Psycho-Oncology
Psycho-Oncology **23**: 307–314 (2014)
Published online 14 October 2013 in Wiley Online Library (wileyonlinelibrary.com). **DOI**: 10.1002/pon.3421

The Basic Documentation for Psycho-Oncology (PO-Bado): An innovative tool to combine screening for psychological distress and patient support at cancer diagnosis

Nena Stadelmaier[1]*, Odile Duguey-Cachet[1], Yael Saada[2] and Bruno Quintard[2]
[1]*Department of CARE, Institut Bergonié, Bordeaux, France*
[2]*Univ. Bordeaux, Bordeaux, France*

**Correspondence to: Department of CARE, Institut Bergonié, 229 cours de l'Argonne, 33076 Bordeaux, France. E-mail: n.stadelmaier@bordeaux.unicancer.fr*

Abstract

***Objectives*: The Basic Documentation for Psycho-Oncology (PO-Bado) is a semi-directive instrument for assessing psychosocial difficulties in cancer patients. It is based on subjective status and not on degree of symptom severity. Our objectives were to assess whether use of the PO-Bado during post-cancer-diagnosis consultations improves the quality of communication by establishing a supportive relationship between nurses and patients and to assess nurses' satisfaction of their communication skills.**

***Methods*: Data were collected from post-diagnosis 'bad-news' consultations across four Cancer treatment centres in South West France. Eleven nurses who had never used the PO-Bado ('inexperienced group') received training on the instrument (short-form). Twenty-one pre-training consultations without the PO-Bado were recorded and compared with 21 post-training consultations with the PO-Bado. Twenty consultations with four nurses with experience using the PO-Bado ('experienced group') were included for between-group comparisons. Nurses' satisfaction was evaluated through semi-directive consultations at the end of the study and completed by a visual analogue scale.**

***Results*: We transcribed and analysed 62 consultations. We observed greater use of techniques encouraging patient expression in consultations with PO-Bado-experienced nurses ($p < 0.01$); after PO-Bado training for 'inexperienced' nurses ($p < 0.05$) and less use of non-encouraging techniques after PO-Bado training for 'inexperienced' nurses ($p < 0.01$). Nurses felt more satisfied with their communications skills after PO-Bado training and stated that they felt more competent, particularly for referrals to psychologists.**

***Conclusions*: The PO-Bado is beneficial for the quality of the communication between nurses and patients at bad-news delivery consultations and for the satisfaction of nurses with regard to their relational skills.**

Received: 5 February 2013
Revised: 5 September 2013
Accepted: 9 September 2013

Introduction

The French 'Breaking Bad News in Cancer Plan' (*Dispositif d'annonce en cancérologie*) aims to improve the delivery of the cancer diagnosis and to establish adapted and personalised patient support. According to French National Institute of Cancer recommendations, the structure of the bad-news delivery plan is divided into four stages [1]: a medical stage; a clinical support stage (*Temps d'Accompagnement Soignant*, TAS); an allied health professional support stage (psychologist, dietician, social worker, etc.) and a stage relating to the home–hospital link.

This work focuses on the second stage of the delivery plan, the clinical support stage, consisting of a post-diagnosis TAS consultation with a nurse lasting around 45 min and usually taking place several days after the bad-news delivery (primary cancer or recurrence). The first part of the TAS consultation, the 'informative sequence', focuses on listening, exchanging and providing practical information regarding the treatment of the disease, examinations, treatments and potential secondary effects. The second part involves 'needs screening' aiming to identify and anticipate potential current and future medical-psycho-social and nutritional needs. According to the needs detected, the medical professional can refer the patient towards other allied health professionals (social workers, dieticians, psychologists, etc.). Such a consultation is far from straight-forward, both for the patient and for the medical professional. Several publications report on the various difficulties encountered by medical professionals in consultations, for example, when delivering bad news [2–7], facilitating expression of emotion for the patient [8–10], evaluating psychological distress and supportive care needs [11–13] and assessing the quality of support offered by friends and family [14].

On the patient side, several procedures have been designed to better inform and identify needs, particularly, in terms of psychological distress or quality of life. Among the psycho-oncology instruments available to

evaluate psychological suffering, the most common screening tools are the Hospital Anxiety and Depression Scale [15] and the Center for Epidemiological Studies–Depression Scale [16,17]. The General Health Questionnaire [18,19], the Rotterdam Symptom Checklist [20] or the European Organisation for Research and Treatment of Cancer Quality of Life [21,22] questionnaires are also used. However, the time needed to administer these questionnaires limits their use in clinical practice. Several simple and quick tools have been developed, like the Distress Thermometer of Holland and Roth [23–27], the Visual Analogue Scale for psychological distress, [28] or the Psychosocial Screen for Cancer [29–31], but these have the disadvantage of being too superficial (e.g. the Visual Analogue Scale) or too invasive.

