

Original Article

Skills of Oncology Nurses in Diagnosing the Psychosocial Needs of the Patients

Tuğba Pehlivan, MSc Psychiatric Nursing

Koç University, Department of Oncology-Haematology Inpatient Service, Istanbul

Leyla Küçük, PhD

Associate Professor, Istanbul University, Florence Nightingale Nursing Faculty, Department of Mental Health and Psychiatric Nursing, Istanbul, Turkey

Correspondence: Leyla Küçük, PhD, Associate Professor, Istanbul University, Florence Nightingale Nursing Faculty, Department of Mental Health and Psychiatric Nursing Şişli-Istanbul/Turkey

E- mail: leylak73@istanbul.edu.tr

Abstract

Aim: This study was performed to evaluate the skills of the nurses in diagnosing the psychosocial requirements of oncology patients.

Introduction: Cancer is included in a group of diseases with the highest potential of psychological difficulties and problems. Nurses, when performing an extensive health diagnosis, should plan nursing interventions focused on the physical, spiritual, psychosocial, and mental requirements of the patient

Method: This study is a descriptive-cross sectional study. Data were collected using a survey form. Section I consists of 15 questions about the demographics and professional specifications of the nurses and 13 questions to evaluate the psychosocial requirements of the patients. In Section II, patient admittance and continuous diagnostics in 12 dimensions based on Gordon's functional health patterns were analyzed using a visual analog scale (VAS).

Results: Mean age of the nurses included in the study was 29.3 ± 6.2 years with a mean working period in oncology unit of 4.6 ± 5.6 years. When the factors affecting the psychosocial evaluation were assessed, the most common factor was "not able to spend time for psychosocial requirements of the patient because of work load" with a percentage of 80.3% (n: 126), followed by "do not have knowledge to perform psychosocial evaluation" with a rate of 22.9%.

Conclusion: Factors such as work load and inadequate knowledge might be suggested to prevent nurses from psychosocially evaluating their patients. Nurses who had received training in this field perform better in the psychosocial evaluation.

Implication for nursing practice and health policy: Patients of oncology are also at a substantial risk of developing psychiatric disorders, and thus they should be comprehensively evaluated in terms of biopsychosocial dimensions.

Key Words: nurses, skills, diagnosis, psychosocial needs

Introduction

In the overlapping field of medicine and psychiatry, the basic philosophy and clinical application in accordance with this is to approach to patients with a biopsychosocial model (Ozkan 1993; Kocaman 2005; Bag 2012). The main principle of the holistic

health approach is that an individual is a whole of the physical, mental, psychological, and social components and each individual should be evaluated together with his/her environment individually (Kostak 2007). Nurses, when performing an extensive health diagnosis, should plan nursing interventions

focused on the physical, spiritual, psychosocial, and mental requirements of the patient (Kocaman 2005).

Cancer is a chronic and fatal disease; however, it is at the same time an important issue resulting in emotional, mental, and behavioral reactions. It is included in a group of diseases with the highest potential of psychological difficulties and problems (Bahar 2007; Bag 2013; Skoogh et al. 2013) in their evaluation of the psychosocial requirements of patients with testicular cancer reported that 63% of the patients had a crisis for the first time at the time of diagnosis and 76% had a crisis during the diagnosis and initiation of treatment. Most of the patients declared that patients required psychosocial support, especially starting with the time of the diagnosis and initiation of treatment, independent of the stage of the disease. Nakaguchi et al. (2013) in their study on the psychosocial requirements of the patients receiving chemotherapy and the degree of awareness of the oncology nurses of this requirement, reported that many physical symptoms were detected due to chemotherapy among these patients (fatigue, hair loss, lack of appetite, dyspnea, pain, constipation, and insomnia). They reported that during routine care, the level of awareness of the nurses of the psychosocial requirements and physical and psychosocial symptoms of the patients were low. It was concluded that the nurses could not adequately diagnose the patients, their psychosocial symptoms and psychosocial requirements in particular.

Nursing is a continuously developing and changing occupation, focusing on providing care to individuals. While nurses are providing care to meet the physical requirements of the in-hospital patients, they encounter emotional, spiritual, and psychosocial requirements of the patients who are struggling to comply with their state of health. The nurse should define precisely the state of health and disease to facilitate the accommodation of the patient to the new condition, should be able to evaluate the coping mechanisms of the patient and the effects of them, and should plan and apply the nursing interventions in accordance with the information she/he has obtained (Yildirim & Gurkan 2010). Patients of

oncology are also at a substantial risk of developing psychiatric disorders, and thus they should be comprehensively evaluated in terms of biopsychosocial dimensions. The current study attempted to detect the level of the skills of the nurses in the psychosocial diagnosis of patients and to define the factors preventing psychosocial diagnosis. This study is important since this issue has not been previously evaluated and this manuscript is thought to contribute to the literature.

Method

The Aim and Type of the Study

This study was performed with the aim of evaluating the skills of the nurses to diagnose the psychosocial requirements of the patients and is a descriptive- study.

Study Questions

1. What is the level of the diagnostic skills of the oncology nurses in detecting the psychosocial requirements of the patients?
2. What are the factors affecting the evaluation of the oncology nurses of the psychosocial requirements of the patients?

Participants:

The universe of the study comprised oncology nurses working in hospitals with the highest number of oncology beds. The sample of the study comprised 157 nurses who were working in the oncology units of those hospitals and who consented to participate in the study.

