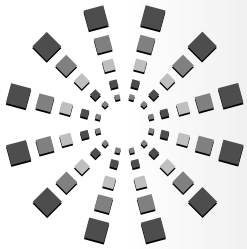

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Identifying and Responding to Depression in Adult Cancer Patients

Evaluating the Efficacy of a Pilot Communication Skills Training Program for Oncology Nurses

KEY WORDS
Ambulatory oncology nurses
Cancer patient depression
Communication skills training

Depression is a common response among cancer patients to their diagnosis and treatment; however, it goes undetected by healthcare providers in about 50% of cases. Communication skills training has been suggested as means to help nurses detect and respond to patient depression. We developed and pilot tested a communication skills training workshop based around 6 strategies. The training program consisted of 2 half-day experiential workshops that included didactic teaching, exemplary video, and role play. The aim of the study was to evaluate the effectiveness of the communication skills training. Fifteen nurses were recruited from the ambulatory nursing service at (redacted). Standardized patient assessments were used to measure strategy uptake. The presence of each strategy was rated on a 4-point scale from ''not attempted'' to ''successfully attempted.'' Nurses also completed evaluations of the training program. The nurses attempted 3 of 6 strategies more commonly after training, and a trend to significance was observed in a fourth strategy. The nurses reported more confidence to deal with patient depression and had greater self-efficacy. This short training program demonstrated success in improving nurse communication skills and confidence in dealing with patient depression. A larger trial of the training is planned.

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Depression is a common psychological response to a diagnosis of cancer. Adults with cancer are 3 times more likely to experience depression than those in the general population.[1] Depressive disorders are prevalent in the cancer population, with 20% to 25% of patients reporting depressive symptoms.[2–4] The likelihood of a depressive episode or symptoms increases with cancer progression.[5]

In spite of the high prevalence of depression reported in the cancer population, healthcare professionals fail to recognize depression about 50% of the time in their general population of patients.[6,7] Although oncology nurses are often in the front line in caring for cancer patients, surveys of oncology nurses' rates of detection of depression reveal similar results,[3] underscoring the problem of underdetection and the challenges of assessing patient depression and making appropriate treatment referrals to mental healthcare professionals in oncology care.

Depression-screening tools are effective ways of identifying the presence and predictors of depression as a first step; however, they do not necessarily lead to comprehensive clinical action.[8] Furthermore, because many of the symptoms of depression are similar to symptoms of cancer and the side effects of cancer treatment, the detection and treatment of depression pose a significant challenge to healthcare professionals. Untreated depression can impede a cancer patient's full physical recovery and lead to unnecessary long-term suffering for the patient.

Nurses report reluctance to address patients' depression because they are concerned that initiating such a discussion may worsen a patient's mood and cause additional upset.[9] In an analysis of healthcare professionals' actual interactions with their cancer patients, Maguire et al[10] found that healthcare professionals lack training in key interviewing skills and fear adverse consequences of inquiring about patients' emotional responses to their illness. Nurses do not feel equipped to discuss the management of depression with patients. Finally, the prevalence of depression in cancer patients leads to minimizing the degree of suffering and thus failing to address the patients' problems.[10,11]

Compounding this is the fact that many patients are reluctant to bring up their sense of sadness and depression with their physicians and nurses because they do not want to burden the treatment team and may fear being stigmatized.[12] Both patients and healthcare providers also hold a belief that depression is a normal outcome of a diagnosis of cancer and therefore not a serious comorbid and treatable condition.[13]

To address these communication difficulties, attempts have been made to educate oncology staff members to overcome some of their concerns about dealing with patient depression and to change behavior with the goal of improving clinical practice. Two different types of interventions are reported in the literature—didactic education focusing on increasing knowledge and skill-based training focusing on development of specific skills. Passik et al[14] conducted a 1-hour educational training session involving didactic teaching and videotaped case presentation designed to improve the ability of medical oncologists and oncology nurses to recognize their patients' depressive symptoms. Oncologists' and oncology nurses' ability to detect depression improved with training, particularly in less complex cases. In a small pilot study, Strong et al[15] demonstrated the efficacy and feasibility of an educational training intervention for oncology nurses that led to improved nurse competency in assessing patient depression and eliciting concerns. Razavi et al[16] conducted a randomized trial of a communication skills training program designed to increase nurses' use of emotionally laden words. The results of the study revealed that trained nurses used significantly more emotionally laden words, which, in turn, facilitated increased use of emotionally laden words by cancer patients. Although these 2 different approaches (education and communication skills training) specifically addressed effectively identifying depression or engaging in psychosocial discussion, responding to patient depression was not a specific focus of inquiry.