Few psychological screening tools encourage assessment of patient views to elicit their post-cancer-diagnosis needs and expectations [32–37], identify patient needs and help staff to structure post-diagnosis consultations with the least possible biases. The PO-Bado is a semi-directive consultation guideline for all steps of patient care, constructed and validated in Germany [38–40]. It enables the evaluation of patients' psycho-social needs using the patient's subjective experiences over the last 3 days with regard to specific issues. By using open questions, six items covering tiredness, mood swings, anxiety, depression, other social or family problems or functional limitations in daily activities are explored by one or several questions. These are summarized by the evaluator at the end of the consultation in a summary sheet scoring the intensity of psychological distress for each item on a scale of 0–4. Based on precise criteria, the healthcare professional can thus identify patients requiring referral to a psychologist. More detailed information is given in Herschbach *et al.* [39], and the full PO-Bado can be found at http://www.po-bado.med.tu-muenchen.de/pdf/English%20Version/PO-BadoManual_english.pdf. By using the PO-Bado, the healthcare professional does not encounter high levels of patient reluctance often generated by a direct approach and is less confronted by the risk of difficulties in managing the consultation, which can occur with a non-directive approach [41].

We implemented this tool in a Comprehensive Cancer Centre in the Bordeaux region in 2006, following the French 'Breaking Bad News in Cancer Plan' recommending a post-cancer-diagnosis consultation with a nurse for all patients. From a clinical point of view, this tool seems to improve the satisfaction of nurses with the consultation [42]. After 5 years of clinical experience (over 3000 consultations administered in this centre with the short form PO-Bado), this tool appeared to present two main benefits in addition to those presented in the original publication in that it assisted nurses to better structure consultations and to establish a supportive relationship [41,43].

The principal aims of the current study are to analyse whether the use of the short form PO-Bado during a post-cancer diagnosis TAS consultation (for primary cancers or recurrence) improves:

(1) the quality of communication by establishing a supportive relationship with the patients,
(2) the satisfaction of nurses with regard to their communication skills.

A subsidiary aim was to assess whether the use of the PO-Bado after training for the 'inexperienced' group of nurses would have an impact on the rate of referrals to psychologists [44,45].

Methods

Participants

Nurses were recruited from four cancer treatment centres in the Greater South-West region of France. One pilot centre, where the PO-Bado was already used systematically in TAS consultations since the launch of the Breaking Bad-News in Cancer Plan in 2006, plus three intervention centres were selected. To ensure recruitment of a sufficiently diverse population, centres were selected according to specific criteria: an established post-diagnosis cancer plan recognised in the mission statements of the centre and departments in which the nurse's work; diversity of the establishments (public/private; large/small) and diversity of cancer types. The public/private pilot centre was a large tertiary referral centre, treating over 2500 patients per year. One military hospital, a general hospital and a public/private institution were chosen as intervention centres. The military hospital treats over 600 patients per year and the remaining two treat fewer than 150 patients per year.

All nurses at the pilot centre with at least 6 months experience carrying out post-diagnosis consultations were contacted to participate and four agreed to participate on a voluntary basis (considered 'PO-Bado experienced'). All nurses carrying out post-diagnosis consultations (without the PO-Bado) at the intervention centres were contacted and 11 agreed to participate on a voluntary basis ('PO-Bado inexperienced' group) (Table 1). Anonymity was guaranteed.

As part of the regular post-diagnosis consultations, the nurses informed patients of the study. Sixty two patients (Table 1) (19 men and 43 women) gave informed consent to participate in the project on a voluntary basis. All post-diagnosis consultations were carried out in an individual hospital room or in a specifically dedicated post-diagnosis room. Ethics approval was obtained for this study from the National Committee for the Protection of Individual (*Comité de Protection des Personnes*) and the French National Commission on Information Technologies and Liberties (*Commission Nationale de l'Informatique et des Libertés*).