Data Collection Materials: Data were collected using a survey form prepared by the investigator parallel to the literature findings.

Data collection form

The data collection form created by the authors, after consulting related literature (Onan 2009; Martensson et al. 2010a; Fetter 2012; Goldsmith et al. 2012; Bag 2012; Wittenberg-Lyles et al. 2013, Enç and Can 2012, Gordon 1987; Birol 2009), and is divided in two sections.

*Section I:

Questions 1-15= These questions are set in order to elicit information about sociodemographic variables (age, gender,

level of education, and marital status), duration of working, work place, postgraduate education, and satisfaction.

Questions 16-28= This section included questions to evaluate the identification of the psychosocial requirements of the patients and about current applications performed by the nurses. It also included questions about emotional and psychiatric problems seen in patients

***Section II**

Gordon developed a model of nursing care dealing extensively with the psychosocial dimensions of the individuals in 1982. This model, called “Functional Health Patterns,” explains the requirements of the individuals in 12 functional fields.

In Section II, 12 dimensions based on Gordon’s Functional Health Patterns on patient admission and continuous diagnosis were evaluated using a visual analog scale. Nurses were asked to give points for each dimension from 0 to 10 on a scale to report how much they could evaluate that dimension (0= never; 10= every time). These dimensions were understanding health/disease, nutrition and metabolic state, excretion system, activity and exercise state, cardiovascular system, respiratory system, sleep and rest, psychological state, self-perception and self-respect, roles and relations, sexuality and reproduction, and coping and system tolerance. By using a visual analog scale (VAS), it was possible to bring some subjective values into numeric values. The experiences of proficiency of the participants on each item were marked on a scale. The distance from the “none” end of the scale to the marked point represented the grade of the proficiency.

Ethical Consideration

Ethics board approval for the study was obtained from the Ethics Board for the Clinical Investigations of Yeditepe University (No: 68774383-001/214)

Data Collection

The survey was performed by the investigator on each participant to provide the correct collection of data. The duration of each interview lasted approximately 30 minutes.

Data Analysis

All data obtained as a result of the investigation was analyzed using the SPSS 16.0 (Statistical Package for Social Sciences) package program.

Limitation of study

The results of this study are limited to the institution and sample group examined in scope of the study and therefore cannot be generalized.

Results

The mean age of the nurses that participated in this study was 29.3 ± 6.2 years with a mean duration of working in this occupation of 7.6 ± 7.3 years; the mean working duration of the nurses in an oncology unit was 4.6 ± 5.6 years.

Most of the nurses were female [90.4% (n = 142)] and 62.4% of them (n = 98) were single. Sixty-six point two percent of them (n = 104) had a bachelor’s degree and more than half [50.3% (n = 79)] were working in a private hospital. The majority of the participants [58.6% (n = 92)] stated that their financial state was intermediate. % 52.9 of the nurses were working in the oncology unit on their own will and 47.8% (n = 75) of them were found to have a relative with cancer. A majority of the nurses [52.2% (n = 82)] were happy to work in an oncology unit. The nurses who were not happy to work in an oncology unit or were partially happy to work there [74.7% (n = 56)] explained the rationale for this with their response to the “presence of a large number terminal phase patients and death.” The remaining explained the situation in descending order of frequency with the following: “deficiency of materials and personnel” [54.7% (n = 41)], “treatment is intense and complicated” [42.7% (n = 32)], “communication problems with the patients” [28% (n = 21)], and “communication problems with families” and “insufficiency of physical environment” [25.3% (n = 19)]. A majority of the nurses reported that they were affected by working with cancer patients [73.9% (n = 119)].

When the postgraduate education that the nurses received was analyzed (Figure 1), “communication and communication skills” was ranked first [72% (n = 113)].

“Management of stress and crisis” was ranked second among the types of postgraduate education [64.3% (n = 101)], while the rates of “approach to a patient/family with cancer” [55.4% (n = 87)], “psychological aspect of cancer” [52.2% (n = 82)], “approach to death and terminal patient/family” [56.7% (n = 89)], and “field directed knowledge and skills” [53.5% (n = 84)], were ranked close to each other.

The majority of the nurses that participated in the study [98.7% (n = 155)] were identified to believe that the patients should be evaluated from a psychosocial perspective. More than half of the nurses [51.6% (n = 81)] stated that they were able to evaluate the patients psychosocially, while 48.4% (n = 76), stated that they were not able to evaluate the patients psychosocially. The majority of the nurses reported that all the patients required psychological treatment and support [66.2% (n = 104)].

Regarding the question of the timing of psychosocial problems of the patients was reported to be responded to as: “always” [29.3% (n = 46)], “at admission” [21.7% (n = 34)], “at each nursing shift change” [24.2% (n = 38)], and “every day” [24.8% (n = 39)], and the rates of different responses seemed to be close to each other.

Some 40.8% (n = 64) of the nurses had some knowledge about liaison psychiatry, while a 38.2% (n = 60) of them had no information. The patients requiring psychosocial support were directed to a psychologist and to a specialist of psychiatrist by the nurses in 45.9% (n = 72) and 40.8% (n = 64) of the cases, respectively. %90 (n=142) of the nurses thought that a psychiatry nurse should be present on the team. %58.6 (n=65) of the patients reported that a health professional evaluating the patients psychosocially and providing support for them was not present in their unit. Most of the nurses [99.4% (n = 156)] were using a nursing diagnostic form in patient admission and follow-up.

