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Reported Interventions for Reducing Anxiety and Distress in Adult Oncology Patients throughout their Cancer Experience: A Review of the Literature and an Analysis of Adults in Remission

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RUNNING HEAD: INTERVENTIONS FOR REDUCING ANXIETY & DISTRESS IN ONC
PATIENTS

Reported Interventions for Reducing Anxiety and Distress in Adult Oncology Patients
throughout their Cancer Experience: A Review of the Literature and an Analysis of Adults in
Remission

By

Katie Gomez

Submitted in partial fulfillment of the requirements of the Nursing Department and the Honors
Program

Dominican University of California

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NURS 4998 Honors Directed Research

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Abstract

Background: The purpose of this paper is to identify present methods at relieving anxiety and distress in adult oncology patients. According to the American Cancer Association (2016), 1.7 million American will be diagnosed with cancer in 2016, and therefore, it is important for nurses to be competent caregivers to this growing patient population.

Literature Review: A comprehensive review of current literature showed that consistent, competent caregivers, honest communication from the medical team, back massage, and music therapy were effective at cutting mean anxiety and distress scores by as much as 50 percent. Sixteen peer-reviewed articles from around the world and published in the last three years, plus one seminal article from 2004 were included in the literature review.

Research: A phenomenological interview process with nine volunteers from a convenience snowball sample, who were diagnosed and treated over the age of 18 in California.

Findings: Oncology patients benefit from personal coping methods such as: having a strong support system, having either personal or religious faith, and staying busy throughout their treatment. Medical personnel can supplement patient coping by providing clear expectations, by being compassionate and forthright, by prefacing negatives with positives, and by ensuring clinical competency in the skills performed.

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Introduction

In 2016, according to the National Cancer Institute (NCI), 595,690 people will die of cancer in the United States, and 1,685,210 new cases will emerge (NCI, 2016). Cancer is “a group of many diseases of multiple causes, that can arise in any cell, that is able to evade regulatory controls over cell proliferation and differentiation” (Arikian, Brown, Burckhardt & Redemske, pg. 381, 2014), meaning that any cell in the body can fall prey to the illness. Cells become damaged and diseased, they replicate continuously, potentially spreading the disease throughout the body. Uncontrolled replication of the cells can result in an abnormal (malignant) growth or tumor. Continuous growth of these tumors creates a pyramid effect in which a larger number of existing cancer cells have the capability to produce a larger number of newly diseased cells.

In order to combat the often rapid progression of cancer, treatment is very aggressive. The most common treatment is combination therapy, consisting of chemotherapy, radiation and/or surgery. Chemotherapy is a variety of drugs that interfere with the replication of cells, normal and abnormal. Radiotherapy, utilizes radiation, such as gamma rays, to directly target the tumor externally, or radioactive material is internally implanted inside the tumor. Surgery is an option if the tumor appears operable for complete resection or debulking. Combination therapy is used to eliminate cells at various points in the cell cycle, and to suppress the development of new cancer cells. Recently, treatments have evolved to include immunotherapy, a medication regimen to target a specific type of cell using an individual’s immune system. This allows for more accurately targeted therapy with fewer adverse effects. However, immunotherapy is still very new, not widely used, and not well known by the general public. (American Cancer Society, 2016).

Chemotherapy and radiation have many potential adverse side effects, including but not limited to: anorexia, nausea, vomiting, diarrhea, pain, alopecia (loss of hair), fatigue, ototoxicity (loss of hearing), stomatitis (painful swelling and sores inside the mouth), radiation burns, malnutrition, and bone marrow suppression, among others (Arikian, Brown, Burckhardt & Redemske, 2014). Knowing how difficult these treatments can be, newly diagnosed individuals often experience anxiety and distress. Anxiety is defined as “fear, dread, or uneasiness caused by stress,” whereas distress is defined as “emotional, mental, social, or spiritual suffering” (National Cancer Institute, 2016). The initial diagnosis, the fear of what is to come, the knowledge of treatment, and the potential possible existential crises can all cause tremendous stress in cancer patients, regardless of age, sex, or race. It is within a nurse’s scope of practice to help relieve patients’ anxiety and distress.