DOI: 10.1002/pon

Table 1. Characteristics of the patients and of the nurses carrying out consultations with PO-Bado

	PO-Bado experienced group	PO-Bado inexperienced group	
N Nurses (*N*)			
N	4	11	
Median years experience (range)			
-with Post-diagnosis consultation (*y*)	3 (0.5–3)	4 (0.18–6)	
-with PO-Bado in post-diagnosis consultation (*y*)	3 (0.5–3)	0	
Sex–female	3	11	
Consultations (*N*)	20	Before training 21	After training 21
Patients (*N*)			
Age	M = 61.4 (SD: 14.2)		
Patients accompanied by family member	22 (20 family members intervened during consultations)		
Cancer			
Primary	58		
Recurrent	2		
Missing	2		
Site			
Breast	21		
Gastrointestinal	10		
Thorax	5		
Gynaecological	4		
Head and neck	3		
Central nervous system	2		
Urology	2		
Haematology	1		
Skin	1		
Not recorded	13		

Procedure

To evaluate whether the PO-Bado improves the quality of communication by establishing a supportive relationship with the patient, we recorded, transcribed and analysed 62 TAS consultations across the 15 nurses ('inexperienced' pre-training and post-training and 'experienced'). The training for the 'inexperienced' group was administered by a psychologist (NS) and a doctor from the Pilot centre over 3 days. Two days were dedicated to recalling the techniques of semi-directive consultations and to presenting the PO-Bado with illustrations from consultations recorded in the Pilot Centre. On the third day, the 'inexperienced' nurses observed actual consultations led by experienced nurses at the Pilot Centre.

So as to assess the impact of the PO-Bado on the quality of exchanges with the patient and the establishment of a supportive relationship, we used precise indicators of communicative techniques favouring patient expression (open questions, reformulation of content and emotion, reflection, echo, clarification, focalisation and confrontation techniques and respect of silences) and those not favouring patient expression (evaluation, interpretation, investigation or problem solving responses or affective support) drawn from the previous research [41,43,46,47]. As well as these indicators, we also evaluated:

- the number of informative sequences (data relative to the illness, treatments, etc.) in each consultation, because one of the objectives of the TAS is to clarify and to reformulate medical information transmitted from the doctor to the patient during the diagnostic announcement;
- the number of sequences centred on the patient's experience with regard to the disease and the treatment;
- the number of sequences concerning elements relative to the history of the disease (beginning and discovery) by the patient.

To assess whether nurses' satisfaction of their communication skills during post-diagnosis consultations was improved with the use of the PO-Bado, we interviewed all nurses to explore various elements of their experiences using the instrument; differences perceived between consultations carried out before and after training (for 'inexperienced') and difficulties with the use of the instrument. These consultations were recorded and transcribed completely. For the nurses from the 'inexperienced' group, this consultation took place approximately 4 to 5 months after the PO-Bado training.

Statistical considerations

Firstly, the content of each consultation was analysed manually using qualitative analysis techniques [48–50] for the frequency of occurrences of communication techniques used by the nurses and the principal themes cited by patients. This was performed separately by two psychologists (BQ and YS) who subsequently compared the results of their analyses to obtain a common final version. Then, the Fallery and Rodhain [49] procedure was used with the NVivo (version 8, QSR International, Chesire, UK) [51] software to analyse the content of the consultations by coding segments, terms and thematic categories. Finally, by using SPSS (version 18, Chicago, IL), we compared the groups based on the number and the frequency of the consultation techniques used by the nurses and the themes pronounced by the patients: Student *t*-test for independent samples to compare the consultations of the experienced group with the 'inexperienced' group and Student *t*-tests for matched pairs to compare the pre-training and post-training consultations of the 'inexperienced' group. Given the small sample size, all *t*-tests were confirmed with the non-parametric Mann–Whitney U-test.

DOI: 10.1002/pon

Results

Comparison of consultation techniques between 'experienced' and 'inexperienced' nurses and effects of training

Comparison of consultation techniques of experienced and 'inexperienced' nurses (before training)

Techniques, promoting patient expression, were used 45.8% more often in the experienced group than in the 'inexperienced' group before training ($t(1,38) = 3.15$, $p < 0.01$) (Table 2). These techniques involved the use of open questions, for example, 'OK, and what was your reaction to this news?' or 'What is your biggest worry at the moment?'. Communication sequences centred on the subjective experience of the patient were 46% more frequent in the group of experienced nurses than in the group of nurses before training ($t(1,37) = 2.64$, $p < 0.01$). The following extract illustrates the place allocated to the patient to express their experiences: 'Well yeah, some days I'm OK, some days I'm not, every time I come here I go home in a terrible state. Every time I get some new bad news, even though I know that they were going to tell me certain things, each time it shocks me, you don't expect to hear everything that they tell you. Sometimes you feel like you are living on another planet, or you're living someone else's life, not your own'. (participant 7, p.2, 30–35). No differences were observed in the use of techniques not promoting patient expression ($t(1,24) = 0.68$, $p = 0.67$). The following nurse's response to a patient anxious about chemotherapy illustrates affective support and identification responses not helpful for the patients: 'Yes, I understand, for me it's the same' (participant 2, p.5, 47). We did not observe a difference in the number of informative sequences used $t(1,38) = 1.87$, $p = 0.44$), nor in the frequency of statements regarding the history of the patient's illness ($t(1,23) = 0.77$, $p = 0.18$).