When the factors effecting the nurses’ psychosocial evaluation of the patients were analyzed (Figure 2), the factor “no spare time for psychological needs because of work load” was ranked first, with 80.3% (n = 126).

The rate of the factors of “low number of working nurses,” [65% (n = 102)], and “high number of patients” [62.4% (n = 98)] had similar response rates, and were ranked second and third, respectively. “No knowledge of performing a psychosocial evaluation” [22.9% (n= 36)], “believe that this is one of the psychiatry nurse’s job” [12.1% (n = 19)], and “no spare time for psychological needs because of work load” [1.3% (n = 2)], were the factors least affected the nurses’ psychosocial evaluation of the patients.

When the answers of nurses responding “yes” to the question, “does working with cancer patients affect you?” were analyzed (Figure 3), 54.3% (n=63) were found to have a fear of cancer developing in herself/himself or a family member. %50 (n = 58) were happy since they believed that they helped the patients, 44.8% (n = 52) were more careful to keep herself/himself in good health since they understood the value of health, 43.1% (n = 50) had intense sorrow, and 29.3% were found to have work satisfaction by working in this field.

As seen in Figure 4, more than half of the nurses [51.6% (n = 81)] stated that they were able to evaluate the patients from a psychosocial perspective and 48.4% (n = 76) stated that they could not.

As seen in Figure 5, the psychiatric problems most commonly seen in patients by the nurses are in descending order of frequency were: “anxiety disorder” [96.2 (n = 151)] “depressive symptoms” [91.1% (n = 143)] and “compliance problems” [80.3% (n = 126)]. “Organic mental problems” [42.7% (n = 67)] and “sexual functional disorders” [25.5% (n = 40)] were the least frequently reported problems.

The total point (VAS total points) of the dimensions that the nurses evaluated in the psychosocial diagnosis was 89.6 ± 17.9 . The subdimension of “excretion” (8.9 ± 1.6) had the highest points in patient admission and continuous diagnosis.

The points of the dimensions of “nutrition” (8.9 ± 1.6), “respiration” (8.9 ± 1.4), “activity and exercise” (8.2 ± 2.0), and “cardiovascular system” (8.8 ± 1.8) were found to be similar.

Figure 1. Postgraduate education of nurses (n = 157).

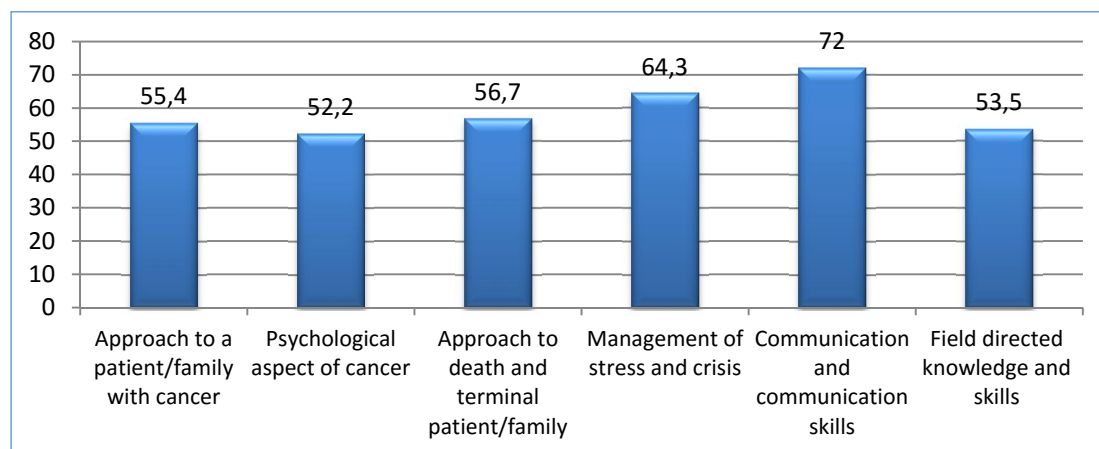


Figure 2. Factors effecting the nurses' psychosocial evaluation of patients (n = 157).

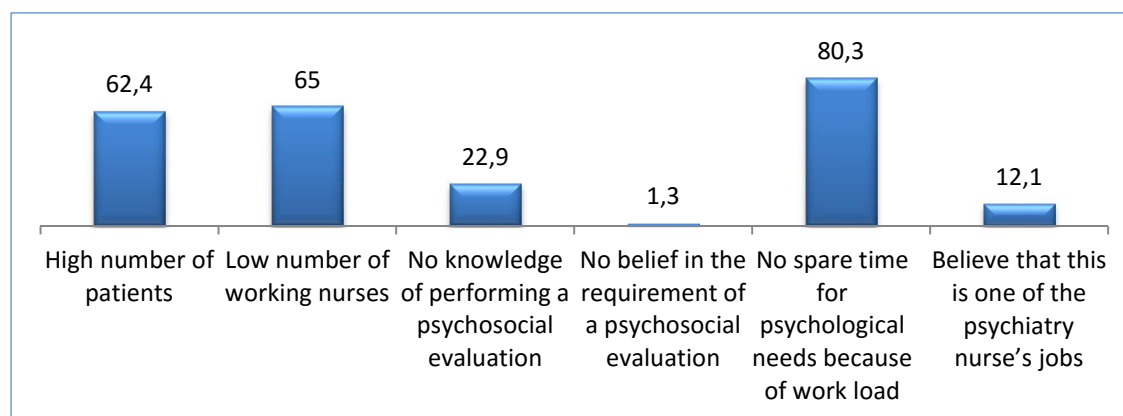


Figure 3. Emotional feelings of the nurses when working with cancer patients (n = 157).

