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Responding to Challenging Interactions With Families: A Training Module for Inpatient Oncology Nurses

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Abstract

Introduction—Sustaining the well-being of the caregiving family is a critical agenda in cancer care. In the multidisciplinary team, nurses often serve as a bridge between the family and oncology team. Evidence suggests that dealing with difficult family dynamics is a common source of stress for oncology nurses, yet nurses typically receive very little guidance on how to achieve an effective partnership with families under these circumstances. We report on the application and preliminary evaluation of a new training module for improving nurses' skills in responding collaborative to challenging family situations.

Method—Training was delivered to 282 inpatient oncology nurses at a comprehensive cancer center over 2 years. Posttraining surveys measured perceived changes in confidence working with

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families, as well as the utility and relevance of this training. A 6-month follow-up survey measured continued use of skills.

Results—Of the nurses, 75%–90% reported that the skills learned were useful and relevant to their setting. Retrospective pre–post ratings suggested increased confidence in managing stressful encounters with families.

Discussion—Further investigation is needed to observe how nurses transport these skills into their practice settings and to understand the role of the nurse-as-family champion within the larger multidisciplinary team.

Keywords

family; communication; family nursing; oncology; family centered

Sustaining the well-being of the caregiving family is a critical agenda in supportive cancer care and aligns with a broader initiative in medicine to advance family-centered care practices (Northouse, 2012). Partnering with families in health care settings (e.g., conducting family meetings, allowing family presence during rounds) has been associated with improved clinical outcomes for patients and families and decreased stress for medical staff (Davidson et al., 2007; Doolin, Quinn, Bryant, Lyons, & Kleinpell, 2011; Kirchhoff, Pugh, Calame, & Reynolds, 1993; Schaefer & Block, 2009; Traeger et al., 2013). These practices have been implemented primarily in critical care and pediatric settings, where family members serve as surrogate decision makers (Kazak et al., 2007; Tomlinson, Peden-McAlpine, & Sherman, 2012). In these settings, competency in communication with the family has become a recognized indicator of quality care (Davidson et al., 2007; Kazak et al., 2007).

In adult oncology, the extent to which families are integrated into patient care remains inconsistent (Ekstedt, Stenberg, Olsson, & Ruland, 2014; McLeod, Tapp, Moules, & Campbell, 2010). Ambiguity in the role of families is a common source of tension with the health care team (Levine & Zuckerman, 1999; Tomlinson, Swiggum, & Harbaugh, 1999). Kleinman (2010) argued that one of the reasons for growing distrust of medical providers is that medical training has departed from an emphasis on hands-on caregiving, which is increasingly delegated to families. Yet in the hospital setting, the prevailing ethic of care prioritizes the patient's needs, with the family construed as adjunctive to this effort. Most efforts to improve communication skills among oncology providers target provider–patient communication, with less attention given to the engagement of families (Bylund et al., 2010). In this article, we report on the implementation and preliminary evaluation of a new training curriculum for improving skills in responding to stressful interactions with families during a patient's hospitalization.

Nurse as the “Relational Bridge”

In the oncology team, nurses are uniquely positioned to initiate and model supportive care of the family. Because of frequent contact with the family, nurses learn about support needs and function as a “relational bridge” (McLeod et al., 2010, p. 97), translating the perspectives of health care providers to the family and vice versa (Hamric, 2001). Patients perceive nurses

as more affiliative than other providers and as playing a critical role in communicating about illness (Auerbach et al., 2005; Koutsopoulou, Papathanassoglou, Katapodi, & Patiraki, 2010). Although nurses describe their relationships with families as rewarding, dealing with conflictual family dynamics can generate considerable stress (Traeger et al., 2013). In a survey of 912 hospital oncology nurses in the United States, the highest rated obstacle to providing high quality end-of-life care was “dealing with anxious family members.” Of the top 10 rated obstacles identified by oncology nurses in this study, 7 pertained to families (e.g., “family not accepting patient’s poor prognosis” and “nurse having to deal with angry family members”; Traeger et al., 2013).

