The Distress Thermometer: Cutoff Points and Clinical Use

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Purpose/Objectives: To establish an optimal cutoff point for the National Comprehensive Cancer Network’s Distress Thermometer (DT) as a screening measure to identify and address psychological distress in individuals with cancer, and to examine whether distress as measured by the DT significantly changes across the treatment trajectory.

Design: Secondary analyses of baseline data from a longitudinal parent study examining a computerized psychosocial assessment.

Setting: Three diverse comprehensive cancer centers across the United States.

Sample: 836 patients with a current or past diagnosis of cancer.

Methods: Study participants were selected from a randomized clinical trial. Patients during any stage of the cancer treatment trajectory were recruited during a chemotherapy infusion or routine oncology appointment.

Main Research Variables: The Behavioral Health Status Index and the DT were administered and compared using receiver operating characteristic analyses.

Findings: Results support a cutoff score of 3 on the DT to indicate patients with clinically elevated levels of distress. In addition, patients who received a diagnosis within the 1–4 weeks prior to the assessment indicated the highest levels of distress.

Conclusions: Providers may wish to use a cutoff point of 3 to most efficiently identify distress in a large, diverse population of patients with cancer. In addition, results indicate that patients may experience a heightened state of distress within 1–4 weeks post-diagnosis compared to other stages of coping with cancer.

Implications for Nursing: Using a brief measure of distress can help streamline the process of screening for psychosocial distress.

Psychological distress as a consequence of cancer care is related to diagnoses of anxiety, depression, adjustment disorders, and decreased quality of life (Mitchell et al., 2011). Despite estimates that 24%–50% of patients with cancer exhibit symptoms of distress, and can experience the aforementioned effects, psychological symptoms are not consistently addressed by all care teams (Carlson et al., 2004; Holland & Bultz, 2007; Jacobson & Ransom, 2007; Mitchell, Vahabzadeh, & Magruder, 2011; van Scheppingen et al., 2011). Even in patients exhibiting high levels of distress, rates of referral and access to psychosocial services tend to be low (Carlson, Waller, & Mitchell, 2012; Ellis et al., 2009; Verdronck-de Leeuw et al., 2009; Zebrack et al., 2015). Whether from of a lack of education regarding the use of psychosocial support or stigma regarding mental health care, highly distressed patients may not even express interest in, use, or follow up with a variety of psychosocial services (Roth et al., 1998; Tuinman, Gazendam-Donofrio, & Hoekstra-Weebers, 2008; Waller, Williams, Groff, Bultz, & Carlson, 2011). This discrepancy between high distress and low engagement in therapeutic interventions is problematic and warrants further investigation.