Several other studies have shown that the second method, training in communication skills, has been successful in helping nurses elicit patient concerns,[17] respond to patients' emotional cues,[18] and make assessments of psychological distress.[19,20] In a cancer-specific context, Wilkinson et al[21] evaluated a communication skills program delivered to 308 oncology nurses. Each of 9 areas of assessment displayed statistically significant improvements after the course. As in the previous study,[16] results showed that the areas of most significant improvement were those that were especially emotionally laden. When Wilkinson et al[22] provided 108 cancer/palliative care nurses with condensed 3-day workshops in communication skills, statistically significant improvements were again demonstrated in almost all key areas of assessment, as evaluated 6 weeks after the course. However, these studies were not focused on nurse detection and responses to patient depression, rather they targeted more general assessments of patient well-being. Taken together, these studies demonstrate that communication skills training is successful in altering cancer nurses' attitudes and communication behaviors around psychosocial issues.

This focus on communication skills training is founded on 3 basic premises. First, effective communication skills in consultations are linked to important patient and clinician outcomes. Good communication skills have been linked to higher patient satisfaction, greater patient adherence to treatment, better patient health outcomes, fewer physician malpractice claims,[23] reduced patient anxiety, increased recall, and improved understanding of complex information.[24] One randomized controlled trial of communication skills training provided to oncologists revealed that the patients of oncologists randomized to receive training reported lower levels of depression than the patients of the physicians in the control group did.[25] Second, communication skills are not always optimal; thus, these patient outcomes could be improved. Third, as noted above, communication skills training interventions are effective in changing behavior. Although much of the focus of communication skills training has been on physicians,[26] these preliminary studies of nurse communication skills training referred to above provide support for the efficacy of training to aid nurse communication.

No communication skills training workshops coupled with an education session have targeted the improvement of nurse communication in the context of detecting and sensitively responding to patient depression, although this has been previously reported as a significant difficulty. Our group has developed a set of 6 communication strategies to assist nurses in this difficult task. We have developed a communication skills training workshop based on these strategies using our own previously described theoretical and conceptual framework.[27] These are briefly summarized below.

Theoretical Framework

We have drawn from 2 theories that explain the ways in which people formulate their communication: (1) goals, plans, and action theories and (2) sociolinguistic theory. Communication theorists provide a clear ordering of the components of interpersonal communication in goals, plans, and action theories[28] based on the premise that when people communicate, they rely on goals and plans[29] to guide their communication. Goals have been defined as "future states of affairs that individuals desire to attain or maintain."[30(p68)] Plans are more concrete than goals—they are mental representations of actions needed to achieve a goal.[31] Plans vary in complexity and specificity. Actions are even more concrete because they are the enacting of the behavior that is planned. As a second theoretical foundation for the Comskil model, sociolinguistic theory offers clarification about communication styles. According to this theory, there are 2 basic communication orientations: the position-centered approach and the person-centered approach. The position-centered communicator relies on a restricted code of communication, following the rules and norms of a communication situation. The person-centered communicator adapts his/her communication in response to the perspectives, feelings, and intentions of others.[28] Our goal is that if curricula are based on the Comskil model, they will aid in participants' acquisition of and practice with the skills they need to enable them to take a person-centered approach. The Comskil model offers potential strategies and skills that individuals can use while adapting them to a variety of challenging situations.

Conceptual Model

To operationalize these theoretical foundations, the Comskil conceptual model seeks to explicitly define the important components of a consultation. We propose that consultation communication can be guided by an overarching goal, which is achieved through the use of a set of strategies. Strategies are achieved through the use of communication skills, defined as a discrete mode by which a physician can further the clinical dialogue. Process tasks, sets of dialogues or nonverbal behaviors that create an environment for effective communication, are also critical to achieving strategies.

This pilot study aimed to explore the impact of this communication skills training program guided by the Comskil training model on the skills uptake of ambulatory oncology nurses.