Successful Engagement of Families

Barriers to engaging families exist at the level of the family (e.g., poor communication or team-work within the family) and at the level of the health care system (e.g., insufficient resources and time; Beckstrand, Collette, Callister, & Luthy, 2012; Hudson, Aranda, & Kristjanson, 2004). A major barrier is the scarcity of training among nurses in family systems approaches to cancer care and the tendency to construe family responses to illness in a manner that emphasizes deficits rather than strengths. Failure to create an early alliance, taking sides in family conflicts, and giving premature advice have been cited as common missteps that nurses may unknowingly make (Wright & Leahey, 2005). In an analysis of “breakdowns” in nursing care with intensive care unit families, Chesla and Stannard (1997) observed that when family-related stress mounted, nurses distanced themselves from the family and adopted pathologizing, cause-effect explanations (Chesla & Stannard, 1997).

McLeod and colleagues (2010) elicited perspectives from families and oncology nurses on what constitutes successful partnership (McLeod et al., 2010). Two key components emerged: (a) “knowing the family,” that is, the nurse’s ability to assess family relationships, read nonverbal cues, and acknowledge family members as active participants, and (b) “attending to family concerns or distress,” that is, the nurse’s ability to inquire about coping and educate families about managing the impact of cancer on family life.

Engaging families in this manner is a complex task, requiring skill in establishing multiple alliances, under conditions of high stress. To our knowledge, there have been no training efforts that specifically focus on how to respond collaboratively to difficult family dynamics in the setting of patient care. In a review of the Institute of Medicine recommendations on promoting quality cancer care, Ferrell, McCabe, and Levit (2013) underscored the importance of communication skills training to empower nurses to take a leadership role in modeling effective collaboration with families.

Current Study

We present a new training module for inpatient oncology nurses, called Responding to Challenging Interactions with Families (RCIF). RCIF was developed to help nurses respond to stressful family situations using a collaborative, strength-based, and family-centered framework. The module targets nurses as the front-line providers who have most frequent contact with families during an admission. We review the conceptual basis and content of

the training module and present preliminary data on its efficacy in increasing nurses' perceived competence to respond to difficult family situations.

Preliminary Work

Preliminary to the development of RCIF, we elicited feedback from acute care nurses to determine training interests and identify challenging scenarios that arise in working with families. A survey was administered to inpatient oncology staff at Memorial Sloan Kettering Cancer Center (MSKCC; $N = 30$), asking them to rate the degree of challenge associated with 10 common family situations that arise in an inpatient setting, as well as interest in training for each. Situations rated most challenging were family conflict, poor teamwork, and discrepant views on goals of care. Interest in training was strongly endorsed across all situations, regardless of perceived difficulty. To further aid in the development of this module, we convened an advisory group of members from Acute Care Nursing and the MSKCC Communication Skills (Comskil) Training Program, who reviewed training content for relevance and acceptability. Finally, we asked nurses to anonymously submit responses to the prompt, "Describe a challenging interaction you had with a family." Three types of family-level challenges were described (a content analysis is under way and will be published separately). These are outlined below, with illustrative excerpts from nurses' responses.

Family-Level Challenges

Nurses described relational difficulties within the family itself, such as poor communication, discrepant goals of care, or concern about the welfare of a particular member. The following scenarios illustrate within-family challenges:

The sisters of the patient flew the parents in that night and the parents did not know the patient was dying. I was being yelled at by the sisters of the patient to not tell the elderly parents their son was dying ... I felt it was unfair for the parents to not know the condition of their son.

I took care of someone whose parents were on two different ends of the spectrum. The mom wanted to keep fighting and kept thinking that the patient was coming around and making improvements even though he was terminal, and the dad was grasping the reality of the situation.

When relational difficulties within the family go unrecognized, staff may inadvertently align with one perspective over others or become a communication conduit for family members who have difficulty communicating directly. When the nurse is able to recognize and assess *within-family* dynamics that have become magnified by a medical crisis, they can maintain their stance as an ally to the whole family and help other providers avoid becoming entangled in unresolvable conflicts.

Partnership Challenges

A mismatch between the viewpoints of the oncology team and family regarding the goals of patient care was a commonly cited source of friction. Discrepant beliefs were overt (e.g., religious and ethnic differences) or less salient (e.g., assumptions about who should be

involved in care or who is most competent to give help). The following scenarios described by nurses illustrate this challenge:

A patient's husband was extremely demanding about her care, had many complaints about nursing staff's response time to his wife's calls. After spending time speaking with him, I found out that he is filled with a lot of guilt because he had discouraged his wife from visiting a doctor when she first developed symptoms and he blamed himself for her advanced disease.

