices for the improvement of patient care. This project has also helped me grow as a leader in nursing.

Project Manager

The creation of this guideline allowed me to be a project manager and demonstrate my leadership ability as identified by the AACN (2006) DNP Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking. Walden University provided me with the skills and resources to manage this project from start to end. My previous education as well as my personal and professional experiences have helped shape and guide me as I completed a successful DNP project that is applicable to the clinical setting.

Summary

The goal of this project was to identify a gap in nursing practice and develop an evidence-based CPG to address it. This guideline could be placed into clinical practice and have a positive effect on overall project site patient/resident outcomes and readmission rates. The process of earning a DNP provided me with leadership experience, confidence, and the knowledge to make a positive impact on patient care

while promoting social change. While this is the terminal degree for my educational process, I plan to continue my education working toward my PhD. I am so passionate about nursing that I want to continue to share my knowledge, experiences, and expertise with further generations as an instructor.

References

Abbey, G., Thompson, S., Hickish, T., & Heathcote, D., (2015). A meta-analysis of prevalence rates and moderating factors for cancer-related post-traumatic stress disorder. *Psycho-Oncology, 4*(4), 371–381.

AGREE Research Trust. (2019). Webpage title. Retrieved from http://www.agreetrust.org

Allen, J., Willard, V., Klosky, J., Li, C., Srivastava, D., Robinson, L., Phipps, S. (2018). Posttraumatic stress-related psychological functioning in adult survivors of childhood cancer. *Journal of Cancer Survivors, 32 (2),* 641–646.

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from http://www.aacn.nche.edu/publications/position b/dnpessentials.pdf.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Andrykowski, M., Steffens, R., Bush, H., & Tucker, T. (2014). Disparities in mental health outcomes among lung cancer survivors associated with ruralness of residence. *Psycho-Oncology, 23*(4), 428-436.

Atwoli, L., Stein, D., Koenen, K., & Mclaughlin, K. (2015). Epidemiology of posttraumatic stress disorder: Prevalence, correlates and consequences. *Current Opinion Psychiatry, 28*(4), 307-311.

Carmack, C. L., Basen-Engquist, K., & Gritz, E. R. (2011). Survivors at higher risk for adverse late outcomes due to psychosocial and behavioral risk factors. *Cancer Epidemiology, Biomarkers & Prevention, 20,* 2068–2077.

Caruso, R., Nani, M., Riba, M., Sabato, S., & Grassi, K. (2017). The burden of psychosocial morbidity related to cancer: Patient and family issues. *Journal of International Review of Psychiatry, 29*(5), 1-14.

Chan, C., Ng, C., Taib, N., Wee, L., Krupat, E., & Meyer, F. (2017). Course and predictors of post-traumatic stress disorder in a cohort of psychologically distressed patients with cancer: A 4-year follow-up study. *Cancer, 124*(2), 406-416.

Cordova, M., Riba, M., & Spiegel, D. (2017). Post-traumatic stress disorder and cancer. *The Lancet Psychiatry*, *4*(4), 330-338.

DeSantis, C. E., Lin, C. C., Mariotto, A. B., Siegel, R. L., Stein, K. D., Kramer, J. L., . . . Jemal, A. (2014). Cancer treatment and survivorship statistics. *Cancer Journal for Clinicians, 64,* 252–271.

Desimone, M., Spriggs, E., Gass, J. DeSantis, C. E., Lin, C. C., Mariotto, A. B., … Jemal, A. (2014). Cancer treatment and survivorship statistics. *Cancer Journal for Clinicians, 64,* 252–271.

Fineout-Overholt, E., Melnyk, B. M., Stillwell, S. B., & Williamson, K. M. (2010). Evidence-based practice step by step: Critical appraisal of the evidence: part I. *AJN The American Journal of Nursing*, *110*(7), 47-52.

Folkman, S., & Moskowitz, J. T. (2000). Positive affect and the other side of coping. *American Psychologist, 55*, 647–654.

French-Rosa, L., Moye, J., & Nail, A. (2015). Improving the recognition and treatment of cancer-related posttraumatic stress disorder. *Journal of Psychiatry Practice, 17*, 270–276.