Problem Statement

Kaiser Permanente Healthcare (Kaiser) has implemented a new protocol in the last decade that has effectively lowered the incidence of heart attack and stroke in its members by 65 percent. The PHASE (Preventing Heart Attack and Stroke Everyday) Protocol incorporates lifestyle changes and medication therapy to reduce the effects of coronary artery disease. Due to the success of PHASE, coronary-artery-disease-related complications are no longer the primary cause of death in adult Kaiser patients. Now, in 2016, cancer is the leading cause of death in Kaiser members. The United States Government endowed Kaiser a grant to distribute PHASE protocol throughout community hospitals and other leading providers. The success of PHASE thus far increases the probability that cancer will emerge as the leading cause of death in more than just the Kaiser population. Based on this data, nursing will play a greater role in the care of

oncology patients, increased awareness of the special needs and care of the oncology population may be warranted

The National Cancer Institute projects that breast, lung, bronchus, prostate, colon, rectum, bladder, skin, lymphoma, thyroid, renal, leukemia, endometrial, and pancreatic cancer, will be the most prevalent cancers in 2016 in the United States. Among the 1,685,210 newly diagnosed individuals with cancer, the National Cancer Institute (NCI) reports that nearly half will experience some kind of anxiety or distress. These feelings may heighten while waiting for test results, or waiting for a diagnosis. These psychologic reactions can be attributed to changes in body image, pain, fatigue, social isolation, fear of the unknown, and/or fear of death. Anxiety and distress can lead to increased perception of pain, fatigue, nausea, and to decreased ability to cope. (NCI, 2016).

Purpose Statement

The nurse is a cancer patient's biggest ally, and as such should be able to help the patient find alternative therapies to help quell anxiety and distress. The purpose of this paper is to specifically investigate the most effective methods for reducing anxiety and distress in adult oncology patients' perceptions of their diagnoses, treatments, and longevity.

Literature Review

As a prospective oncology nurse, this nursing student's purpose for reviewing the literature is to examine current alternative, non-pharmacological therapies to reduce anxiety and distress in cancer patients. Again, anxiety is defined as "fear, dread, or uneasiness caused by stress," whereas distress is defined as "emotional, mental, social, or spiritual suffering" (National Cancer Institute, 2016).

Fifteen recently published articles were selected for their relevance to the population. The articles were broken down into three categories of non-pharmacologic cancer treatment: caring behaviors done by the nurse and/or caregiver, communication between patient and nurse, and interventions that focus on therapeutic touch and music therapy.

Overview of Studies Selected

Of the 15 selected research studies and their articles, 12 were conducted outside of the United States: one each in Italy, Australia, Greece, Japan, China, Belgium, the United Kingdom, Taiwan, India, and Turkey (Bartirromo, Capuzzo, Grazia De Marinis, Matarese & Piredda, 2016; Rose & Yates, 2015; Karlou, Papathanassoglou & Patiraki, 2015; Komatsu & Yagasaki, 2014; Zhang et al., 2015; Lewis et al., 2015; Skea, MacLennan, Entwistle & N'Dow, 2014; Chen, Wang, Shih & Wu, 2013; Krishnaswamy & Nair, 2016; Karagozoglou & Kahve, 2013, respectively). Two were conducted in Sweden (Udo, 2014; Mullaney et al., 2016). Two were conducted in the United States, one in New York City, New York, and one in Indianapolis, Indiana (Cassileth & Vickers, 2004; Banerjee et al., 2016; McLennon et al., 2013, respectively).

Seven articles were qualitative in nature. Five relied on phenomenological interview processes (Matarese & Piredda, 2016; Rose & Yates, 2015; Komatsu & Yagasaki, 2014; Skea, MacLennan, Entwistle & N'Dow, 2014; Udo, 2014; McLennon et al., 2013). One was a case study (Rose & Yates, 2015) and one was a free-response survey (Banerjee et al., 2016). The remaining eight articles were quantitative. Six relied on data derived from pre and post State Trait Anxiety test scores (Lewis et al., 2015; Chen, Wang, Shih & Wu, 2013; Krishnaswamy & Nair, 2016; Karagozoglou & Kahve, 2013; Mullaney et al., 2016; Cassileth & Vickers, 2004). The final two articles used cross-sectional comparisons to derive statistical significance (Zhang et al., 2015; Karlou, Papathanassoglou & Patiraki, 2015).