[The] medical team thought [the] patient should be end of life/comfort care, but the family was completely for doing everything and anything. The medical team had explained that there wasn't anything they could do more for the patient. The family was very anxious, understandably and also hostile at times toward the staff.

Escalation Challenges

Sequences of interaction can occur in which the clinician and family each contribute to mounting escalation. Symmetrical escalation (e.g., increased anger met with increased anger) has been distinguished from complementary escalation (e.g., increased demand met with increased withdrawal) in relationships between families and larger systems (Imber-Black, 1988). For example, a family may be labeled as "difficult," causing staff to enter an encounter with vigilance; this in turn may prompt the family to feel criticized or kept at distance, resulting in defensive behavior on their part, therefore confirming the nurse's original view of the family. One such scenario is illustrated below:

After an unsuccessful attempt at an IV insertion, a patient's mother said, "Can we get a nurse who knows how to put in an IV?" ... I spent 30 minutes explaining the procedure to the patient and convincing her to cooperate. The patient was expressing verbal understanding, but the mother would say, "Let's just do it." After an hour of this, the team decided to cancel the patient for the day ... and it was very upsetting for everyone involved.

Modular Content

The RCIF training module was part of a training series delivered to acute care nurses by the MSKCC Comskil Training Program. Consistent with the training framework used in this program, the module has an overarching goal, achieved through a set of broad strategies (Brown & Bylund, 2008). These strategies are in turn achieved through nonspecific communication skills common to all Comskil modules and family-specific skills (i.e., process tasks) designed to create an appropriate environment for effective communication. The goal of this module was to provide nurses with strategies for partnering with caregiving families under stressful circumstances. Strategies, skills, and process tasks associated with each challenge reviewed above are summarized in Table 1.

Strategy 1, *checking your emotional posture*, encourages nurses to become mindful of any emotional vigilance during an interaction with a family. The purpose of this strategy is to empower nurses to pause and attend to their own stress so that they can respond skillfully. Nurses are encouraged to rate their "emotional temperature" (1–10) and take steps to shift

their stance from reactive to curious. The 3-min Breathing Space is an exercise drawn from Kabat-Zinn's (1993) Mindfulness-Based Stress Reduction program, incorporated here as a simple tool for disengaging from the anxiety of a situation, witnessing it without judgment, and making a clear-minded choice about how to respond. Nurses are encouraged to practice appreciative listening and slow down the natural impulse to problem-solve.

Strategy 2, *becoming an ally to the family*, emphasizes the benefits of acknowledging the multiple perspectives in a family. This is accomplished by eliciting each member's concerns, identifying overlap among stated concerns, highlighting positive intentions, and identifying aspects of the problem that the nurse and family can unite around. Reinforcing the family's unique expertise is also encouraged as a means of aligning with the family and engaging them as a resource to each other and to the health care team.

Strategy 3, *frame choices*, describes ways to address discrepant perspectives between the family and nurse, enabling the nurse to maintain collaboration and support to the family. Nurses are encouraged to be transparent with the family about what choices are available to them and the parameters of their role (e.g., expectations within the hospital setting). This strategy emphasizes the importance of reinforcing the positive intentions of the nurse, even when at variance with the family's wishes.

Strategy 4, *respond empathically*, involves acknowledging, validating, and normalizing sources of distress and/or mistakes made. Skills include normalizing the family's experiences, conveying that concerns are being taken seriously, and, when applicable, reframing anger as a dimension of worry and grief.

Strategy 5, *block escalation if inevitable*, recognizes those occasions when the nurse or the family becomes too distressed to maintain constructive discussion, at which point facilitating a transition to a "timeout" with a clear plan to return is an encouraged solution.

Method

Participants and Procedure

Participants were 282 inpatient bedside nurses who were nominated for training by nurse leaders in acute care at MSKCC. Nurses participated in groups of 10–12 (26 groups in total) over 2 years. Participants included acute care, pediatric, urgent care, and intensive care nurses. MSKCC's institutional review board approved this educational study and the publication of these data. Participants completed surveys immediately after the module and were sent an online survey link 6 months after completion of training to elicit follow-up data on use of specific skills taught in this module.