Comparison of consultation techniques of PO-Bado 'inexperienced' nurses pre-training and post-training.

Techniques, promoting patient expression, were used 57% more often in the 'inexperienced' group after training, comparatively to the same group before training ($t(1,15) = 2.35$, $p < 0.05$ (Table 2). This post-training consultation extract illustrates this: Nurse: 'How are you?' Patient: 'Oh, not too bad.' Nurse: 'not too bad,….' Patient: 'yeah'. Nurse: 'what do you mean by not too bad?'(participant 11, p. 1, 5–9). Before training, the 'inexperienced' group used attitudes not promoting patient expression 49.6% more frequently compared with after training ($t(1,9) = 3.57$, $p < 0.01$). For example, this excerpt comes from a consultation before PO-Bado training and use: (*the patient states that he hasn't told his close friends and family)* Nurse: 'if something happens, and your family find out about it, how are you going to fix that?' (participant 15, p. 4, 18).

The use of the PO-Bado during the TAS improved the quality of the consultation in terms of consultation content. Communication sequences centred on the subjective experiences of the patient in the 'inexperienced' group after training were used 44.7% more than before training ($t(1,13) = 3.90$, $p < 0.01$). The number of informative sequences was not significantly modified by the training ($t(1,15) = 0.38$ $p = 0.71$). There were no significant differences concerning the number of sequences relating to the history of the disease (beginning and discovery) in the group of 'inexperienced' nurses before training compared with after training ($t(1,7) = 1.18$ $p = 0.27$).

Comparison of consultation techniques of 'experienced' versus 'inexperienced' nurses (after training)

No differences were observed between the consultations with experienced nurses and those of 'inexperienced' nurses after training in terms of use of techniques promoting patient expression ($t(1,38) = 0.27$, $p = 0.46$)

Table 2. Frequency of use of communication techniques in post-cancer-diagnosis consultations by nurses

	PO-Bado 'inexperienced' group			p values		
	Before training	After training	PO-Bado experienced group	PO-Bado inexp. pre-training versus post-training	PO-Bado inexp. post-training versus PO-Bado experienced	PO-Bado inexp. pre-training versus PO-Bado experienced
Techniques encouraging patient expression	1.3%	2.2%	2.4%	<0.05	ns	<0.01
Techniques not encouraging patient expression	1.2%	0.6%	0.94%	<0.01	ns	ns
Sequences centred on the subjective experience of the patient	8.6%	15.5%	15.9%	<0.01	ns	<0.01
Informative sequences	61.9%	57.5%	50.1%	ns*	ns	ns
Statements regarding the history of the patient's illness	8.3%	7.6%	6.7%	ns	ns	ns

*ns, not significant

DOI: 10.1002/pon

(Table 2); consultation techniques not promoting patient expression ($t(1,25) = 0.87$, $p = 0.15$); number of communication sequences centred on subjective patient experience ($t(1,37) = 0.11$, $p = 0.41$); number of informative sequences ($t(1,38) = 1.30$, $p = 0.95$) and frequency of elements relating to the history of the patient's illness ($t(1,39) = 0.23$, $p = 0.63$).

Referral to a psychologist after the post-diagnosis consultation

We compared the number of patients referred to a psychologist across groups: PO-Bado experienced nurses referred patients to psychologists in 7/20 (33%) of cases. PO-Bado 'inexperienced' nurses referred patients in 14/21 cases before training (66%) and 9/21 cases after training (42%). Before training, PO-Bado 'inexperienced' nurses thus referred more patients to psychologists than PO-Bado experienced nurses ($X^2 = 4.11$, $p < 0.05$), but referral rates were similar between the experienced group and the 'inexperienced' group after training ($X^2 = 0.11$, $p = 0.74$), nor between the 'inexperienced' group before and after training despite the reduction in referral rates ($X^2 = 2.50$, $p = 0.11$).

Duration of consultations

Consultations were slightly shorter with the use of the tool (mean = 32 m43s; SD = 13 m) than without (mean = 39 m24s; SD = 18 m).

Nurses' satisfaction with the Basic Documentation for Psycho-Oncology

We interviewed the 15 nurses evaluating their satisfaction about the post bad-news consultation on psycho-social issues and their perception of their communication skills. Of the 11 'inexperienced' nurses receiving PO-Bado training, two reported not using the PO-Bado regularly after training; one citing a lack of time and the other claiming that the use of the tool was too complicated.