The 15 studies' purpose statements can be divided into four groups that focused on the ways communication, caring behaviors, music therapy, and massage affect oncology patients' anxiety and distress levels. The majority of the studies used pre and post-tests and interviews to assess changes in patients' perceptions of anxiety and distress following an intervention.

Participants were selected purposefully in five of the research studies depending on their literacy (Chen, Wang, Shih & Wu, 2013), demographics (Piredda et al., 2016; Skea, MacLennan, Entwistle & N'Dow, 2014; McLennon et al., 2013), or for lack sensory impairments (Karagozoglou & Kahve, 2013). The remaining ten studies relied on convenience samples of voluntary participants.

Caring Behaviors

Piredda et al. (2016) suggest that allowing patients to depend heavily on their nurses and caregivers immediately following their diagnosis allows patients time to learn to cope with their illness without the stress of self-care. However, as the illness and treatments progress, patients' coping mechanisms should be in place in order to allow them to regain as much independence as possible. One of the main struggles that researchers encountered in their 13 patient interviews was the initial inability of the patients to ask for help. Accepting help led to significantly lower anxiety scores. Once patients had regained some independence they became more comfortable asking for help .

Rose and Yates (2015) found that providing patients with one continuous nurse at their bedside throughout radiation therapy was appreciated by both patients and their families. The 216 subjects were divided into two cohorts that both filled out pre and post Quality of Life questionnaires following 12 months of a newly developed care model. The continuum of care

helped to increase quality of life by reducing the distress experienced with constant healthcare provider changes.

Greek researchers Karlou, Papathanassoglou and Patiraki (2015) claim that care is a metaphysical concept that connotes attendance to a patient's being; however, its meaning has changed to include tasks that facilitate medical treatment. The study concluded that nurses' technical competency was the most important component of being an adequate caregiver. While the 138 patients appreciated their psychosocial needs being met, the majority claimed they would forgo psychosocial treatment in favor of technical competency. This study was limited to Greek patients in one hospital, so this result may not necessarily translate to a larger, international population.

University and hospital researchers in Sweden (Mullaney et al., 2016) chose to focus their study on the environment of the outpatient clinic in which 892 patients were receiving care. They were able to conclude that when radiotherapy patients were left alone during or surrounding their treatment, anxiety levels were significantly higher on the State Trait Anxiety Inventory scale.

Another Swedish study from Udo at Dalarna University examined how nurses can better care for the existential needs of their patients. Udo found that nurses need to be better trained in counseling patients regarding difficult topics, such as death. The training should address the nurse's personal beliefs, and the nurse's ability to be objective. Nurses experiencing conflict should refer the patient to another nurse who can better accommodate the emotional, mental, and spiritual needs of the patient. When discussing death, patients need to be able to discuss their options openly with their nurse, and the nurse needs to be supportive and able to provide knowledgeable, impartial feedback. Udo added that one thing nurses can do to stave off

existential despair is help their patients find meaning in their lives. This can be done through discussing the patient's life, their accomplishments, their regrets, what they have learned, and what good they have done. (Udo, 2014)

Self-efficacy was the main factor influencing Zhang, et al.'s 252 Chinese patients' anxiety and distress surrounding their diagnosis and treatment, indicating that nurses should do their best to maintain patient autonomy, but also allow room for dependence and seeking of help. Significantly higher anxiety was also found in individuals over 60 years of age, with a body mass index (BMI) of under 18.5 or over 25, in females, and in single or divorced patients. (Zhang et al., 2015)

Komatsu and Yagasaki (2014) found that in Japan, the best way to alleviate patient distress was by initiating and maintaining a therapeutic relationship that stayed professional throughout their involvement. Twenty-one nurses said they could connect on a therapeutic level when they uncovered their patients' perceptions towards the illness, and what they truly needed to begin their recovery. The researchers found that finding and regaining the patient's potential for managing their disease was a key factor in improved psychosocial care. Potential was reached in this study by reassuring the patient, and encouraging them to move forward with their treatment and take the next step. This gave patients confidence in their plan of care, and autonomy in their choice to move forward.