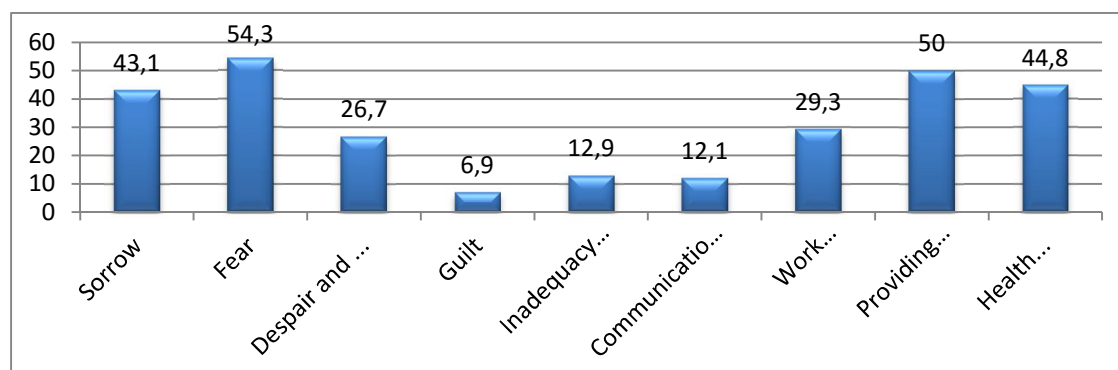


Figure 4: Adequacy of the Nurses in Diagnosing the Psychosocial Requirements of the Patients (N=157)

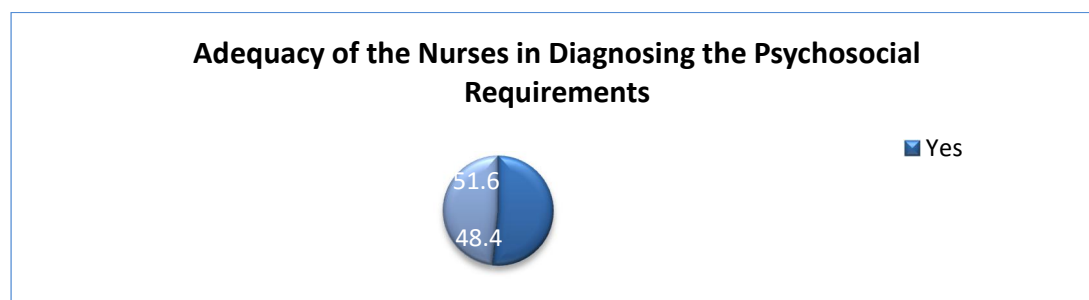
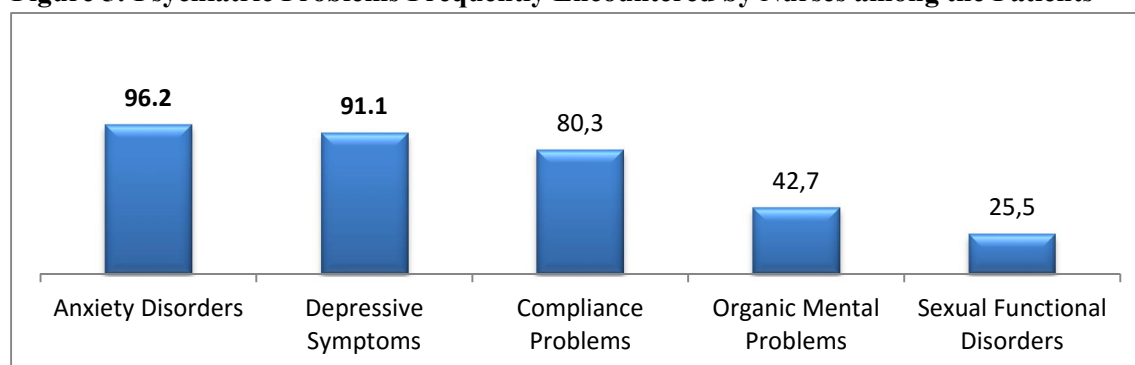


Figure 5: Psychiatric Problems Frequently Encountered by Nurses among the Patients



*More than one option is marked

Table 1: VAS points given by the Nurses for the Psychosocial Evaluation of the Patients

	Mean ± s.s.
Perception of Health	7.2 ± 2.3
Nutrition Metabolic State	8.9 ± 1.6
Excretion System	8.9 ± 1.6
Cardiovascular System	8.8 ± 1.8
Respiratory System	8.9 ± 1.4
Sleep/Rest	7.8 ± 2.1
Mental State	7.4 ± 2.6
Self-Perception and Self Respect	6.4 ± 2.9
Roles and Relations	5.9 ± 2.7
Sexuality and Reproduction	4.6 ± 2.9
Coping and Stress Tolerance	6.4 ± 2.6
Activity and exercise	8,2± 2,0
Total VAS Points	89.6 ± 17.9

The mean points of the dimensions of “perception of health” (7.2 ± 2.3), “sleep/rest” (7.8 ± 2.1), “mental state” (7.4 ± 2.6), and “coping/stress tolerance” (6.4 ± 2.6) were lower. The areas that were least frequently evaluated by the nurses in patient admission and continuous diagnosis were, in descending order, found to belong to the dimensions of “self perception” (6.4 ± 2.9), “roles and relations” (5.9 ± 2.7), and “sexuality” (4.6 ± 2.9) (Table 1).

