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The perception of support received from breast care nurses by depressed patients following a diagnosis of breast cancer

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ABSTRACT

INTRODUCTION Due to their specialist training, breast care nurses (BCNs) should be able to detect emotional distress and offer support to breast cancer patients. However, patients who are most distressed after diagnosis generally experience least support from care staff. To test whether BCNs overcome this potential barrier, we compared the support experienced by depressed and non-depressed patients from their BCNs and the other main professionals involved in their care: surgeons and ward nurses.

PATIENTS AND METHODS Women with primary breast cancer (n = 355) 2–4 days after mastectomy or wide local excision, self-reported perceived professional support and current depression. Analysis of variance compared support ratings of depressed and non-depressed patients across staff types.

RESULTS There was evidence of depression in 31 (9%) patients. Depressed patients recorded less surgeon and ward nurse support than those who were not depressed but the support received by patients from the BCN was high, whether or not patients were depressed.

CONCLUSIONS BCNs were able to provide as much support to depressed patients as to non-depressed patients, whereas depressed patients felt less supported by surgeons and ward nurses than did non-depressed patients. Future research should examine the basis of BCNs' ability to overcome barriers to support in depressed patients. Our findings confirm the importance of maintaining the special role of the BCN.

KEYWORDS

Breast cancer – Breast care nurses – Depression – Support

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Maguire *et al.*[1] were the first to show that a specialist nurse could reduce psychological morbidity following diagnosis of breast cancer, and the role of the breast care nurse (BCN) was developed in response. Further evaluation confirmed that the BCN can identify patients at risk of distress and provide effective emotional support.[2–5] As a third or more of patients are clinically depressed or anxious immediately after diagnosis,[6–8] the BCN is now a key member of the breast multidisciplinary team[9,10] and often cited by patients as their most valuable contact.[11]

The role of the BCN has evolved and now includes many technical clinical roles such as seroma draining, patient follow-up and management of lymphoedema.[11] These changes can compromise the traditional role in support and information giving. The current NHS climate threatens further to erode this role. Value is placed on items of service which attract a tariff under 'payment by results' or which save doctors' time. The BCN's traditional role in providing support is more difficult to measure and quantify and there is evidence that this is being valued less by NHS trusts in a climate of financial stringency.[10]

We, therefore, investigated the efficacy of the BCN in the traditional supportive role. Patients with breast cancer or other medical problems who are distressed feel less supported by hospital clinical staff than do those who are not.[12,13] Therefore, those patients who most need support

find it hardest to access it. Because of its association with reduced motivation for social interaction and with feelings of low self-worth, depression, in particular, would be expected to compromise patients' ability to experience support. However, the specialised skills and training of BCNs should equip them to overcome this barrier. We have compared the BCN to the two other main practitioners whom patients see around the time of diagnosis and surgery – the surgeon and the ward nurse. Using patients' own judgements, we compared the support provided by the BCN and these other clinical staff. Specifically, we tested the prediction that, whereas depressed patients would describe feeling less supported than non-depressed patients by the surgeon and ward nurse, the support received by the BCN would be high, irrespective of the presence of depression.

Patients and Methods

Participants and recruitment

Participants were female patients from two Merseyside breast units, who had received a diagnosis of primary breast cancer followed by mastectomy or wide local excision. We excluded patients with metastastic or recurrent cancer, those receiving neo-adjuvant chemotherapy or primary endocrine treatment, with insufficient English to consent and complete questionnaires, and those who were judged by a clinician or the researcher to be too distressed to take part.

After ethical approval, patients were briefly informed about the study by a BCN on the pre-operative home visit and then fully informed and asked for consent by the female researcher 2–4 days postoperatively before discharge home. All patients had met their surgeon, breast care nurse and ward nurses. The researcher administered questionnaires (see below for measures used) to consenting patients at the bedside or in a private room, as the patient preferred. Demographic information was also collected. Where patients were unable to complete questionnaires in hospital, or were discharged before 2 days, the procedure was completed as soon as possible after discharge.

Measurements

Emotional distress was measured by the Hospital Anxiety and Depression Scale (HADS).[14] This is a widely used 14-item measure with two subscales – anxiety and depression. As recommended, patients scoring 8 and above were regarded as probable cases of depression. Professional support was measured by questions 'about people you might have talked with about your illness' based on those developed by Hill *et al.*:[15] 'Have you felt able to ask him/her questions that are most in your mind?' and 'Can you trust, talk frankly, and share your feelings with him/her?' Each was answered separately for 'your surgeon', 'your specialist breast nurse' and 'the ward nurse you saw most often' on a 5-point scale from 'never' to 'always'. Where a patient chose a further response option that they had 'not seen' this professional, their response was regarded as missing. Responses were summed to provide a single score for each professional, ranging from 0–8.

