

【特集 メンタルヘルスにおける家族支援の意義】

自死遺族への支援

Support for people bereaved by suicide

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自死遺族の経験する問題—生活上の混乱

2007年に自殺総合対策大綱が閣議決定されて以降、自死遺族支援は常にとりくむべき重点課題の一つであった。7年が経過し実践例やデータは決して十分とはいえないが、海外の研究を含め重要な知見も得られている。本稿では、自死遺族の経験する問題を3つにわけて整理し¹⁶⁾、その上で、支援のあり方について検討していくことにしたい。

大切な家族を失って最初に経験することになる、それゆえに最も優先されるべき問題は、生活上の混乱に対する対応である。故人との死別に際しての諸手続きの中には、それまでの生活では意識していないものが少なくない。死亡届等はいつまでにどこに提出すべきなのか、葬儀費用の補助が受けられるのか、故人の所有していた各種の免許、会員資格、銀行などの口座や財産についての手続き、本人のクレジットカードやインターネットの解約の時期や方法も調べたことはないかもしれない。このような一つ一つの作業は、悲嘆過程に向かい、喪の作業に取り組む時間を自死遺族から奪うことになる。

一方、故人が家計を担っていた場合には、その家族は収入の確保が問題になる場合もある。また、子供が成長すると教育費などの負担が増す。自殺に関連して借金が残される場合では、相続放棄の手続きを期限内に実施する必要がある。さらに、自殺に関連した不動産の瑕疵について（貸借住宅で自殺が発生すると借り手がなくなる等）、損害賠償を求められるケースもあるなど、経済的な問題は軽視できない。

生活の混乱は、直接的にストレスとなり自死遺族

の生活の質に影響を与えるばかりでなく、十分な休養をとり喪の作業に取り組むための時間を奪うことによって、精神的身体的な回復の過程、そして悲嘆過程を妨げる可能性があり、その支援は重要である。

心身の不調

自死遺族が経験する問題の二つ目は、心身の変化と不調に関するものである。自死遺族には自然死の遺族に比べいくつもの指標で精神健康の悪化がみられるという報告がある。たとえば藤井らは、検案書が発行される際に同意を得た17名のうち、死別から8ヶ月の時点でK6の「気分・不安障害相当」は17.6%、「重症精神障害相当」は11.8%、IES-RによるPTSDハイリスクは58.8%だったとしている⁹⁾。また川野は、自死遺族グループと接点をもつ自死遺族111名に質問紙調査を行い、気分・不安障害相当が48%であったと報告している¹⁶⁾。

ただし、このようなメンタルヘルスの状況は、自死遺族に限らず、殺人・事故などの「暴力的死別」の遺族に共通するものである²⁵⁾。たとえば子供を失った親の研究では、全般的な精神健康および心的外傷後ストレス症状は、事故および自死の遺族のほうが乳幼児突然死症候群の遺族よりも高かったが、事故死と自死の間では差がなかった⁷⁾。また、自死の遺族では子供を亡くした後うつ、不安、夫婦関係の悪化が見られるものの、交通事故の遺族との差は（交通事故遺族の方がうつが高い以外）ほとんどなかった²⁾ことが報告されている。一方、親を亡くした子供の研究では、自死遺族はうつ病とアルコール・薬物乱用がコントロール群と比べて高いものの、事故遺族との差はない³⁾。アルコール・物質関連障害について他の研究もみられ¹²⁾、また、肥満になりやすい³⁴⁾という報告もあるが、いずれも自死と他の死因との間での差は見出されていない。