Analysis of the thematic content of these consultations (Table 3) showed that all nurses considered that this tool enabled them to better detect and evaluate patient needs; offer more attentive and more comprehensive listening for patients and encourage patient expression. They highlighted a more attentive listening attitude and more space for the patient. They also reported that they made fewer 'assumptions' that they 'no longer interpreted patient dialogue' but based themselves on 'what the patient said'. This tool was perceived as assisting them to 'target needs' and 'better orientate supportive care'. They were more comfortable and felt more competent in suggesting supportive care. They also mentioned that the tool helped them to 'structure' and 'give a framework' to the consultation and that the TAS was 'better organised' accordingly.

Table 3. Online only: Themes identified and opinions of nurses

Theme	Consultations in which theme appeared at least (15 total)	Times theme appeared in total (across all 15 consultations)
Facilitates screening and evaluation of patient needs	11	16
Facilitates a more engaged and deeper listening	6	10
Enables more supportive attitudes and exchanges	12	18
We no longer interpret what they are saying but we base ourselves on their words	5	7
Enables us to feel more comfortable and legitimate in suggesting a specific orientation	5	9
Helps to structure and define the consultation: the time allocated is better organised	9	18
No real difficulties attached, but some apprehension	5	5
Some training is necessary so that it's use becomes automatic	3	3
Difficult to remember all the themes and to get through them in the consultation in a natural way	6	7

On a scale of 0 to 10, the nurses were satisfied with training on the tool (mean = 8.5, SD = 0.8), felt that could manage the consultation better (mean = 7.4, SD = 1.3) and considered that the training helped them to better orientate patients in distress towards psychological consultations (mean = 8.3, SD = 1.2).

Discussion

The first aim to assess whether the introduction of the PO-Bado during the post-diagnosis bad-news consultation would improve the quality of communication by establishing a supportive relationship with the patient was supported by this study. We saw a significant increase in the number of communication sequences focused on the subjective experiences and emotions of patients in consultations with nurses using the PO-Bado, as well as a significantly higher use of techniques promoting patient expression. To be able to express emotions, worries and also distress are one of the main expectations of patients [35], but also one of the major difficulties for nurses in terms of managing the relationship [9,10]. This appears to be facilitated by the use of the PO-Bado. The PO-Bado assisted the nurses to be more available and present in post-diagnosis TAS consultations and thus to initiate a closer and deeper relationship with the patients. This is an essential element to a supportive relationship [52] where communication between the patient and the nurse must be characterised by empathetic and supportive elements aiming to ensure the patient's comfort [52] [53].

DOI: 10.1002/pon

It is interesting to note that the use of techniques promoting patients' expression of needs is quickly obtained with the PO-Bado, and that this acquisition appears to be maintained over time as the trained nurses reported in their consultations. These results are compatible with a previous publication [42]. Furthermore, before PO-Bado training, the nurses used significantly more techniques not promoting patient expression (evaluation, interpretation responses, etc.) than after training or in comparison to the experienced group. However, it should be noted that the nurses in the experienced group used techniques promoting expression at the same rate as the nurses after training, although they also used techniques not promoting expression at the same rate as the 'inexperienced' nurses before training. This may be explained by a 'routinisation' risk for experienced nurses, where over time they return to using not recommended attitudes in supportive exchanges sequences. In this regard, it may be useful to plan 'top-up' training sessions so as to inform professionals about the risk of reverting to inadvisable spontaneous interventions that have a negative impact on consultations.

Interestingly, the medical information sequences proposed at the beginning of the consultation did not differ in duration, nor frequency across groups. Thus, the use of the PO-Bado does not hinder the first objective of the TAS consultation, that is, the provision of additional medical information, necessary for the patient's understanding of the illness and treatment that will be administered. This result corroborates the work of Kirk *et al.*[53] who reported that patients wish to receive information that is adapted to their needs. It also supports publications reporting that communication in oncology needs to meet two objectives: the first relating to the quality of the exchanges necessary to obtain patient trust and offer support and the second concerning the exchange of information including the provision and recording of information. [54,55]

Another important organizational and practical element of post-diagnosis consultations is the duration that was not modified after the introduction of the PO-Bado. On average, consultations were not longer with the PO-Bado, in fact, they were shorter than those without. This observation tends to confirm that this tool enables a more condensed and structured consultation and that it is entirely compatible with the realities and expectations of the field and treatment activities (TAS consultations should not exceed 45 minutes on average).