Grassi, L., Spiegel, D., & Riba M. (2017). Advancing psychosocial care in cancer patients. *Journal of Research,* 6, 2083.

Gradus, J. L., Farkas, D. K., Svensson, E., Ehrenstein, V., Lash, T. L., Milstein, A., ... & Sørensen, H. T. (2015). Posttraumatic stress disorder and cancer risk: a nationwide cohort study. *European journal of epidemiology*, *30*(7), 563-568.

Graziano, S., Rossi, A., Spano, B., Petrocchi, M., Biondi, G., & Ammaniti, M. (2016). Comparison of psychological functioning in children and their mothers living through a life-threatening and non-life-threatening chronic disease: A pilot study. *Nursing Journal of Child Health Care, 20*(2), 174–184.

Kaden-Lottick, N., Vabderwerker, L., Block, S., & Prigerson, H. (2015) Psychiatric disorders and mental health service use in patients with advanced cancer: A report from the coping with cancer study. *Cancer, 104*(12), 2872-2881.

Katzman, B. & John, R. (2018). Adolescent cancer survivors: A literature review of psychological effects following remission. *Journal of Oncology Nursing Society, 22*(5), 507-515.

Kendall, J., Glaze, K., Oakland, S., Hansen, J., & Parry, C. (2011). What do 1281 distress screeners tell us about cancer patients in a community cancer center?. *Psycho-oncology*, *20*(6), 594-600.

Kimerling, R., Prins, A., Yeager, D. E., & Magruder, K. M. (2010). An interval approach to screening for PTSD in primary care. Poster presented at the 44th Annual Conference of the Association for Cognitive and Behavior Therapy, San Francisco, CA.

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*(2), 111–116.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.

Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., Price, J. L., & Schumm, J. A. (2008). Change in posttraumatic stress disorder symptoms: Do clinicians and patients agree? *Psychological Assessment*, *20*(2), 131-138.

National Institute of Health. (2019b). Cancer statistics. Retrieved from www.cancer.gov/about-cancer/understanding/statistics

National Institute of Health. (2019a). Adjusting to cancer. Retrieved from: www.cancer.gov/about-cancer/coping/adjusting-to-cancer.

Northern Psychiatric Associates. (2019). Caring for the mental health needs of all ages. Retrieved from www.northernpsychiatric.com.

Staton, A., Rowland, J., & Ganz, P. (2015) Life after diagnosis and treatment of cancer in adulthood: Attributions from research in psychosocial oncology. *American Psychology, 70*, 159-174.

Stuber, M., Meeske, K., Leisenring, W., Stratton, K., Zeltzer, L., Dawson, K.,… Krull, K. (2011). Defining medical posttraumatic stress among young adult survivors in the Childhood Cancer Survivor Study. *General Hospital Psychiatry*, *33*(4), 347-353.

Tang, W. P., Chan, C. W., Leung, D. Y., & Chan, D. N. (2019). The effects of psychoeducational interventions on caregivers of children with cancer: A meta-analysis of randomized controlled trials. *Journal of Child Health Care*, 1367493518814917.

Vachon, M. (2006). Psychosocial distress and coping after cancer treatment. How clinicians can assess distress and which interventions are appropriate--What we know and what we don't. *American Journal Nursing, 106*(3), 26-31.

Vodermaier, A., Linden, W., & Siu, C. (2009). Screening for emotional distress in cancer patients: A systematic review of assessment instruments. *Journal of National Cancer Institiute, 101*(21), 1464–1488.

Walden University. (2011). Student publications: Vision, mission, and goals. Retrieved from http://catalog.waldenu.edu.

Walden University Writing Center. (2018). Course-specific resources: For graduate Courses. Retrieved from http://academicguide.waldenu.edu/writingcenter/coursespecificresources/graduate

Zebrack, B., Kayser, K., Sundstrom, L., Savas, S. A., Henrickson, C., Acquati, C., & Tamas, R. L. (2015). Psychosocial distress screening implementation in cancer care: an analysis of adherence, responsiveness, and acceptability. *Journal of Clinical Oncology*, *33*(10), 1165-1170.