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死別や大きな喪失のあとに経験する心理的变化はグリーフプロセス＝悲嘆過程と呼ばれ、そのプロセスの捉え方については、多様なモデルが提案されている。段階説はグリーフのある側面を経験したのちに、次の側面に移行するというような不可逆な過程として捉えるもので、Kübler-Rossが示した「否認と孤立」「怒り」「取引」「抑うつ」「受容」の5つの段階がよく知られている²⁰⁾。これに対して、フェーズ間の遷移として捉えるのが、Neimeyerの「回避」「同化」「適応」という提案である²⁶⁾。段階説のように個々の（感情）状態を表すのではなく、3つのフェーズは死別の経験への取り組み方、つまり回避する、同化する、適応するといった認知や行動にも関わる能動的な表現が用いられている。ここからグリーフプロセスは主体的な過程であると特徴づけられ、したがってその軌跡は一律ではなく、たとえば人によっては3つのフェーズを行きつ戻りつするなど、段階説では想定されていないグリーフの姿が説明される。一方、Wodenは、「喪失の現実を受け入れる」「グリーフの痛みを消化していくこと」「故人のいない世界に適應すること」「新たな人生を歩み始める途上において、故人との永続的なつながりを見つけること」の4つを課題として提示している³⁶⁾。この課題の達成を目安として、悲嘆過程の支援を検討できる。ただし、これらのモデルのうちどれが最もよくグリーフを捉えているのかについては、まだ十分にわかっていない¹⁸⁾。たとえばKübler-Rossの段階説はこれまで多様に批判されてきているが、実証的な裏づけがあるとする研究もある²²⁾。そこで本稿では特に断りがない限り、グリーフプロセス＝悲嘆過程とは、喪失に伴う感情的な反応の変化のみならず、心身状態の変化全体について表すものとする。

悲嘆過程では驚愕、茫然自失、否認・歪曲、離人感、自責、抑うつ、不安、怒り、記憶の加工、非難、他罰、疑問、合理化、隠蔽、救済感、二次的トラウマなど、多様な心理反応がみられる³³⁾が、自殺という特殊な経験に対する自然な反応であって決して異常ではない。そして、一定期間の後にこれらの反応は減衰していく。

これに対して複雑性悲嘆は、通常の悲嘆とは異なり、悲嘆反応が強いレベルで長時間にわたり持続し、社会的・職業的・その他の領域における障害をきたした状態である。故人への思慕、恋しさ、熱望と分

離の苦痛がその中核にあり、さらに、死を受容できず怒りを感じることで、呆然とした感覚あるいは喪失後の感情の麻痺、死や故人を想起させるものの回避、故人のいない人生は虚無で無意味であるという感覚、他者を信じることの困難などアイデンティティや社会的機能の困難についての症状が、死別後6ヵ月にわたってみられる。さらにこのような心理的苦痛ばかりでなく、自殺念慮の高まり⁶⁾、²¹⁾ やうつ病など精神障害の併存¹⁾、³⁰⁾ がみられることから、治療の対象とするべきではないかという指摘があり、DSM-5およびICD-11の改定に向けて診断基準の提言が行われてきた。その結果、2013年に改定されたDSM-5では、Persistent bereavement disorder(持続性複雑死別障害)として精神障害として採択されたが、診断基準については今後研究を進めるべき疾患のところで取り上げられている²⁵⁾。

複雑性悲嘆の一般集団の有病率については2.4%から4.8% (DSM-V)、日本の研究では死別から10年以内の複雑性悲嘆の罹患率は2.4%という報告がある¹⁰⁾。この数字と比べると、自死遺族の複雑性悲嘆の有病率は高いことが報告されている。たとえば、一般住民1445人を対象としたInventory of Complicated Griefを用いた調査では、含まれた22人の自死遺族の18.1%¹⁹⁾、60人の自死遺族を対象に同じスケールを用いた調査では43.3%²⁴⁾、死別後3ヶ月以内の配偶者もしくは一親等の153人の自死遺族にInventory of traumatic griefを用いた調査では38%¹¹⁾、子どもを自死で失った自死遺族に同じくInventory of Traumatic Griefを用いた調査では死別から平均15ヶ月の時点で78%が複雑性悲嘆に該当した⁷⁾と報告されている。なお、遺体をみた親は悪夢と侵入性想起を多く経験するものの、直感的な理解とは異なり、見ていない親と比べて不安やうつの症状に差がみられないという報告があり²⁷⁾、複雑性悲嘆のプロセスについては、さらなる研究が必要である。