Discussion

Oncology patients are at a substantial risk in terms of psychiatric disorders, and thus it is important to evaluate them with biopsychosocial integrity. Psychosocial interventions have been known to have positive effects on the course of the disease, psychosocial state, symptoms, treatment, and side effects. Psychosocial interventions were proven to decrease the stress of both the patients and relatives and increase the quality of life (Regan et al 2012).

In this study, which was performed on oncology nurses to evaluate the psychosocial diagnostic skills and factors affecting these skills, the mean age, years working in this occupation, and years working at an oncology unit of the nurses was 29.3 ± 6.2 years, 7.6 ± 7.3 years, and 4.6 ± 5.6 years, respectively. The majority of the nurses were female and single and had a bachelor's degree, worked in a private hospital, and were found to be working in the present clinic on their own will. To be able to choose the clinic that the nurse herself/himself will work is a factor that would positively effect the patient care and work satisfaction (Alaca 2008). Most of the patients were found to be happy to work in an oncology unit. The satisfaction of the nurses in the working environment decreases work stress and increases work satisfaction and quality of patient care. Most of the nurses who were not happy or were partially happy to work in an oncology unit stated the reason for this was the “high number of terminal patients and death.” The context of being surrounded by terminal patients and death results causes intense emotional stress in the oncology nurses and this level of intense stress results in ineffective coping

mechanisms, and thus burn out (Aycock & Boyle 2008; Fetter 2012; Davis et al 2013).

When the postgraduate education of the nurses was analyzed, “communication and communication skills” was ranked first. Communication is defined as a necessary component of cancer care (Wittenberg-Lyles et al 2013). Since the communication of the nurses focuses on the patient and includes the family, and requires knowledge of psychosocial cancer care, most nurses have difficulty in integrating the psychosocial and social effects of cancer on the patients and the biomedical past history of the patients and the methods to communicate with these patients. It has been reported in the literature that to provide patient-oriented communication and care, nurses should receive education on communicating with the patients and families (Wittenberg-Lyles et al 2013). “Management of stress and crisis” was ranked second in this study among the types of postgraduate education obtained. It is known that oncology nurses have work stress and this may result in burn out in the future (Traeger et al 2013). The results of this study are compatible with the literature findings stating that receiving the required education decreases stress and increases work satisfaction. In a study by Traeger et al., (2013) receiving training on the psychosocial skills for the management of difficult conditions was reported to help substantially in decreasing the emotional fatigue and stress of the nurses.

Most nurses reported that they were affected by working with cancer patients and they were happy to work with this type of patient and found work satisfaction in spite of the fear, sorrow, and anxiety they felt during work. The emotional conditions that the nurses experience while providing care to cancer patients in the literature are compatible with our findings. The close relationship between the oncology nurses and patients, trust, spending time together, and the connection between them provide work satisfaction for the nurses (Mok & Chiu 2004; Dowling 2008; Martensson et al 2010a; Oflaz et al 2010) in their study, reported that oncology nurses caring for terminal patients experienced intense emotional distress.

Most of the nurses participating in this study were identified to believe that these patients should be psychosocially evaluated. Almost half of the nurses stated that they were able to psychosocially evaluate the patients and half of them reported that they were not (Martensson et al 2010b) in their study, reported that nurses must support the patients psychosocially, and thus it is important to diagnose emotional stress; however, the nurses were found to be inadequate in evaluating the emotional stress of cancer patients. From this perspective, the results of the study are compatible with the literature.

When the factors affecting the psychosocial evaluation of the nurses of the patients were evaluated, the response of “no spare time for psychological needs because of work load,” was ranked first. The rates of “low number of working nurses” and “high number of patients” were close and these two were ranked second and third, respectively. “No knowledge of performing a psychosocial evaluation” is among the factors less frequently affecting the nurses’ psychosocial evaluation of the patients. The results of a study by Noble & Jones (2010) were similar to the results of this study, in which they state that the inadequacy of the nurses in terms of knowledge and education and time constraints are the main barriers to define the psychosocial requirements of the patients. Work load increases work stress and have a negative effect on providing a quality care by oncology nurses (Barrett & Yates 2002; Grunfeld et al 2005). In this context, the high number of patients in the clinics and the low number of workers in the present circumstances in oncology clinics might be considered as a barrier to the psychosocial evaluation of the patients.