Training Format

Training entailed a didactic presentation (30–45 min) followed by a large-group experiential role-play (45–60 min). The module was cofacilitated by the first author (T. Zaider) and coauthors Stacey Hammonds, Ruth Manna, Carol Krueger, and Nessa Coyle. Participating nurses initially observed a didactic presentation that reviewed research on family distress during hospitalization, general principles in collaborative care with families, and strategies

for responding effectively to challenging interactions. Exemplary videos were embedded into the presentation to illustrate key skills. The facilitator then led a group role-play in which simulated (actor) patients followed prescribed roles of a family featuring discrepant perspectives on goals of care. Each nurse participant was asked to practice specific strategies with the simulated family, and frequent timeouts were used to invite reflection. The observing group was also invited to suggest and model alternative strategies to address the difficulties that arose. The role-play segment enabled nurses to directly apply the new skills in a safe, supportive learning environment, with peer-led feedback to address common barriers. Participants were provided with a workbook reviewing the conceptual framework and skills in the current module.

Measures

Course evaluations distributed immediately after completion of the module asked nurses to rate the content, helpfulness, and relevance of the curricular activities utilized in our teaching (booklet, exemplary videos, role-play experience, etc.). In addition, nurses anonymously rated their agreement/disagreement with seven statements about the module using a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Nurses were asked to retrospectively rate their confidence in responding effectively to a challenging interaction with a family before training and then rerate their post-training confidence. The remaining five items inquired about the utility and relevance of the skills learned.

Results

Of the 282 acute care nurses who attended this module, 278 (98.6%) provided complete data on evaluation surveys. The most common reason for missing data was the nurse forgetting to submit questionnaires before leaving the training.

Paired *t* tests compared mean ratings of perceived confidence in responding to challenging family interactions as retrospectively reported before training ($M = 3.32$, $SD = 0.79$) and after participation in training ($M = 3.96$, $SD = 0.61$). Results indicated a statistically significant difference, with mean confidence ratings higher following training ($t = 14.46$, $df = 276$, $p < .001$; see Table 2).

Additional responses are summarized in Table 3, where we present the proportion of nurses who endorsed the statements listed in reference to the training. As shown in Table 3, the overwhelming majority of nurses (90%) reported confidence in the usefulness of the skills taught, and over three quarters indicated that aspects of the training itself (e.g., large-group role-play, facilitation) were helpful in facilitating development of specific skills. Whereas only 36.8% of nurses reported high confidence in this aspect of care prior to the training, 78% endorsed confidence posttraining.

Qualitative feedback was elicited about potential areas of improvement. In response to the question, "Was there anything about the module that could have been improved?" 27 (9.7%) nurses responded "yes," and of these, 24 offered narrative suggestions (e.g., "there should be more time for role-play"). Comments predominantly focused on the role-play experience. Suggested improvements included a preference for small-group role-play and extended time

to discuss role-play feedback. Additional suggestions focused on broadening the content and varying the level of escalation presented in family scenarios for role-play practice.

Follow-up Evaluation

Follow-up questionnaires were obtained from 93 of 210 nurse participants 6 months posttraining. Because questionnaires were completed anonymously, we were unable to examine differences between completers and noncompleters. Nevertheless, the available follow-up data give a preliminary look at the sustained use of skills over time. The proportion of nurses who reported continued use of family collaboration skills was 40.9% ($n = 38$) for “eliciting each person’s perspective,” 37.6% ($n = 35$) for “summarizing differences in viewpoints,” and 43.0% ($n = 40$) for “highlighting positive and common intentions for families.”

Discussion

Competent communication with families is an important component of delivering high-quality cancer care (Schaefer & Block, 2009). Few training interventions are designed to target escalated family nurse interactions, despite evidence that dealing with difficult family dynamics is a frequently cited source of stress for oncology nurses (Traeger et al., 2013). Establishing an alliance with a family under conditions of conflict requires skill in systemic assessment and intervention (e.g., synthesizing information from multiple informants, maintaining neutrality, and structuring a focused discussion; Friedlander, Escudero, & Heatherington, 2006).

We presented an initial evaluation of a new training module designed to help acute care oncology nurses respond more effectively to challenging interactions with families. Post-training surveys suggested that nearly all nurses felt that the skills learned were useful, relevant, and applicable to their settings. Retrospective pre–post ratings suggested increased confidence in managing stressful family encounters. An important next step in this research is to measure the transfer of skills to the clinic setting, as confidence levels do not necessarily predict actual performance. Our findings are consistent with results from similar training modules developed to strengthen family care skills (Gueguen, Bylund, Brown, Levin, & Kissane, 2009; Krimstein et al., 2011). The elicitation of initial reactions following training represents an important first step in ensuring the acceptability and perceived relevance of this module (Hutchinson, 1999).