対人関係の問題

悲嘆反応とメンタルヘルスに関するシステムティックレビュー³¹⁾では、自殺と他の死因との間で一般的なメンタルヘルスの指標、うつ、PTSD、不安、希死念慮に差はないものの、自死の場合、遺族がスティグマの存在や恥を感じ、死因が自殺であ

ることを隠す傾向にあることを指摘している。これらは、自死遺族が生活上の問題や心身の不調について援助を求め難くすると考えられる。自死遺族支援グループに関連する111名を対象とした調査では、約半数が必要なときに支えや助けが得られなかったと回答しており、その理由としてあげられていたのは、1. 自責の念があり助けを求めるときではないと考えていること、2. 誰かに話しても聞いてもらえなかったという経験であった。後者について客観的な被害の有無というより主観的な経験であることに着目し、「二次的傷つき体験」と呼ぶ¹⁵⁾。

この調査では、自死遺族と接する機会のある様々な関係について、この二次的傷つき体験と助けられた経験を尋ねてみると、家族、親戚、友人、近隣住民、上司・同僚などは、自死遺族にとって支援の提供者となる頻度が高いのと同時に、高い頻度で二次的傷つき体験の相手にもなっている。つまり、両者はコインの裏表であり、自死遺族の関係への志向性(死別初期の、誰かに聴いてほしいという思い)から始まり、体験(受け入れられたり、傷つけられたりすること)から生まれる二つの表現形である。この二次的傷つき体験がメンタルヘルスに影響を与える可能性について検討したところ、家族、親戚、友人、他の遺族との間で二次的傷つき体験があると、K6での気分不安障害相当のカットオフポイントを超える可能性が高くなる、すなわちメンタルヘルス状況が悪くなることがわかった。このように二次的傷つき体験で生活問題や心身の不調全般に対する援助希求を押し留め、それぞれの問題の解決を遅くしている可能性があるばかりではなく、メンタルヘルスそれ自体に影響を与えている可能性がある。

また、これまであげた3つの問題の背景に、自殺に対する文化や習慣、社会制度上の問題、あるいは偏見の問題をみることができるといえる。これらは自死遺族個人の経験する問題として扱うと典型的なミクロマクロ問題となるため、ここでは直接的には言及していないが、自死遺族支援においてきわめて重要な側面であることは強調しておきたい。

生活支援

では上記の3つの問題群に対して、どのような支援が提供され得るのだろうか。生活上の混乱に対して考えられる支援は、まず適切な情報提供である。

大倉らは故人の続柄ごとにフォーカス・グループ・インタビューを実施し、自死遺族が望む情報提供のあり方について以下の点を共通項目として抽出した²⁸⁾。

1. 自殺と判明した直後から葬儀後までに実施、2. 遺族コーディネーターのような新しい職種や体制による実施、3. 警察や行政死亡窓口、葬儀社などの既存の専門家が自死遺族に特化して関わる、4. 口頭ではなくリーフレットや冊子をさりげない形で封入して提供する。現在、自死遺族支援のためのリーフレットは都道府県の精神保健福祉センター等で配布されているほか、さまざまな団体が情報を発信している。

また、福祉制度の利用ならば社会福祉士や精神保健福祉士、相続放棄や借金の問題などは弁護士や司法書士など法律の専門家の支援が有効な場合が少なくない。今日、日本社会福祉士会、日本精神保健福祉士協会、全国司法書士会連合会などの職能団体やその部会は、自殺対策や自死遺族支援に積極的に関わっている。弁護士会の中には自殺対策のワーキンググループを設置している場合もあり、自死遺族支援に関しては自死遺族支援弁護士、自死遺族権利擁護研究会など自主的にとり組んでいるグループもある。なお、日本司法支援センター(通称法テラス)は、相談料について減免する仕組みを利用することができるため、経済的な問題を抱えた遺族の最初の法律に関する相談先として適切である。加えて、自殺の経緯について遺族が過労死裁判をすすめる場合にも、法的な支援は必要になる。