The most commonly observed psychiatric problems in the patients were, in descending order of frequency: anxiety disorder, depressive symptoms, and disorders of compliance. Organic mental problems (42.7%) and sexual problems were less frequently encountered. In the literature, the most frequently reported psychopathology in patients with cancer was major depression (Elbi 2001; Alici et al 2011; Kutlu et al 2011; Snyderman & Wynn 2009; Gulec & Buyukkinaci 2011; Avucan et al 2006). Tokgoz et al. (2008) identified the rate of

major depression in cancer patients to be 22%, while Kutlu et al. (2011) reported intermediate and severe depression in 18.6% and 12.7% of cancer patients, respectively. The results were evaluated according to the DSM and ICD criteria in the meta-analysis study by Mitchell et al. (2011). A total of 70 studies performed in oncology and hematology clinics were detected (10,071 individuals from 14 countries) and depression according to DSM and ICD was found to be present in 16.3% of those patients. Nordin et al. (2001) in their study evaluating the probable future rates of anxiety and depression performed on 522 patients with newly diagnosed cancer, found that 39% of the patients were found to be close to having diagnoses of anxiety and depression after six months. Yen et al. (2006) in a study on patients with diagnosed breast cancer and patients with breast tumors, compared the rates of depression, quality of life, and level of stress between the groups and found that the quality of life of patients with breast cancer was lower and the level of stress was significantly higher compared to the other group. One of the clinical pictures of psychiatric disorders seen among cancer patients is compliance disorder with a prevalence of 25% (Gulec & Buyukkinaci 2011). Atesci et al. (2003) reported that lack of compliance was at the first place in their study with a rate of 55.8%. Another psychiatric clinical picture frequently encountered in cancer patients is delirium. Delirium, seen secondary to the direct or indirect effects of cancer on the nervous system and due to results of the treatment, is encountered in 14-55% of the cancer patients and in 90% of advanced phase cancer patients (Gulec & Buyukkinaci 2011; Noyan 2012). When the results of the present study and the literature data were analyzed, routine psychiatric assessment might be considered in cancer patients, taking into account the frequency of psychiatric disorders seen among them and the effects of these disorders on the clinical course and compliance to treatment.

Discussion of the Evaluation of the Dimensions that Nurses Evaluated During Psychosocial Diagnosis

In 1982, Gordon developed a nursing care model handling the individuals extensively

using a biopsychosocial dimension. Gordon's functional health patterns that emphasize the nursing process, critical thinking, and clinical judgment are used in regulations and evaluations of the nursing interventions in hospitals and in community health (Murphy 2006; Onianwa 2007; Gbobbo 2008; Aizenstein 2009; Epstein et al. 2010; Sabanciogullari et al., 2011; Rivas et al. 2012). In the current study, a total of 12 dimensions based on the functional health patterns of Gordon were evaluated using a VAS score and the total VAS score was 89.5 ± 17.9 . Nurses should be able to define the psychosocial requirements of the patients, in addition to their physical needs, while using a holistic approach in cancer care (Bahrami., 2010). In the study of Bahrami (2010) on the quality of life of cancer patients performed in both patients and nurses, it was found that the nurses were not following a holistic approach and required an evaluation tool to perform an extensive evaluation. Griffiths (1998) identified that the nurses ignored the psychosocial requirements of the patients while defining their biophysical requirements in a study of defining the problems of the patients and evaluation of data using the contents of the Gordon's Functional Health Patterns model. Nurses were found to mention psychosocial problems or requirements only verbally during the shift changes and that they were not recorded in anywhere else, such as care plans, and were not solved (Griffiths 1998).

In the current study, the subdimension of "excretion" had the highest points (9.0 ± 1.6) in patient admission and continuous diagnosis. Cancer negatively affects the renal functions by metastasizing to the kidneys, while it indirectly causes electrolyte imbalances and acute renal failure. The drugs used in chemotherapy may cause a drug nephrotoxicity (Dilek 2002). System of excretion is one of the most important factors to be evaluated in cancer patients and the nurses were found to have the highest points from this field. The points of the dimensions nutrition, respiration, activity and exercise, and cardiovascular system were similar. Cancer patients receiving chemotherapy may have problems related to respiration, which is one of the main functions required to sustain life. Problems such as obstruction of

the respiratory tract and dyspnea are commonly seen in patients with lung cancer or lung metastases. A detailed system evaluation must be performed in respiratory problems seen in all phases, especially in the terminal phase of care, of cancer patients (Akyolcu 2002). The mean points of the dimensions of perception of health, sleep/rest, mental state, and coping/stress tolerance were found to be more than five. The fields that were evaluated lowest by the nurses in patient admission and continuous diagnosis were found to be self perception, roles and relations, and sexuality.

The results of this study revealed that the nurses focused more on the physical needs of the patients, while they evaluated the needs related to the psychosocial field least frequently. In the holistic care approach that focuses on individuality and accepts the presence of very close relations between the body, mind, and spirit emphasizes that each dimension of the human is unique, while they are bound to each other (Kocaman 2005; Kostak 2007). Oncology patients who are at risk for developing psychiatric disorders should be comprehensively evaluated in biopsychosocial terms. The interactions between the medical, psychic, and psychosocial conditions should be evaluated using an extensive medical-psychiatric examination and the treatment and care should be considered in the field in which the struggle has a priority. Basic health care and mental health care have not been integrated yet in Turkey; therefore, the inadequacy of psychosocial evaluation compared to the other dimensions in this study might be accepted as an expected result.

Conclusion

Through this descriptive study, the state of oncology nurses was defined in terms of their ability to psychosocially evaluate patients during their treatment and care, and a general analysis on this issue is provided.

Most of the nurses were identified to consider the necessity of the psychosocial evaluation of the patients. More than half of the patients reported that they were able to psychosocially evaluate the patients, while 48.4% ($n = 76$), reported that they were not.

When the factors affecting the psychosocial evaluation of the nurses' of the patients were analyzed, "no spare time for psychological needs because of work load" was ranked first with 80.3% (n = 126), while 22.9% of the nurses reported that they had "no knowledge of performing a psychosocial evaluation."