Close to 40% of nurses reported retention of specific skills 6 months after training. This figure is promising given the low dose of training and the complexity of the content addressed. Institutional and resource barriers pose challenges to integrating family-centered practices into routine care (Hudson et al., 2004). The use of skill consolidation workshops following training has been shown to increase the transfer of skills to the clinic setting (Delvaux et al., 2005). In a pilot study under way, we are testing a model of family-centered skills training that includes peer-led consolidation sessions. In these sessions, nurses are invited to present active cases on their service and use ongoing peer support to reinforce the skills developed during training.

Although the majority of nurses evaluated the training experience favorably, qualitative feedback suggested that the role-play exercises were controversial, with some nurses preferring a small-group format and others finding benefit in the large-group, “fishbowl” approach. Experiential role-play exercises are known to be a key ingredient in effective, learner-centered communication skills training (Kissane et al., 2012). To our knowledge, there has been no direct comparison between formats of experiential exercises in such training. Our experience across 26 training groups suggests that the large-group format enables nurses to model skills and allows for diverse perspectives to emerge for discussion, but it also requires effective time management and can create greater discomfort. Strategies to encourage participation include inviting nurses to participate in teams of two cofacilitators and encouraging frequent stops to consult and strategize with the larger group.

Limitations of this preliminary study include our evaluation process, in which changes in confidence were assessed retrospectively at a single time point and did not include direct observation of the skill transfer to the nurses’ practice setting. The limited response rate at the 6-month follow-up assessment also limits generalizability about sustained training effects. Finally, there is a need to elicit feedback directly from families who are under the care of participating nurses to determine impact on quality of care.

During hospitalization, the family and oncology team interface more frequently and in a climate of greater urgency than occurs during routine outpatient visits. This temporary “social grouping” requires the patient, family, and providers to function as a larger caregiving system with common concern for the ill patient (Reiss & Kaplan De-Nour, 1989). Training initiatives that are designed to strengthen the cohesiveness of this larger family provider system will become increasingly important as patients and their families seek a more integrated cancer care experience (Rushton & Adams, 2009).

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Table 1

Summary of Module Strategies and Skills

Strategy	Skills	Process tasks
Check stance: responsive vs. reactive (<i>Reciprocal escalation challenges</i>)	•	Take emotional temperature (1–10)
	•	3-min breathing space
Be an ally to the family as a whole (<i>Family-level challenges</i>)	•	Ask open questions
	•	Clarify
	•	Restate
	•	Summarize (differences)
Frame choices (<i>Partnership challenges</i>)	•	Ask open questions
	•	Clarify
	•	Restate
	•	Summarize
Provide empathic response	•	Acknowledge (anger, any mistakes made)
	•	Normalize
	•	Praise family's efforts
	•	Validate
Block escalation if inevitable (<i>Reciprocal escalation challenges</i>)	•	Encourage expression of feelings
	•	Review next steps
	•	Disengage if escalation seems inevitable
	•	Suggest time out with plan to return
		Redirect volatile family members

Table 2

Participant Confidence Change Pre-Post (Range From 1–5)

Item from module evaluation	Mean	SD
Before this module, I felt confident in responding to challenging family interactions.	3.32	.79
Now that I have attended this module, I feel confident in responding to challenging family interactions.	3.96*	.61

*
 $t = 14.46$;

$df = 254$; $p < .001$.

Table 3

Participant Evaluation of Module

Item from module evaluation	Agree or strongly agree, % (n)
Before this module, I felt confident in responding to challenging family interactions.	36.8 (103)
Now that I have attended this module, I feel confident in responding to challenging family interactions.	78.0 (221)
I feel confident that I will use the skills I learned in this module.	90.7 (254)
The skills I learned in this module will allow me to provide better patient care.	90.4 (253)
The module prompted me to critically evaluate my own communication skills.	88.6 (248)
The experience of observing the large group role play was helpful to the development of my skills.	76.1 (213)
The large group facilitator was effective.	87.9 (246)