Data analysis

In repeated measures analysis of variance, 'staff' was the within-subjects variable distinguishing ratings of the BCN, surgeon and ward nurse. 'Depression' ('depressed' versus 'not-depressed') was the between-subjects factor. Significant effects were, where appropriate, analysed using *post hoc* LSD tests.

Results

Sample characteristics

Of 474 patients who were approached, 374 (79%) agreed to participate, although 14 (4%) of these subsequently withdrew, and 5 (1%) provided too few data to be included in the analysis. The final sample was, therefore, 355 patients. There were a few missing data in ratings of support: 28 (7.9%) for BCN, 14 (3.9%) for surgeon, and 21 (5.9%) for ward nurse. Mean age was 58.2 years (SD 10.4).

Professional support and depression

Thirty-one patients (9%) reached the criterion for depression. As expected, analysis of variance confirmed that depressed patients recorded less support than did non-depressed patients ($F = 7.78$; df = 1,317; $P < 0.01$). Patients reported different levels of support from different staff ($F = 19.330$; df= 2,634; $P < 0.001$). However, the interaction between depression and type of staff was also significant ($F = 4.953$; df = 2,634; $P < 0.01$; Table 1). *Post hoc* tests confirmed that, for both non-depressed and depressed patients, the BCN was more supportive than the surgeon or ward nurse ($P < 0.05$). However, whereas depressed patients reported less support from the surgeon and the ward nurses than did non-depressed patients ($P < 0.05$), these groups did not differ in the support experienced from the BCN.

Table 1 Mean support (range 0–8) from each professional, rated by depressed and non-depressed patients

Professional		Mean	SE
Breast care nurse	Depressed	7.26	0.25
	Not-depressed	7.42	0.08
Surgeon	Depressed	6.37	0.31
	Not-depressed	7.04	0.09
Ward nurse	Depressed	5.56	0.37
	Not-depressed	6.86	0.11

Discussion

Surgeons and ward nurses could not support depressed patients to the same degree as non-depressed patients. This study, therefore, provides further evidence that patients who, because of their level of distress, most need the support of clinical staff experience it least.[12,13] The novel and important finding was that the BCN was able to overcome this: depressed patients did not experience less support from BCNs than did non-depressed patients. In addition, patients experienced the BCN as more supportive than either the surgeon or ward nurse. Our findings are, therefore, in line with evidence that patients consider the BCN to be their most valuable clinical contact.[11] However, the additional evidence of the present study is that their role is distinctive in providing effective support specifically to depressed patients who, while they need more support than others, generally feel less supported by clinical staff.

Further research is needed to understand why depressed patients felt generally less supported by clinical staff, and how the BCN overcame this. Depressed patients might express their needs less transparently than other patients. However, in primary care at least, emotionally distressed patients give more verbal cues to distress than do non-distressed patients.[16] Instead, their cues might elicit less support than those of other patients. Alternatively, depressed patients might receive objectively similar levels of support as do non-depressed patients, but feel less supported by it; that is, they might need staff to provide more support in order to allow them to feel equally supported as others. Correspondingly, the special skill of the BCN might be in assessing emotional distress, in providing support, or in judging the level of support needed. Further research could identify this skill and explore its origin. It might be a characteristic of those who choose to become BCNs, a result of their special training or experience, or a result of their greater contact with patients or contact at key times: BCNs interact with patients at several critical times from the preoperative home visit to receiving results postoperatively.

The study has limitations. Support from all three professional groups was rated as high, by both depressed and non-depressed patients, and the differences in support experienced by depressed and non-depressed patients were modest by comparison. Whether the generally high level of ratings reflects general satisfaction with support, or patients' well-known tendency to be positive when evaluating their care staff[17] is not clear. We measured support shortly after diagnosis and surgery, and findings may differ as this crisis period recedes.

Nevertheless, the present findings have important implications for policy regarding the BCN role. If the current re-orientation of the role to technical aspects of clinical care continues, the multidisciplinary breast care team will lose skills in providing support to vulnerable patients that are currently not shared by other clinical staff whom patients routinely see around the time of diagnosis and surgery.

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