Psychoeducational Interventions

Rationale, Structure, and Nursing-Sensitive Patient Outcomes

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The course of cancer can be divided into three phases. The first of these is when a patient receives the initial diagnosis and goes into active treatment. The patient then enters a period of survivorship assuming that this treatment results in cure or remission. If initial or subsequent treatment is not successful the final phase of cancer shifts to focus on end of life issues. This paper will present psychoeducational interventions that have been found useful during the first phase of cancer, diagnosis and initial treatment. A rationale for the use of such interventions, their basic structure, and nursing sensitive outcomes will be provided.

Scope of the Problem

The United States’ National Comprehensive Cancer Network (NCCN) has defined the psychosocial scope of cancer problems as distress. “Distress is a multi-factorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears to problems that become disabling such as depression, anxiety, panic, social isolation, and existential and spiritual crisis.” It was decided that distress is more acceptable and less stigmatizing than psychiatric, psychosocial, or emotional. Distress sounds more normal and is less embarrassing. In addition, it can be defined and measured by self report. The Distress Thermometer is a simple 10-point scale similar to the pain scale and is a useful clinical tool. It is accompanied by a problem list that helps to identify the specific areas causing distress. (Access the tool at: http://www.nccn.org/professionals/physician_gls/PDF/distress.pdf).

Rationale for Psychoeducational Interventions

Possible manifestations of distress at the time of diagnosis include denial of the disease and refusal of medical care, a prolonged search for other treatment options, giving up and a fatalistic refusal of treatment, acute grief, anger and anxiety, and depression. General manifestations of distress during treatment include anxiety, fear, sadness, depression, loss of control, helplessness, hopelessness, anger, and guilt. There may be additional manifestations of distress that are relative to the type of treatment employed. Patients facing surgery may postpone the procedure or seek non-surgical alternatives. There can be grief reactions to changes in body image, and postoperative reactive depression. Patients scheduled for radiotherapy may experience fear of the machinery, fear of abandonment, and psychotic-like delusions and hallucinations. Chemotherapy can cause fear of side-effects including body image changes, isolation, or drug-induced organic brain syndrome (e.g., psychosis).

Distress can be managed very effectively for most patients with cancer through a combination of psychoeducational interventions. Many of these interventions can be delivered time- and cost-effectively by nurses who are in the forefront of oncology care.

Structure of Psychoeducational Interventions

A wealth of research has supported the evidence base for psychoeducational interventions (Fawzy et al., 1990, 1993, 1994, 1995; Fawzy, N., 1995). This research has elucidated four primary components of psychoeducational interventions: 1) health education, 2) stress management. 3) coping skills, and 4) psychological support.

Health education

The goals of health education are to reduce the sense of helplessness and inadequacy due to uncertainty and lack of knowledge and then to replace feelings of helplessness with a sense of mastery and control.

Stress management

The goals of stress reduction are to help patients cope more effectively with the overall emotional impact of cancer, enhance compliance with medical regimens, and assist in the management of treatment side effects (e.g., pain, nausea, vomiting, and sleep disturbance). Stress management begins with an awareness of stress. This requires the identification of personal sources of stress followed by identification of personal reactions to stress.

There are three effective stress management techniques. First, is the use of problem solving to eliminate or modify the source of stress making it less stressful. Here it is important to identify the problem causing the stress. One may think that their problem is anxiety: the real problem is what is causing the anxiety. Anxiety is a psychological reaction to the problem, Third, brainstorm for possible solutions. This process itself can be relaxing and amusing and foster creativity. Fourth, select one feasible solution and implement it. Fifth, evaluate the result of the selected solution. Finally, if the solution worked, celebrate! If it has not worked, go back to steps 3 or 4 and keep on trying until a solution is reached or the conclusion that this particular problem is not solvable. In this case try one of the following techniques.

The second stress management technique involves changing the attitude toward or perception of a problem. This can be done via cognitive restructuring. This involves asking questions such as, “How really important is the issue?” or “Is it really worth getting upset over?” Such questions help to look at a situation from a different, and hopefully, less stressful, perspective.