Communication

Belgian researchers Lewis et al. (2015) analyzed first-time radiotherapy patients by assessing 227 patients' demographics, coping mechanisms, perceived self-efficacy, and the diagnosis itself. They were able to ascertain that the presence of anxiety was predictable in patients that rated themselves ineffective at communicating with their multidisciplinary team.

With this significant finding, Lewis et al. encouraged team members to proactively communicate with the patient, so that the patient is not only knowledgeable about the procedure, but also has time to think of questions. The use of proactive communication enabled the nurse and the medical team to better understand the patient's fears, and how to best help the patient cope.

(2015)

Research from the United Kingdom by Skea, MacLennan, Entwistle and N'Dow (2014) also outlines the importance of effective communication between the patient, the nurse, and the care team. Twenty-six patients reported that effective and consistent communication made them feel respected, valued, and supported, all of which contributed to decreased levels of distress. To these British patients, effective communication included having care needs anticipated, staff follow-through on commitments, medical staff honesty regarding prognosis, being recognized as unique individuals, and being given enough support and autonomy. (2014)

The Memorial-Sloan Kettering Cancer Center Study by Banerjee et al. (2016) revealed six main challenges that 121 American nurses experienced when speaking with their oncology patients. These included the inability to provide empathy due to dialectic differences, unwillingness to give bad news, lack of empathetic communication skill, hospital barriers, challenging situations, and perceived differences between patient and nurse. Researchers found that nurses need additional training in empathy and communication to conquer these challenges. Patients claimed communication had been successful when they and their family had an accurate understanding of their prognosis, which was obtained only after the nurse had spent enough time with them to provide empathic support. (2016)

Researchers from three universities in Indianapolis, Indiana (McLennon, et al., 2013) considered the nurse's role in prognosis-related communication with oncology patients, finding

that both nurses and patients were most comfortable when all available information had been disclosed to everyone involved. Twenty-seven nurses found their niche between the physician and patient: clarifying, reiterating, and interpreting information. With their closer proximity to the patient, nurses also found that being able to assess the patients' needs was a helpful factor in anticipating future needs and furthering communication.

Interventions

Initial research offered evidentiary support for several alternative, non-pharmacological methods to reduce anxiety and distress including music therapy, therapeutic touch, aromatherapy, and acupuncture. However, further research showed that only music therapy and therapeutic touch were consistently successful in treating patients' anxiety and distress.

Chen, Wang, Shih, and Wu (2013) found that in Taiwan, 15 minutes of music prior to radiotherapy cut 100 patients' stress in half, compared against a control group of 100 whose stress levels remained unchanged. They also found that the higher a patient's stress level prior to the procedure, the more beneficial the music therapy proved to be. Patients who were given music therapy also exhibited higher oxygen saturation, lower blood pressure, and lower heart rate. Researchers allowed patients to select their music from a collection of traditional Chinese songs ranging from 60 to 80 beats per minute. (Chen, Wang, Shih & Wu, 2013)

Indian researchers Krishnaswamy and Nair (2016) found that when 14 patients were not given a choice of their music, there was no significant decrease in anxiety, further underscoring the role of patient autonomy in anxiety, although there was a significant decrease in pain, a factor of distress.

Massage therapy was used by Cassileth and Vickers in 2004 and was found to have dramatic effect. There was a 54 percent mean reduction in symptom (nausea, fatigue, anxiety,

and depression) severity among 1,290 patients. Pain scores were also reduced by a mean of 45 percent. Further statistical analysis demonstrated that reduction in symptom severity would compound with each subsequent treatment. Researchers limited the type of massage to either Swedish or foot, with no significant difference in results between the two.