Regarding the subsidiary aim, results showed that nurses using the PO-Bado expressed a high level of satisfaction with their communication skills during post-diagnosis consultations. They had a more positive perception of their skills for managing patients' psycho-social difficulties, a domain that they previously tended to avoid (before PO-Bado use). They felt more competent in orientating patients towards supportive care, in particular referral to psychologists. With respect to the latter, we observed a modification in practices: before PO-Bado training the 'inexperienced' nurses referred patients to a psychologist in two thirds of cases. After training, only 42% of patients were referred for psychological consultations. These rates are similar to rates after consultations with experienced professionals (33%) and concord with the prevalence of psychological distress in the cancer population estimated around 30–40% [23,27,56–59].

This study has certain limits to keep in mind when interpreting results. In the same way that the satisfaction of nurses was assessed over time, it would have been interesting to assess the satisfaction of patients just after completion of consultations using the PO-Bado, and several weeks after, and to compare this to patients in consultations without the PO-Bado. In addition, it would have been interesting to perform long-term follow-up of the patients received in a TAS with the PO-Bado to evaluate the impact of this tool on their psychological experiences over time. Finally, although the initial German language version of these PO-Bado semi-directive consultation guidelines has been validated both in its full and short versions [38–40,60] with good psychometric properties, the French version used in this study has not yet been scientifically validated. This is an objective that we will carry out in the near future.

Conclusions

This study confirms the clinical interest of this tool, improving the quality of post-diagnosis TAS consultations and increasing nurses' satisfaction with their communication skills. For French nurses involved in the Breaking Bad-News Plan, the PO-Bado is a supportive tool enabling them to better structure the post-diagnosis consultation, to give a framework to the patient's expression and to better anticipate the psychosocial care of the patient. The PO-Bado was implemented in other centres as part of this study, enabling us to test the feasibility of the appropriation of this tool, in terms of training, acquisition and integration with pre-existing practices. These results encourage the extension of the use of the PO-Bado to other teams and to other stages of the illness. For example, the German team has shown that this tool is adapted both for acute situations and for long-term follow-up of patients, in hospitalised and out-patient settings [38,60]. The clinical screening qualities of the PO-Bado and the initiation of a supportive relationship offer undeniable support for teams dealing with the psychological distress of cancer patients, throughout their illnesses.

Acknowledgements

The authors thank the Fondation de France for financial support, participating centres: Institut Bergonié, Centre Hospitalier Niort, Maison de Santé Protestante Bagatelle, and Robert Picqué Military hospital, and Pippa McKelvie-Sebileau for medical

editorial assistance. Funding was received from the Fondation de France. They had no role in the study design, analysis and manuscript drafting.

Conflicts of interest

The authors have declared no conflicts of interest.