心身の不調についての支援

一方、悲嘆過程は先に述べたように、自殺という特殊な経験に対する自然な反応であって決して異常ではない。そして、一定期間の後にこれらの反応は減衰していくものであるから、特に支援は必要ないということもできる。ただし、ここまで述べてきたように、生活上の問題や対人関係の問題を含めた環境が、経験に向きあい悲嘆過程を歩む機会や資源を損なっている可能性がある。それは複雑性悲嘆への危険性を高めるともいえる。

今日の日本において、自助グループと支援グループは、悲嘆過程を歩む自死遺族にとって最も充実した自死遺族支援の資源である。その詳細については後に改めて述べる。ただし、このようなグループにすべての人が参加できるわけではない。開催時間・場

所が不都合な人、社会的な偏見が気になって参加しづらい人、そのようなグループに参加することを好まない人もいる。

このような場合、入手しやすい資源として関連書籍が考えられる。たとえば川島(2014)が作成した、自死遺族の悲嘆過程を促進するためのワークブックは、自宅で時間があるときに、自分一人でも取り組むことができる(あるいは、家族や友人、カウンセラーと一緒に取り組むことも推奨されている)¹⁸⁾。このワークブックではナラティブ死生学という立場を表明しており、1. 自分自身のやり方でそれまでの人生観や世界観を再構成する、2. 自らの経験を他者と語りなおすことで意味を再構成する、3. 遺族それぞれのやり方でグリーフを十分に経験するとしているが、これは先に述べた Neimeyer の悲嘆過程モデルに近いもので、死別に関するストーリーを何度も生成すること、また語ることを重視する点が特徴といえる。これ以外にも、周囲の大人や教師が自死遺児の悲嘆過程について知り、それを支える方法について、米国の遺児支援の民間団体ダギーセンターが作成したガイドラインの日本語訳が出版されている。また、いくつかの自死遺族支援団体や個人が本を出版しており、ここから他者の経験を学ぶことができるので、それらの本を紹介することも支援となるだろう。ただし、これらの評価については報告されていない。

その意味では、書籍ではないがイギリスの国営医療サービス NHS が提供している遺族のための手引き Help is at hand は、2008年に作成されたのち、どのような立場の人が入手しているのか、また手にした時期は適切だったか、個々の章は助けになったかといった点から評価が試みられていることは興味深い¹⁹⁾。この手引きは自死遺族支援に関する情報を幅広く網羅しており、実際的な問題として遺族が早い時期に経験する警察での取調べ等や葬儀、遺書の扱いや生命保険などについて触れ、次に死別の経験として、悲嘆など遺族が経験する心理過程とそれへの対処の仕方、特別な支援ニーズとして、子を亡くした親、児童、若者、高齢者、性的少数者、学習障害のある人についての支援について述べている。さらに友人や同僚にできることについて触れたあと、支援のための資源として以下のものが紹介されている。死別に関する支援組織、自助グループ、自殺予防に積極的なグループ、スピリチュアルカウ