Researchers in Turkey (Karagozoglu & Khave, 2013) administered one back massage per day in order to assure the consistency of the massage delivered. Forty patients received 15 minutes of massage before the procedure, 15 minutes every hour between the 25th and 40th minute, and 15 minutes after the treatment. Mean fatigue and anxiety scores decreased significantly in the intervention group, and no difference was found between gender, diagnosis, or history of treatment. This indicates that massage is an effective therapy in most oncology patients to help reduce anxiety and certain factors of distress.

Discussion

With regards to caring behaviors, literature indicates that nurses can best alleviate anxiety and distress by providing continuous care, allowing patients to depend on them, ensuring patient safety, promoting autonomy when the patient is ready, and helping to realize patient potential. The final factor of successfully caring for patients is the nurse exhibiting technical clinical competency.

Open, honest, empathic dialogue is the most important factor in successful patient-nurse communication. Neither the patient nor the nurse found withholding information to be a successful communication technique. Further training and education may be beneficial for nurses in successfully relaying the information and options available.

Though there are several complementary therapies available to oncology patients, massage and music therapy prove to be the most widely used, and most significantly successful

treatments. Music therapy can be conducted with or without a licensed music therapist, and massage can be administered without a licensed masseuse. Both therapies are noninvasive and cost effective.

Implications for Nursing Practice and Further Research

Oncology nurses can use the techniques presented in the literature to help reduce their patients' levels of anxiety and distress. These techniques include open, honest communication, continuous, safe care, promoting autonomy while allowing patient dependence, 15 minutes of music therapy, and massage before and during treatment.

While the literature provided a comprehensive, multinational view of complementary therapies for oncology patients, more domestic research may be beneficial to nurses practicing specifically in the United States. Since the United States is so multicultural, it is likely that this researcher's findings through a review of the literature will parallel future findings in domestic research; however, in order to prove this hypothesis, a regional breakdown of the United States' oncology therapies may prove educational.

As complementary therapies progress and transform, more research can be done on combinations of alternative therapies. For instance, does providing patients with music and a back massage simultaneously provide more relief than giving either therapy individually? Additionally, how can less common and traditionally less successful therapies like aromatherapy and acupuncture be better employed to reduce symptomology? Lastly, further research can be done on the effect of complementary therapies as performed by a licensed therapist versus a registered nurse.

Theoretical Framework

Gerteis, et al. (1997) proposed a patient-centered model of care that encompasses the primary ideas found in this researcher's review of current literature. Physical comfort, information communication, education, coordination of care, respect for the patient's values, preferences, and expressed needs, transition, community, involvement of family and friends, emotional support, and alleviation of fear and anxiety are the primary factors that, when addressed, lead to better patient-centered care. Figure 1 shows this model in a graphic.