References

1. National Cancer Institute I. French Cancer Plan II. 2003–2007. France www inca fr, 2007.
2. Buckman R, Kason Y. How to Break bad News. A guide for health care professionals, 1992.
3. Cohen L, Baile WF, Henninger E, *et al*. Physiological and psychological effects of delivering medical news using a simulated physician-patient scenario. *J Behav Med* 2003 Oct;**26**(5):459–471.
4. Desauw A, Christophe V, Antoine P, Cattan S, Nandrino JL. Quelle perception les praticiens ont-ils de l'annonce de mauvaises nouvelles en oncologie? Analyse qualitative du vécu et des stratégies de régulation émotionnelle. *Psycho-Oncologie* 2009;**3**(3):134–139.
5. Dias L, Chabner BA, Lynch TJ, Jr., Penson RT. Breaking bad news a patient's perspective. *Oncologist* 2003;**8**(6):587–596.
6. Tattersall AJ, Bennett P, Pugh S. Stress and coping in hospital doctors. *Stress Med* 1999;**15**(2):109–113.
7. Voelter V, Mirimanoff RO, Rousselle SI, Leyvraz S. L'annonce d'une mauvaise nouvelle en oncologie. *Rev Med Suisse* 2005;**20**:1350–1353.
8. Dolbeault S, Bredart A. Announcing cancer diagnosis: which communication difficulties from professional and from patient's side? Which possible improvements?. *Bull Cancer* 2010;**97**(10):1183–1194.
9. Razavi D, Delvaux N, Marchal S, De Cock M, Farvacques C, Slachmuylder JL. Testing health care professionals' communication skills: the usefulness of highly emotional standardized role-playing sessions with simulators. *Psycho-Oncology* 2000;**9**(4):293–302.
10. Razavi D, Delvaux N, Marchal S, *et al*. Does training increase the use of more emotionally laden words by nurses when talking with cancer patients? A randomised study. *Br J Cancer* 2002;**87**(1):1–7.
11. Brédart A, Dolbeault S. Evaluation de la qualité de vie en oncologie: II Méthodes. *Revue Francophone de Psycho Oncologie* 2005;**4**(1):13–17.
12. Libert Y, Conradt S, Reynaert C, *et al*. Improving doctor's communication skills in oncology: review and future perspectives. *Bull Cancer* 2001;**88**(12):1167–1176.
13. Neuwohner K, Lindena G. Assessment of distress with physical and psychological symptoms of patients in german palliative care services. *Onkologie* 2011;**34**(3):94–98.
14. Moriceau M, Saltel P. Comment améliorer la relation avec le patient en onco-hématologie? *Revue Internationale de Soins Palliatifs* 2004;**19**(1):3–8.
15. Zigmund A, Snaith R. The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavia* 1983;**67**:361–370.
16. Devins GM, Orme CM, Costello CG, *et al*. Measuring depressive symptoms in illness populations: psychometric properties of the Center for Epidemiologic Studies Depression (CES-D) Scale. *Psychol Health* 1988;**2**(2):139–156.
17. Radloff L The CES-D scale. *Appli Psychol Meas* 1977;**1**(3):385–401.
18. Goldberg DP. Manual of the General Health Questionnaire, 1978.
19. Goldberg DP, Gater R, Sartorius N, *et al*. The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychol Med* 1997;**27**(1):191–197.
20. De Haes H. Measuring the Quality of Life of Cancer Patients with the Rotterdam Symptom Checklist (RSCL): A Manual. Groningen, 1996.
21. Aaronson NK, Ahmedzai S, Bergman B, *et al*. The European Organization for Research and Treatment of Cancer QLQ-C30 a quality-of-life instrument for use in international clinical trials in oncology. *J Natl Cancer Inst* 1993;**3;85**(5):365–376.
22. Fayers P, Aaronson N, Bjordal K, Curran D, Groenvold M. EORTC QLQ-C30 Scoring Manual. EORTC Quality of Life Study Group, 2ème ed, 1999.
23. Dolbeault S, Bredart A, Mignot V, *et al*. Screening for psychological distress in two French cancer centers: feasibility and performance of the adapted distress thermometer. *Palliat Support Care* 2008;**6**(2):107–117.
24. Hoffman BM, Zevon MA, D'Arrigo MC, Cecchini TB. Screening for distress in cancer patients: the NCCN rapid-screening measure. *Psycho-Oncology* 2004;**13**(11):792–799.
25. Holland JC. Preliminary guidelines for the treatment of distress. *Oncology (Williston Park)* 1997;**11**(11A):109–114.
26. Holland JC, Andersen B, Breitbart WS, *et al*. Distress management. *J Natl Compr Canc Netw* 2007;**5**(1):66–98.
27. Holland JC, Bultz BD. The NCCN guideline for distress management a case for making distress the sixth vital sign. *J Natl Compr Canc Netw* 2007;**5**(1):3–7.
28. Mitchell AJ, Coyne JC. Do ultra-short screening instruments accurately detect depression in primary care? A pooled analysis and meta-analysis of 22 studies. *Br J Gen Pract* 2007;**57**(535):144–151.
29. Jacobsen PB, Donovan KA, Trask PC, *et al*. Screening for psychologic distress in ambulatory cancer patients. *Cancer* 2005;**103**(7):1494–1502.
30. Mitchell AJ. Pooled results from 38 analyses of the accuracy of distress thermometer and other ultra-short methods of detecting cancer-related mood disorders. *J Clin Oncol* 2007;**25**(29):4670–4681.
31. Vodermaier A, Linden W. Screening for Distress, the 6th Vital Sign. The how: Comprehensive review of measures used for distress screening in cancer care. International Psycho-OncologySociety (IPOS) 10th World Congress of Psycho-Oncology, Madrid, Spain, 2008.
32. Butow PN, Brown RF, Cogar S, Tattersall MH, Dunn SM. Oncologists' reactions to cancer patients' verbal cues. *Psycho-Oncology* 2002;**11**(1):47–58.
33. Guilbert P, Peretti-Watel P, Beck F, Gautier A. Baromètre Cancer 2005. Saint-Denis (93), 2006.
34. Libert Y, Reynaert C. Les enjeux de la communication médecin-patient et l'importance des caractéristiques psychologiques du médecin. *Psycho-Oncologie* 2009;**3**(3):140–146.
35. Soum-Pouyalet F, Vega A, Cousson-Gélie F. Le « moral » en cancérologie Stratégies et discours des soignants dans l'accompagnement des malades. *Psycho-Oncologie* 2009;**3**(3):161–167.
36. Spire A, Siri M. De la maladie du secret à la problématique de l'annonce. In: Odile Jacob, editor. Cancer: la malade est une personne, 2010; 57–91.
37. Uitterhoeve R, Bensing J, Dilven E, Donders R, Mulder P, van Achterberg T. Nurse-patient communication in cancer care: does responding to patient's cues predict patient satisfaction with communication. *Psycho-Oncologie* 2009;**18**(10):1060–1068.
38. Herschbach P, Book K, Brandl T, *et al*. Psychological distress in cancer patients assessed with an expert rating scale. *Br J Cancer* 2008;**99**(1):37–43.
39. Herschbach P, Book K, Brandl T, Keller M, Marten-Mittag B. The Basic Documentation for Psycho-Oncology (PO-Bado): an expert rating scale for the psychosocial experience of cancer patients. *Onkologie* 2008;**31**(11):591–596.
40. Knight L, Mussell M, Brandl T, *et al*. Development and psychometric evaluation of the Basic Documentation for Psycho-Oncology a tool for standardized assessment of cancer patients. *J Psychosom Res* 2008;**64**(4):373–381.
41. Rogers C. *Counseling and Psychotherapy*. Dunod: Paris; 1942.
42. Stadelmaier N, Lombard I, Duguey-Cachet O, *et al*. Le dispositif d'annonce en cancérologie: quel outil d'orientation vers la consultation psychologique ? *Psycho-Oncologie* 2009;**3**(3):176–183.
43. Rogers C. *On becoming a Person a Therapist's View of Psychotherapy*. London, 1961.