The dimensions that the nurses evaluated during the psychosocial diagnosis were analyzed using a visual analog scale (VAS). In this study, the mean total point of VAS of the nurses was 89.5 ± 17.9 and the sub dimension of "excretion" obtained the highest points (9.0 ± 1.6). The nurses who received education regarding the "approach to the patient/family with cancer," "psychological aspects of cancer," and "approach to death and terminal patient/family" were found to better evaluate the sub-dimensions (aspects of health, nutrition, activity-exercise, cardiovascular system, and stress tolerance) in a psychosocial diagnosis.

The recommendations based on the findings of this study:

Planning the field directed in-care training of the nurses working in oncology units, including methods and techniques of psychosocial diagnosis and providing that the oncology nurses gain benefits out of the education;

Comprehension of the importance of the use of the data collection form that is developed for an integrated approach, in which the patients are evaluated in all dimensions in all hospitals;

Assigning nurses particularly willing to work in an oncology unit, since the field of oncology requires devoted professionals;

Making others understand the importance of a psychosocial approach in the patient diagnosis/treatment and care processes, and providing that consultation liaison psychiatry nursing care is introduced in these types of clinics.

Performing large scale studies that will provide more precise evidence for providing effective health care by the nurses who were the focus of this study and sharing the results of those studies with healthcare professionals

and directors of the institutions is recommended.

References

- Aizenstein S (2009) Perspective: Implementation of Nursing Language in Long-Term Care and Nursing Education. *Int Jour of Nurs Term and Classif* 20 (3), 145-154.
- Akyolcu N (2002) Dyspnea in cancer patients and nursing care. *Journal of Cumhuriyet University School of Nursing* 6 (1), 1-8.
- Alaca C (2008) Investigation of the requirement in the Consultation-Liaison Psychiatry Nursing. Mersin University Health Sciences Nursing Department Master Thesis, Mersin.
- Alici Y, Weiss T, Holland J, Nelson C, & Roth A (2011) Common psychiatric problems in older patients with cancer: report of one-year experience of a psychiatry outpatient clinic. *Journal of Geriatric Oncology* 137-141.
- Atesci FC, Oguzhanli NK, Baltalarli B, Karadag F, Ozdel O & Karagoz N (2003) Psychiatric disorders in cancer patients and related factors. *Jour of Turk Psychiatry* 14, 145-52.
- Avucan EE, Imrek M & Karaboga I (2006) Psychosocial aspects of cancer. *Turkish Psychology Bulletin* 38 (12), 81-91.
- Aycock N & Boyle D (2008) Interventions to manage compassion fatigue in oncology nursing. *Clin Jour of Onc Nurs* 13 (2), 183-191.
- Bag B (2012) Psycho-oncology, psychosocial problems and methods of measurement] *Current Approaches in Psychiatry*, 4(4), 449-464.
- Bag B (2013) Psychosocial problems in cancer patients seen in the long term. *Current Approaches in Psychiatry* 5 (1), 109-126.
- Bahar A (2007) Psychosocial interventions for cancer patients. *Journal of Ataturk University School of Nursing* 10 (1), 105-111.
- Bahrami M (2010) Do nurses provide holistic care to cancer patients? *Iran Journal Nursing Midwifery* 15 (4), 245-251.
- Barrett L & Yates P (2002) Oncology/hematology nurses: a study of job satisfaction, burnout, and intention to leave the speciality. *Australian Health Review* 25 (3), 109-121.
- Birrol L (2009) *Nursing Process: A Systematic Approach to Nursing*. (9th Edition). Istanbul, Impact Publications.
- Davis S, Lind BK & Sorensen C (2013) A comparison of burnout among oncology nurses working in adult and pediatric inpatient and outpatient settings. *Oncology Nursing Forum* 40 (4), 303.
- Dilek K (2002) Cancer and kidney. *Uludag University Medicine Faculty, Department of Internal Medicine*, 7-8.