■ Methods

Participants

Nurse leadership randomly selected possible participants from the pool of available ambulatory nurses. Once identified, they were approached to participate by 2 of the nurses from the research team, not by nurse leadership. The voluntary nature of this research and the nurses' rights to withdraw from the study at any time were emphasized when they were approached to participate. Because of the exploratory nature of this study, only 15 nurses were approached to participate. All of the 15 ambulatory nurses from Memorial Sloan-Kettering Cancer Center who were approached agreed to participate. Two of the nurses were not involved in the assessments as they had participated closely in developing the depression-specific module and thus were too knowledgeable about the strategies. One participant withdrew from the training program after the initial session. Of the remaining 12 nurse participants, 10 were female and 2 were male. They worked in medical, surgical, or radiation oncology, specializing in lymphoma, gynecology, breast, genitourinary, urology, or head and neck. Their years of experience as nurses working in oncology ranged from 3 to 28 years.

Each nurse understood that he/she was being video recorded for the assessment. The Memorial Sloan-Kettering Cancer Center institutional review board assigned exempt status for the study.

Training

The "Responding to Depression" training program was based on a previously established communication skills training method developed at Memorial Sloan-Kettering Cancer Center.[27] The program consisted of 2 half-day workshops held 1 week apart. Workshop 1 was a preparatory workshop that trained nurses in the conceptual model for communication skills training developed by [redacted] and described elsewhere.[27] Workshop 2, the focus of this research, targeted detecting and responding to patient depression and incorporated the 6 strategies designed to assist nurses in detecting cancer patient depression and making appropriate referrals. The 6 key strategies were developed and refined through regular meetings and consensus review involving wider expert stakeholders and are as follows: "make a transition to a discussion about emotional issues," "discuss patient's emotional experience," "discuss patient symptoms and risk factors," "empathize with emotional distress," "educate patient about depression," and "discuss appropriate referral" (Table 1).

Each workshop incorporated didactic teaching of strategies, exemplary videos modeling ideal behavior, and a skills practice session. The skills practice session included prepared scenarios depicting patient depression and used standardized patients—trained actors taking the role of depressed patients. During

Table 1 • Identifying and Responding to Depression in the Adult Cancer Patient.

Goal	Strategies	Skills	Process Tasks
To gain an understanding of the patient's experience as related to depression and assist in seeking treatment	Make a transition to a discussion about emotional issues	Make a "take stock" statement Ask open questions Normalize	Ensure appropriate setting (1) Seating arrangement, (2) eye level Have tissues on hand Avoid interruptions
	Discuss patient's emotional experience	Encourage expression of feelings Ask open questions	Discuss preference for who is present for discussion Ask direct questions
	Discuss patient's symptoms and risk	Ask open questions Clarify Restate Check patient medical Knowledge	Review patient's experience Explore patient's previous coping mechanisms and support
	Empathize with emotional distress	Acknowledge Validate Normalize Praise patient efforts	Provide hope and reassurance Allow time to process
	Educate patient about depression	Preview information Summarize Check patient understanding Invite patient question	Provide vocabulary and avoid jargon Explain sources of information Allow time to integrate
	Discuss appropriate referral	Express a willingness to help Review next steps Invite patient questions Make partnership statements Offer decision delay Summarize	Explore patient attitudes about treatment for depression Maintain eye contact

the practice sessions, there was the opportunity for skills practice including instant feedback from peers, the facilitator who incorporated video feedback, and the actor. The workshops followed best practice principles in adult learning (learner-centered experiential, involving individualized targeted feedback)[32] and were taught and facilitated by 2 behavioral scientists expert in communication skills training.[33]

Before the workshops, participants were given relevant literature, including a workbook designed specifically for this training program, entitled "Identifying and Responding to Depression in the Adult Cancer Patient: Improving Communication Skills." The workbook included supporting literature, an educational material about risk factors and symptoms of depression, rationale for communication skills training, and the 6 core communication strategies. The prepared booklets mentioned above were sent to participants before their scheduled training date and can serve as a resource for trainees after they come to training. Participants were asked to review the material before attending training. A slide presentation briefly reviewed the background literature and then focused on each of the 6 strategies. Each strategy contained an embedded short (2–3 minutes) digital video clip, in which an expert clinician demonstrates the skills associated with the particular strategy. These were clearly labeled on the video to facilitate integration of the names of skills and process tasks that we emphasize for the completion of each strategy. These video clips were made with a senior nurse from [redacted] and an actor as simulated patient. The actor portrayed a young male with metastatic testicular cancer. Thus, there were 6 video clips presented exemplifying skill use.