44. Schaffeler N, Enck P, Riessen I, *et al*. Screening for mental stress and the wish for psychological support in patients with breast cancer. *Z Psychosom Med Psychother* 2010;**56**(2):207–219.
45. Siedentopf F, Marten-Mittag B, Utz-Billing I, Schoenegg W, Kentenich H, Dinkel A. Experiences with a specific screening instrument to identify psychosocial support needs in breast cancer patients. *Eur J Obstet Gynecol Reprod Biol* 2010;**148**(2):166–171.
46. Mucchielli R. *L'entretien de Face à Face Dans la Relation d'aide: Connaissance du Problème, Applications Pratiques*. ESF: Paris; 1994.
47. Porter EH. *As Introduction to Therapeutic Counseling*. Boston, 1950.
48. Bardin L. *L'analyse de Contenu*. Paris, 2007.
49. Fallery B, Rodhain F. Quatre approches pour l'analyse de données textuelles: lexicale, linguistique, cognitive, thématique. XVIème Conférence Internationale de Management Stratégique, Montréal 6–9 Juin, 2007.
50. Miles M, Huberman M. *Analyse des Données Qualitatives*. Bruxelles, 2003.
51. Deschenaux F. Guide d'introduction au Logiciel NVivo 7. Association pour la Recherche Qualitative, 2007.
52. Manoukian A, Massebeuf A. *La Relation Soignant-Soigné*. 3ème ed. Paris, 2008.
53. Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ* 2004;**328**(7452):1343.
54. Delvaux N, Merckaert I, Razavi D, Liénard A. Communication soignant-soigné : généralités. In: Razavi D, Delvaux N, editors. *Précis de psycho-oncologie de l'adulte*. Masson Elsevier: Paris, 2008; 189–224.
55. Galway K, Black A, Cantwell M, Cardwell CR, Mills M, Donnelly M. Psychosocial interventions to improve quality of life and emotional wellbeing for recently diagnosed cancer patients. *Cochrane Database Syst Rev* 2012;**11**:CD007064.
56. Fallowfield L, Ratcliffe D, Jenkins V, Saul J. Psychiatric morbidity and its recognition by doctors in patients with cancer. *Br J Cancer* 2001;**84**(8):1011–5.
57. Jacobsen PB. Screening for psychological distress in cancer patients: challenges and opportunities. *J Clin Oncol* 2007;**25**(29):4526–4527.
58. Jacobsen PB, Ransom S. Implementation of NCCN distress management guidelines by member institutions. *J Natl Compr Canc Netw* 2007;**5**(1):99–103.
59. Zabora JR, Blanchard CG, Smith ED, *et al*. Prevalence of psychological distress among cancer patients across the disease continuum. *J Psychosoc Oncol* 1997;**2;15**(2):73–87.
60. Herschbach P, Keller M, Knight L, *et al*. Psychological problems of cancer patients a cancer distress screening with a cancer-specific questionnaire. *Br J Cancer* 2004;**91**(3):504–511.