- Dowling M (2008) The meaning of nurse-patient intimacy in oncology care settings: from the nurse and patient perspective. *European Journal of Oncology Nursing* 12, 319-328.
- Epstein S, Geniteau E, Christin P, Hermouet P, Mok E, Fournier J, Hankard R (2010) Role of a clinical nurse specialist within a paediatric multidisciplinary weight-management programme team. *Journal of Clinical Nursing* 19, 2649-2651.
- Elbi H (2001) Cancer and depression. *Psychiatry World* 5, 5-10.
- Enç N & Can G (2012) *Internal Disease Nursing Practice Student Training*. Nobel Medical Bookstores 76-86.
- Fetter KL (2012) We grieve too: one inpatient oncology unit's interventions for recognizing and combating compassion fatigue. *Supportive Care* 16, 550-561.
- Gbobbo J (2008) Strategies for Promoting client's adaptation to renal failure based on nursing process. *West African Journal of Nursing* 19 (1), s: 55-61.
- Goldsmith J, Ferrell B, Wittenberg-Lyles E & Ragan SL (2012) Palliative care communication in oncology nursing. *Palliative Care Communication in Oncology Nursing* 17 (2), 163-167.
- Gordon M (1987) *Nursing Diagnosis: Process and Application*, New York, McGraw-Hill, Second Edition.
- Griffiths P (1998) An investigation into the description of patients' problems by nurses using two different needs-based nursing models. *Journal of Advanced Nursing* 28, 969-977.
- Grunfeld E, Zitzelsberger L, Coristine M, Whelan TJ, Aspelund F & Evans WK (2005) Job stress and job satisfaction of cancer care workers. *Psychooncology* 14, 61-69.
- Gulec G & Buyukkinaci A (2011) Cancer and psychiatric disorders. *Current Approaches in Psychiatry* 3, 343-367.
- Kocaman N. (2005) Psychosocial Care In A General Hospital Practice And Psychiatric Consultation Liaison Nursing. *Journal of Cumhuriyet University School of Nursing* 9 (1), s: 49-53.
- Kostak AM (2007) Spiritual aspects of nursing care. *Firat Journal of Health Services* 6, 105-115.
- Kutlu R, Boruban MC & Demir A (2011) Factors affecting the quality of life and depression in cancer patients. *Journal of Selçuk University Medicine* 27 (3), 149-153.
- Martensson G, Carlsson M & Lampic C (2010a) Is nurse-patient agreement of importance to cancer nurses' satisfaction with care? *Journal of Advanced Nursing* 66, 573-582.
- Martensson G, Carlsson M & Lampic C (2010b) Do oncology nurses provide more care to patients with high levels of emotional distress? *Oncology Nursing Forum* 37, 34-42.
- Mitchell AJ, Chan M, Bhatti H, Halton M, Grassi L, Johansen C & Meader N (2011) Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. *The Lancet Oncology* 12, 160-174.
- Mok E & Chiu PC (2004) Nurse-patient relationships in palliative care. *Journal of Advanced Nursing* 48, 475-483.
- Murphy F (2006) A care study exploring a patient's non-compliance to haemodialysis. *British Journal of Nursing* 15(14), s: 773-776.
- Nakaguchi T, Okuyama T, Uchida M, Ito Y, Komatsu H, Wada M & Akechi T (2013) Oncology nurses' recognition of supportive care needs and symptoms of their patients undergoing chemotherapy. *Japanese Journal of Clinical Oncology* 43, 369-376.
- Noble A & Jones C (2010) Getting it right: oncology nurses' understanding of spirituality. *International Journal of Palliative Nursing* 16, 565-569.
- Nordin K, Berglund G, Glimelius B & Sjoden BO (2001) Predicting anxiety and depression among cancer patients: a clinical model. *European Journal of Cancer* 37 (3), 376-384.
- Noyan A (2012) Psychiatric approach principles to bladder cancer patients and suggestions for urooncology. *Psychooncology* 11 (4), 305-310.
- Oflaz F, Arslan F, Uzun S, Ustunsoz A, Yilmazkol E & Unlu E (2010) A survey of emotional difficulties of nurses who care for oncology patients, *Psychological Reports* 106, 119-130.
- Onan N (2009) Evaluation of Stress Coping Education which is applied to Oncology Nurses. Marmara University Health Sciences Faculty PhD Thesis, İstanbul.
- Onianwa P (2007) Nursing management of a patient with haemophilia: A case report. *West African Journal of Nursing* 18 (2), s: 142-150.
- Ozkan S (1993) *Psychiatric Medicine: Consultation-Liaison Psychiatry*. İstanbul.
- Regan TW, Lambert SD, Girgis A, Kelly B, Kayser K & Turner J (2012) Do couple-based interventions makes difference for couples affected by cancer? A systematic review. *Bio Med Central Cancer* 12, 279.
- Rivas F, Garcia J, Arenas C, Lagos M, Lopez M (2012) Implementation and Evaluation of the Nursing Process in Primary Health Care. *International Journal of Nursing Knowledge* 23 (1), s: 18-28.
- Sabancıogullari S, Ata E, Kelleci M, Dogan S (2011) Evaluation According to the

- Functional Health Pattern Model and NANDA Diagnoses of Patient Care Plans Made by Nurses in a Psychiatry Department. *Journal of Psychiatry Nursing* 2 (3), s: 117-122.
- Skoogh J, Steineck G, Johansson B, Wilderang U & Stierner U (2013) Psychological needs when diagnosed with testicular cancer: findings from a population-based study with long-term follow-up. *Journal of the British Association of Urological Surgeons* 1-7.
- Snyderman D & Wynn D (2009) Depression in cancer patients. *Primary Care: Clinics in Office Practice*, 36, 703-719.
- Tokgoz G, Yalug I, Ozdemir S, Yazici A, Uygun K & Aker T (2008) Prevalence of major depression in patients with cancer and associated factors. *Journal of Anatolian Psychiatry* 9, 59-66.
- Traeger L, Park ER, Sporn N, Repper-Delisi J, Convery MS, Jacobo M & Pirl WF (2013) Development and evaluation of targeted psychological skills training for oncology nurses in managing stressful patient and family encounters. *Oncology Nursing Forum* 40, 327-336.
- Wittenberg-Lyles E, Goldsmith J & Ferrell B (2013) Oncology nurse communication barriers to patient-centered care. *Clinical Journal of Oncology Nursing* 17, 152-158.
- Yen J, Ko C, Yen C, Yang M, Wu C, Huijuan C & Hou M (2006) Quality of life, depression, and stress in breast cancer women outpatients receiving active therapy in Taiwan. *Psychiatry and Clinical Neurosciences* 60, 147-153.
- Yildirim S, Gurkan A (2010) Psychosocial aspects of cancer and the role of the psychiatric nurse. *Journal of Ege University School of Nursing* 26, 87-97.