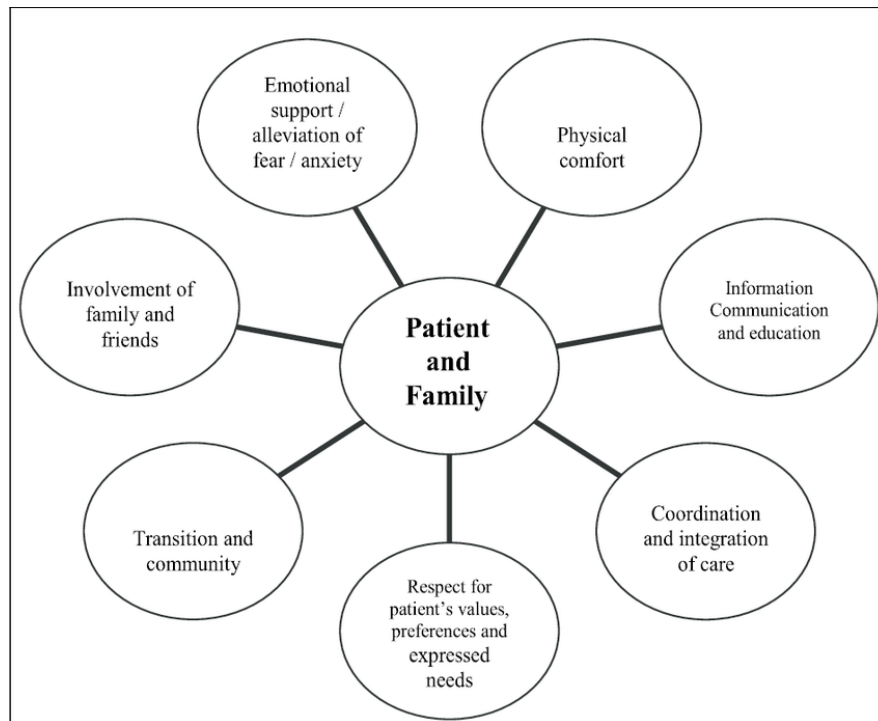


Figure 1. Conceptual model of patient-centered care. Gerteis et al. (1993). *Through the Patient's Eyes*. Jossey-Bass: San Francisco

Upon the review of the literature, this researcher found that suggested methods of anxiety reduction in oncology patients fall under the umbrella of Gerteis et al.'s Patient-Centered Care model. Honest communication with patient and family falls under both "Information Communication and education" and "Involvement of family and friends." Therapeutic touch and massage can be included in "Physical comfort," and music therapy can be applied to "Respect

for patient's values, preferences and expressed needs" as well as "Emotional support." The continuum of care with the same nurse, and clinical competency fall under "Coordination and integration of care," and "Transition and community." All interventions support "Emotional support/alleviation of fear/anxiety." as defined (described) by Gerteis, et al.

This paper focuses on the alleviation of patients' stress and anxiety, though the aforementioned methods all address one or more of the extenuating factors of patient-centered care. This researcher's subsequent proposed research will focus on addressing one or more of Gerteis et al.'s components of patient and family-centered care.

Methods and Design

The purpose of this paper has been to investigate methods for reducing anxiety and distress in adult oncology patients, and address patients' perceptions of their diagnoses, treatments, and longevity. This researcher confined her search to include interventions that the registered nurse can implement on behalf of the patient. While there may be other effective methods that can be performed by a licensed professional of another discipline, or by a family member/caregiver, their existence and effectiveness are beyond the scope of this paper.

A review of the literature shows that effective nursing care for adult oncology patients can be narrowed down to three categories: effective communication, caring behaviors, and alternative interventions such as music therapy and massage. Patients reported decreased levels of anxiety and distress after they had been given an honest assessment of their diagnosis, treatment plan, and prognosis. This indicates that nurses can alleviate anxiety by clarifying the physicians' report, translating the information into terms the patient can understand, and by allowing patients to process the information in their own time. Caring behaviors include allowing

the patient to be dependent on their caregivers until they are ready to face their illness and regain their autonomy. Analysis of caring behaviors also showed that a consistent nurse at the bedside, and the nurse's empathic ability to discuss the patient's options helped alleviate stress. Technical nursing competency was also identified as a caring behavior, as some patients said it is the most important trait in an effective nurse. The last category, alternative interventions, consistently showed that massage and music therapy were both effective before, during, and after chemotherapy and radiation to reduce feelings of distress.

Gerteis et al.'s Conceptual Model of Patient Centered Care encompasses all of the findings the literature proposed, and provides this researcher with the framework to base further questions on. While not every factor will be addressed, every question will pertain to one or more of the factors.

This researcher proposes to use these findings to further the study of non-pharmacologic anxiety and distress management in adult oncology patients through a phenomenological interview process. Phenomenology allows a researcher to analyze the human condition and to address thoughts and feelings, as opposed to a statistical analysis of numerical data. A purposeful, convenience sample with snowballing will be selected from voluntary adults who were diagnosed with cancer after age 18, who received treatment in California, and are presently in remission. Sample size will range from five to ten adults in remission, and the research tool will be in typed transcripts of recorded interviews, conducted by this nursing student.

This nursing student, the researcher, will use an interactive interview process to ascertain the subjects' experiences with their ~~own~~ diagnosis, and treatment. Table 1 includes proposed

demographic related questions, and Table 2 includes interview questions with corresponding rationale.