ンセリング、死別カウンセリング、葬儀、経済問題と遺書、検死に関連する組織、その他の支援組織と Web サイト情報、読書案内などである。

一方、介入方法については、海外では一定の検討が進められている。Mcdaid らは、自死遺族に対する介入の有効性についてのシステマティックレビューを行い、グループセラピーや家族 CBT を用いた 8 つのプログラムを検討したところ、うつや不安について効果が示唆されたが方法的に改善すべき点も多く、結果は安定的ではないと結論づけた²³⁾。これに対して Szumilas らも、自死遺族へのポストベンションプログラムについてシステマティックレビューを行い、学校、家族、そしてコミュニティを基盤とした 16 のプログラムについて検討したが、自殺あるいは自殺未遂にたいして抑制的な効果をもつプログラムはなかった²⁴⁾。ただし、いくつかの副次的指標について有効だったとの報告がある。学校を基盤としたプログラムでは、カウンセリングによる介入では効果が得られなかったが、グループでのデブリーフィングタイプの介入と教育プログラムが自己効力感を押し上げる効果があったとしている。また、学校職員向けの教育プログラムによって関連する知識の増加があった。家族向けプログラムでは、うつや不安の軽減がいくつかのプログラムで報告されているほかに、自殺現場へのアウトリーチプログラムが遺族会への参加や援助希求を促進する効果があることが指摘されている。コミュニティベースのプログラムでは統計的に意味のある効果は見出せなかった。ただし、Comans らは、コミュニティベースでのポストベンションに取り組んで、費用対効果として 803 オーストラリアドルの節約と質調整生存年で 0.02 年の改善がみられるとしている⁵⁾。

複雑性悲嘆については、Wittouck らのメタアナリシスが報告されている³⁵⁾。事前予防もしくは治療 (treatment) についての 14 のランダム化比較試験について検討した。9 つの事前予防には、2 つの認知行動療法と 3 つの筆記を用いた取組、3 つのグループアプローチと 1 つの個人療法が含まれていた。他方、5 つの治療には 3 つの個人を対象とした認知行動療法と二つの短期集団精神療法が含まれていた。プール解析の結果、治療は事後に複雑性悲嘆を改善し、さらに時間をおいたフォローアップ期ではその効果が増大することが示された。事前予防では効果を見出すことができなかった。日本でも、近

年は複雑性悲嘆に焦点をあてた認知行動療法が実施される医療機関があり、またそのトレーニングを受ける機会もある。

一方、薬物療法については、複雑性悲嘆に伴うつについて、オープントライアルが行われている段階で、三環系抗うつ薬は複雑性悲嘆には効果はないが、複雑性悲嘆に並存するうつ状態の改善を示した。またSSRIでは悲嘆症状の軽減が報告されているが、有効性が実証されたとはいえない段階である²⁵⁾。

対人関係の問題についての支援— グループの紹介

自死遺族が支援を求めにくい心理にある場合があること、仮に求めても二次的な傷つき体験をすることがあること、さらに生活上の問題や心身の不調とそれへの対処について情報提供や意見交換、実際的な支援などがその対人関係を介して必要な遺族に伝えられることを考慮すると、当事者同士の出会う場である自助グループ/支援グループは、自死遺族支援の大切な資源であることはいうまでもない。(なお、ここでは、自死遺族が運営し、とくに自死遺族がその経験を語り合う「つどい」において自死遺族のみが参加し、専門家などのファシリテーターを置かない等の形態で運営しているグループを自助グループ、それ以外の形態で自死遺族支援に関わるグループを支援グループと呼ぶことにする。)

日本の自死遺族支援において、これらのグループの成立は初期の重要な目標であった。2007年に閣議決定された自殺総合対策大綱においても、「地域における民間団体が主催する自助グループ等の運営、相談機関の遺族等への周知を支援する」ことを、自死遺族支援の第一の重点目標として掲げ、厚生労働省の研究班はその活動に資するために「自死遺族を支えるために～相談担当者のための指針～」を作成している。

遺族にこれらのグループを紹介することは、有力な支援である。日本での自死遺族支援に関連したグループの全体像を把握する報告等はないが、2014年の時点で自助グループの相互交流を場として機能している全国自死遺族連絡会のHPには29の自助グループについて連絡先が示されている。一方、NPO法人ライフリンクのHPには68の自死遺族の「つどい」の連絡先が示されているが、こちらは自