The third technique of stress management is to change the physical reaction to a problem or stressor. In times of stress, the body responds by releasing a number of chemicals (e.g., epinephrine and cortisol) whose purpose is to enable the body to respond physically to the stressor (fight or flight). In acute stressful situations this response is healthy and adaptive. In chronic stress situations this response becomes maladaptive leading to many illness conditions such as hypertension and may even become immunosuppressive. This management technique is particularly useful when the two previously mentioned techniques fail but it can also be used as a first line technique in many cancer and non-cancer related situations (e.g., during cancer treatment, going to the dentist, or giving a speech).

Coping skills

There are key ingredients of good coping: optimism, practicality, flexibility, and resourcefulness.

Optimism is the expectation of positive change. Practicality is learning that options and alternatives are seldom exhausted. Flexibility involves changing strategies to reflect the changing nature of perceived problems. Finally, resourcefulness reflects the ability to call upon additional information and support in order to strengthen coping.
Coping skills may be defined as methods that are effective (i.e., what works in a given situation) and ineffective (i.e., what doesn’t work in a given situation). Effective methods include active-behavioral and active-cognitive coping.

Active-behavioral coping refers to all of the things that one does (i.e., behaviors or actions) to help solve problems and/or make one feel better. These tend to be effective in both the short and long-term because they are focused on dealing with problems. Examples of active-behavioral coping are exercising, improving diet, forming partnerships with health team, attending support groups, asking questions, and seeking information. Active-cognitive coping refers to all of the thoughts and mental techniques that can help to solve problems and/or make one feel better. These also are focus-focused and tend to be effective in both the short and long-term. Examples of active-cognitive coping include accepting the seriousness of the diagnosis but not automatically accepting a negative outcome, looking for ways in which one is better off than others, assuming that there are options and looking for them, using the situation as a challenge and an opportunity for positive change, and focusing on the positive.

Ineffective coping methods are generally referred to as avoidance coping. These involve both the behaviors and mental activities that may make one feel better in the short-term but are not focused on solving problems. As a result, they do not make one feel better in the long-term. Examples of avoidance coping include abusing drugs (e.g., street drugs, prescription medications, and alcohol), keeping all thoughts and feelings to oneself, overeating or overeating, passiveness or waiting until the problem goes away, and denying the existence or seriousness of the problem.

Psychological support
Nurses provide psychological support via establishment of a trusting relationship, therapeutic communication (questioning, listening, teaching), therapeutic touch (holding a hand, touching a shoulder), and providing a safe and healing environment.

Nursing-Sensitive Patient Outcomes
Nursing-Sensitive Patient Outcomes (NSPO) focus on how patients and their healthcare problems are affected by nursing interventions. They are arrived at, or significantly impacted by, nursing interventions which are within the scope of nursing practice and are integral to the processes of nursing care. NSPO are sensitive to independent nursing care or care rendered in collaboration with other healthcare providers. They represent the consequences or effects of nursing interventions and result in changes in patients’ symptom experience, functional status, safety, psychological distress, and/or costs (Given & Sherwood, 2005).

The Psychoeducational interventions discussed easily lend themselves to outcome measurement. There already exist numerous research instruments and clinical care assessments and terminology to document NSPO resulting from the delivery of psychoeducational interventions delivered by nursing personnel. Potential NSPOs of psychoeducational interventions at the time of diagnosis are:

- acceptance of the diagnosis;
- establishment of an alliance with the health care team;
- development and initiation of a treatment plan;
- enhanced coping and adjustment;
- resolved or decreased negative feelings;
- improvement of quality of life.

NSPO during initial treatment are:

- increased compliance with treatment;
- improved coping and adjustment to treatment;
- improved management of side effects;
- improved affective state;
- successful reintegration of patients into their routine life;
- and improved quality of life.

Nursing-Sensitive Patient Outcomes based on interventions that are evidence-based have an important role in current nursing practice. Neither cancer-related assessment processes nor diagnoses are unique to oncology nursing; both may be performed and provided by different health care personnel. In some cases the interventions, such as the psychoeducational interventions described in this article, are also not the sole purview of nursing. However, when any intervention within the scope of nursing practice is delivered by a nurse, then the outcome should be determined and recorded as such. Today’s professional nurse must take both responsibility and credit for all nursing actions whether they are collaborative or independent. Measuring and recording Nursing-Sensitive Patient Outcomes resulting from evidenced based practice will enable us to do this.

References