Table 1 Demographics

1. Age at time of diagnosis
2. Age at time of treatment completion (when were you declared to be in remission?)
3. Current Age
4. Sex
5. Identified Ethnicity(ies)
6. Primary oncology diagnosis
7. Secondary oncology diagnosis (if applicable)

Table 2 Interview Questions and Researcher's Rationale

Interview Introduction and Questions	Rationale
1. "Tell me about your experience leading up to your diagnosis."	To open the discussion and provide the subject with a place to begin telling their story. This statement may also prompt subjects to just start talking without feeling interrogated.
2. "How did you react to your initial diagnosis?"	If not otherwise stated in the initial response, this question allows the interviewer to understand the subject's coping ability and emotional stability, which will provide insight into the subject's stated anxiety throughout their experience.
3. "What worried you the most about your	Provides insight into what gives the subject the

diagnosis?"	most anxiety and allows for further conversation regarding worries during treatment. May be addressed in the previous question.
4. "What did you think about your treatment options?"	Looks at the treatment portion of the cancer experience and how distress changed following the initial diagnosis phase.
5. "Describe to me a situation during your illness when you experienced more anxiety than normal."	An open ended statement will allow the subject to recall a particularly difficult point in their experience. While everyday anxiety may be normal in most people, this question delves deeper into the individual subject's anxiety and factors affecting it during their treatment.
6. "What did you do to try and reduce your anxiety?"	Gives the researcher insight into how the subject handles his or her own difficulties, as well as the coping skills the subject may lack.
7. "What was your nurse able to do to help alleviate or minimize your distress?"	This question is perhaps the first to truly address the research question as it has to do with the oncology nursing practice. Subjects' responses will indicate successful interventions the nurse performed to help reduce stress, and may also present unsuccessful interventions subjects experienced.
8. "What did other members of your medical team do to alleviate your distress?"	Provides insight regarding other options for the nurse in caring for an oncology patient. While not all methods may fall under a nurse's scope of practice, responses to this question may lead the nurse to the correct referrals and continuing

	educational opportunities.
9. “Is there anything else regarding anxiety throughout your experience that you would like to mention?”	This final statement gives the patient the chance to mention anything they think the researcher may find relevant, as well as provide information previously forgotten.

Findings

A total of nine individuals volunteered to participate in this study. Eight of the nine identified as Caucasian or white, and one as Hispanic or Latino. Five identified as males and the other four as females. Their current age ranged from 50 to 86, averaging 62.6 years old, and their age at the time of diagnosis ranged from 23 to 82 with a mean age of 51.7 years old. All subjects are currently in remission, and were declared to be cancer free between 28 and 84, with a mean remission age of 54.7.

All four females interviewed had varying diagnoses of breast cancer. All four subjects underwent surgical treatment—three lumpectomies (one curative) and one (curative) radical mastectomy. Additionally, two went through chemotherapy, and three went through brachytherapy. Two of the five males had diagnoses of prostate cancer and underwent curative prostatectomies. One male had melanoma and had the surgical resection of the tumor, as did the individual with osteosarcoma of the femur. The last male subject underwent rigorous chemotherapy to eliminate his non-Hodgkin’s lymphoma.

Six of the nine individuals claimed to have anxiety during their experience as an oncology patient. Their anxiety can be attributed to one of the following: fear of the moment of death, fear of leaving their children/families, or fear of treatment side effects.

Example 1: *“...Very worried, yeah. Because I didn’t know. The hardest part about the whole time is that you don’t know.”*

Example 2: *“Biggest thing was: how do you tell your kid your mom may not be there?”*

Example 3: *“I [was] a pretty beat up guy after three hospitalizations [infusions] and so the doc and I had quite a discussion over the fourth one.”*

Example 4: *“I had migraines. And I was exhausted. It just really affected me.”*

Of the three individuals who did not experience anxiety, one claims to have been content with death as a means to reconnect with a deceased spouse, one claims to have profound religious faith and contentedness with death as a means to achieve religious salvation, and the other claims to have had such faith in his/her treatment plan that there was no question of life and death.