Procedure

STANDARDIZED PATIENT ASSESSMENTS

Each participant was assessed both before and after training using a standardized patient assessment (SPA). Standardized patient assessments are useful in evaluating interpersonal communication skills in a specific domain. Using interitem and split-half reliability methods, the SPA was proven to be a reliable assessment tool and had demonstrated discriminant validity.[34–36] The SPAs were used to assess the effectiveness of the training program.[37] Other research in communication skills training has used video-recorded observations in naturalistic settings, that is, actual consultation with patients to assess the efficacy of training. Because it was not possible for us to know when a nurse may interact with a depressed cancer patient, we chose to use SPAs to ensure that we could observe each participant (1) in a situation where there is an opportunity to discuss depression with a patient and (2) in a standardized situation.

Immediately before attending workshop 1, nurses participated in a SPA with a trained simulated patient taking the role of a depressed cancer patient. Simulated patients were trained to respond to strategy and skill use with the goal of accepting

referral to psychosocial services. Each nurse was given 12 minutes in which to interact with the standardized patient. Nurses then participated in workshops 1 and 2. One week after workshop 2, nurses participated in a second SPA (again a trained simulated patient taking the role of a depressed cancer patient). The same 2 simulated patients were used for all SPAs. The 2 actors varied by age, sex, and site of disease. Each nurse saw a different simulated patient for the pretest from that of the posttest. The SPAs were video recorded and later assessed using an expert rater approach. [Redacted] were blinded to the condition (before or after) of the SPA. Each video-recorded SPA was rated on a 4-point scale from 0 to 3 (0—strategy not attempted, 1—strategy attempted but done poorly, 2—strategy attempted with some success, 3—strategy attempted successfully). The nurse's ability to use each of the 6 strategies taught in workshop 2 was rated on this scale. Nurses received feedback letters after both their pre-SPAs and post-SPAs.

COURSE EVALUATION DATA

At the completion of each module, participants were asked to complete an evaluation. Participants were asked to consider change in their general confidence levels about identifying and responding to patient depression before and after training. In addition, after training, participants were asked to rate aspects of their own sense of confidence and self-efficacy in dealing with patient depression in 3 areas: (*a*) confidence in use of new skills, (*b*) ability to provide better care after training, and (*c*) likelihood of critically evaluating his/her own communication skills. Participants were presented with a list of questions and were asked to indicate their response on a Likert scale from 1 to 5, with anchors at 1 (strongly agree) to 5 (strongly disagree).

DATA ANALYSIS PLAN

McNemar χ^2 tests were used on the pretraining and posttraining SPA rating results to test for differences in successful strategy use. These test were conducted as we were comparing matched samples, that is, same group at 2 time points (before and after training). This particular χ^2 test compared the percentage of individuals whose outcomes changed between the 2 measurement time points.

Participant self-report scores are reported as frequencies. Because of the small sample size, we have reported median scores rather than means scores and standard deviations.

■ Results

Nurse Skills Uptake as a Results of Training

The results indicate that in 3 strategies, discuss patient's emotional experience, discuss patient's symptoms and risk factors, and discuss appropriate referral, ratings of successful use were statistically significantly improved before and after training. In one strategy, empathize with emotional distress, a trend to significance was observed. The results are presented in Table 2.

Course Evaluation Data

After training, participants' self-rating of their confidence in detecting and responding to patient depression increased by 1 point on a 5-point scale from a median confidence rating of 3 (before training) to 4 (after training). The 3 other questions about self-efficacy and confidence received a median score of 5, indicating that the nurses strongly agreed that they would use newly acquired skills, provide better care after training, and had been prompted to critically evaluate their own communication skills.

■ Discussion

The aim of this research was to evaluate the impact of a communication skills training workshop targeting specific nurse behaviors during a discussion about a patient's depression and referral for psychosocial support. The nurses used 3 of the strategies, discuss patient's emotional experience, discuss patient's symptoms and risk factors, and discuss appropriate referral more commonly after they were trained. One of the strategies, empathize with emotional distress, almost reached significance.