Example 1: *“I thought I wouldn’t mind going to see [my wife] again.”*

Example 2: *“If I live...life goes on. And if I don’t live, if I die, my body dies, but my soul goes to heaven for eternity. And that’s okay.”*

Example 3: *“I felt very confident. I knew...they would do a biopsy...and they would do a mastectomy...I felt totally positive the whole time. They’re going to do that, and they’re going to fix it, you know.”*

The six individuals who did experience anxiety found comfort in a strong support system, in either religious or personal faith, in survival stories that brought hope, and/or in keeping themselves busy and maintaining their normal routine. Table 1:

Support System
<i>“Having a good support system and just being able to talk about it, talking about it with my partner too.” “The most important thing is having your family around you.” “It’s nice when you can talk to someone who’s actually in there and you don’t feel like you’re the only person going through this stuff.”</i>
Faith and Hope
<i>“I actually prayed a lot. It was just so painful, I must have said about a million Hail Mary’s.” “Everybody knew I was going to die. God just wasn’t quite ready for me to.” “We get cancer, we just beat it.”</i>
Keeping Busy
<i>“What’s going to work for me is moving on, moving forward.” “I got a chance to go for walks without the kids and take a deep breath.” “I organized a company softball team so I played the games. Hung out with friends and did stuff.” “I tried to not sit still and focus.” “...organizational, let’s get through this mentality...”</i>

Assessment of individual coping methods allowed this researcher to better understand any lapses in coping that a registered nurse can assist an oncology patient with. All nine individuals said that having a clear understanding of their diagnosis and treatment plan was critical to lowering stress level, but unfortunately not all nine subjects received this treatment. The majority of subjects also said that a compassionate, forthright demeanor from their medical team was beneficial in maintaining personhood—being treated as a person rather than as a diagnosis. The final comfort measure came from nurses’ clinical competency—the ability to perform their tasks without undue discomfort for the patient. The three methods are exemplified in Table 2:

Clear Expectations
<i>“They were very personable; they took their time explaining things...” “He walked me through the process and clearly explained what they did...” “...pretty much told me everything that was going to happen...doing it in a nice way so there were no surprises.”</i>
Compassion and Forthrightness
<i>“The nurses give you hugs. It was so nice.” “...they [medical personnel] were all helpful and caring and interested.” “They didn’t fluff it but they were also sensitive of the way they were describing it and made sure all questions were answered.” “I was not being tended to, I was being cared for.” “It was really personal, and with a lot of information.” “...he’s candid, he’s compassionate...”</i>
Prefacing with Positivity
<i>“...she was encouraging because she was like a 10-year survivor and was kind of telling me her story...” “...being able to deliver the message, kind of prefacing it with some of the positives of what’s going to be a negative thing.” “...I was constantly asking for stories of people that had good outcomes...that was a huge help.”</i>
Clinical Competency
<i>“It’s trust and confidence in the [team]...” “...she was very proactive and immediately very concerned.”</i>

In addition to the successful methods at reducing anxiety and distress, many subjects wished to express the need for spousal support throughout the oncology experience.

Example 1: *“[my husband] was in pretty bad shape about it. And, obviously that concerned me...some reach out to him could’ve been helpful to him, I’d imagine.”*

Conclusion

Oncology patients' most successful coping methods include having a strong support system, a sense of either personal or religious faith, and maintaining a normal routine as much as possible throughout their treatment. Registered nurses can supplement coping by providing their patients with clear expectations of treatments and daily schedules, by being compassionate and forthright in their delivery, by finding positives in an otherwise negative situation, and by being clinically competent. Discrepancies in patient care came when medical personnel failed to see patients as people, and instead saw them as diagnoses. One patient "felt like a science experiment," as she was left topless in radiology while engineers attempted to fix the mammography machine. Numerous attempts to start an intravenous line was another common complaint.

It is important for registered nurses (RNs), and for all medical professionals involved in direct patient care, to ensure they are treating their patients as people, who are scared, vulnerable, and concerned for their future. RNs must not forget their sense of compassion, nor their duty to veracity. They must also remember that it is okay to ask for help with clinical skills. Asking for help is far better than causing a patient undue discomfort because of an unsure nurse.

Though this study was conducted with oncology patients in remission, the results are applicable in the treatment of all patients. Any individual in a medical setting deserves to be treated with honesty, compassion and forthrightness, as well as the best clinical care possible.

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