These results support many other research studies reporting that communication skills training can be used successfully to alter participants' behavior.[26] Many of these studies report varying degrees of skill and strategy uptake,[33] and this pilot study is no exception. Three of the strategies were used more after training with a substantial magnitude of change. For example, the strategy, discuss patient's emotional experience, was demonstrated successfully 83% of the time after training compared with 7% before training. Two of 3 of these strategies, discuss patient's emotional experience and discuss patient's symptoms and risk factors, are the focus of a large part of both the education component of the training and the skills practice sessions; therefore, to see change is not surprising. Similarly, discuss appropriate referral is a specific goal of the training. Empathizing with emotional distress was the most commonly used strategy before training, being observed in 25% of cases. Although this rose to 75% after training, this did not reach significance. However, with such an increase in skill utilization before and after training, it is likely that this would have reached significance in a larger sample.

One reason for the lack of change for strategy one, make a transition to a discussion about emotional issues may have been the structure of the SPA. The strategy, make a transition to a discussion about emotional issues, was developed to assist nurses in the clinic to overcome barriers to discussions of emotional issues.[9] The ability to control the scenario and assessment context is a strength of the SPA method. One limitation of the method is that participants are not blinded to the context in which they are assessed. Thus, the nurses came to the SPAs with knowledge that they were being

Table 2 • Percent of Nurses Who Successfully Attempted Each Strategy Before and After Training for Responding to Depression (n = 12)

Strategy	Before Training	After Training	McNemars χ^2 Test
1. Make a transition to a discussion about emotional issues	1	2	$\chi^2 = 0$, $P = 1.0$
2. Discuss patient's emotional experience	1	10	$\chi^2 = 5.82$, $P = .016$[a]
3. Discuss patient's symptoms and risk	1	9	$\chi^2 = 6.13$, $P = .013$[a]
4. Empathize with emotional distress	3	9	$\chi^2 = 3.13$, $P = .077$
5. Educate patient about depression	0	2	$\chi^2 = 0.5$, $P = .48$
6. Discuss appropriate referral	2	8	$\chi^2 = 4.17$, $P = .041$[a]

[a] $P < .05$.

observed in the context of addressing patient depression and making a referral. However, as the nurses were previously primed to discuss depression, it is likely that they overlooked the transition phase and moved directly to discussing depression. In future training, we will develop case scenarios that allow time for biomedical discussion and a transition phase, thus more accurately reflecting the clinical reality. Similarly, ''educating patients about depression,'' although never observed before training, was not commonly used after training. It may be that the time allowed for the SPA was not sufficient for such a discussion, and the nurses prioritized the strategies focusing on the emotional rather than information aspects of the discussion. In future training, we will emphasize educational aspects about depression other than risk factors and symptoms. To do this, we will include more explicit messages describing how patients can derive comfort from knowledge about depression, including that it is possible to treat and alleviate symptoms.

Reviewing observational data gained from video recording or audio recording actual consultations provides the best evidence for whether communication skills and strategies are being attempted in the clinical setting. As mentioned earlier, it was not feasible to record a large sample of consultations for each nurse in the event that he/she would discuss depression with a patient. Therefore, we used the SPA method. The self-report data based on the course evaluations suggest that nurses felt confident to address patient depression and that they would use new skills. Coupled with this intention to use the skills clinically, the nurses strongly agreed that their clinical interaction and ability to provide quality care were enhanced by training.

Taken together, these pilot results indicate that, in a small sample of nurses, this workshop, combining both an education session and communication skills training, shows promise in improving nurses' abilities to deal effectively with depression in cancer patients and make appropriate referrals. The limitations of this research have been discussed above with reference to the SPA methodology. In addition, this pilot research was conducted in a small sample of ambulatory nurses at a large American urban comprehensive cancer center. Future research is warranted, exploring the use of this training in a larger sample of ambulatory nurses with a more diverse patient population. The pilot data collected here are being used to support such an application. Research exploring the impact of communication skills training for healthcare professionals on patient outcomes is in its infancy. In the future, we plan to measure patient outcomes such as patient satisfaction with emotional support and patient intention to take up a referral to psychoservices to determine whether it is possible to improve patient outcomes by improving the quality of communication within the consultation. If this workshop demonstrates further use for nurses and eventually for patients, it will be taught as a part of a wider curriculum targeting communication challenges faced by oncology nurses at Memorial Sloan Kettering Cancer Center.

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