助グループ、支援グループの両方が記載されている。また、全国の都道府県や政令指定市の精神保健福祉センターや保健所には、地域のグループの情報があり、紹介を受けることができることが多い。つまり、ほとんどの都道府県ではグループを紹介することができる。

このようなグループの機能についての研究では、具体的な支援と経験の共有があることは報告されているが^{14) 23) 37)}、まだ十分とはいえない。自死遺族自助/支援グループの質的な改善方法の開発は、多様な形態の遺族支援にとっても重要である。そこで川野らは、支援グループの運営者・スタッフ、参加者と研究者による共同研究の形式で、神奈川県4市の自死遺族支援グループ活動の評価を行い、これを通して、自死遺族支援グループの評価モデルを提案し、その課題を提示した¹⁷⁾。この研究は4つのサブテーマから成っているが、自死遺族支援グループの活動を評価するためには、指標として「相互扶助の10の原理」について検討を行った。フェイゲルマンらは、シュルマンが提唱した「相互扶助の原理」²⁹⁾を援用して自死遺族支援グループへの参加の効果について検討を行っている⁸⁾。本研究では、フェイゲルマンらの検討を加味して自死遺族支援グループの機能を示す「相互扶助の10項目」を作成した。

神奈川県4市の支援グループの行政スタッフ、参加者(自死遺族当事者)、神奈川県4市以外の自治体が運営している支援グループのスタッフに、この10項目について自分たちのグループでどの程度大切にしているのかを尋ねると、④～⑩ではこの3群の評価にずれがあった。具体的な相互支援、さらに対社会的な活動に価値を見出すかどうかは、自死遺族の支援グループ間の特徴を考える手がかりと言えるかもしれない。ただし、この研究では自助グループについては検討されていない。

このように、日本において自助/支援グループは、自死遺族のニーズに広く対応する役割を持ちながら、その評価研究は十分ではない。自死遺族支援を狭い意味の「効果」「機能」だけで問うべきではないという議論もあり得るが、支援の質を高めるためには、まずはプロセス評価に積極的に取り組むべき時期にあるのではないだろうか。

表 1. 相互扶助の 10 項目

	項 目	全体平均値	
		頻度	大切さ
①	自分とよく似た悩みや経験を持つ他の参加者に出会い、自分は一人ではないと感じている	2.89	2.98
②	普段は話せない話題(故人に対する怒りや他人への失望感、自殺念慮、負担からの解放感など)について口にしている	2.73	2.93
③	他の人から非難されることも、また他の人を非難することもなく、お互いの気持ちに寄り添っている	2.84	2.96
④	他の参加者が問題を解決するのを手助けしている	1.91	2.11
⑤	のこされた者としての経験(遺品を片付けた、カウンセラーに相談した等)を参加者同士で共有する場となっている	2.44	2.63
⑥	様々な意見を交換することで、自分や他人の信念について深く考える機会になっている	2.02	2.33
⑦	他の参加者に対して何かを求めたり、期待を持つことを避けて、お互いに助け合っている	1.69	1.84
⑧	グループに参加することが、困難な状況や人に対応する方法を学ぶ機会となっている	1.96	2.30
⑨	親しい人の自死という経験を、不十分なメンタルヘルス対策、自殺対策の資金不足、うつ病や自殺への偏見といった、社会的な問題とむすびづけている	1.85	1.91
⑩	社会的な活動に参加し、自分の意見を主張している	1.46	1.85

「自死遺族」カテゴリの連続性

最後に、ここまで前提としてきた「自死遺族」という言葉が指し示す範囲を考えておきたい。英語圏、特に北米では suicide survivors という表現が、自殺で遺された人を称して使われることがある。Cercl によると、この survivors という言葉を歴史的にたどると、当初は自殺で遺されることのインパクトを表現するために用いられていたのが、単に遺された人自身を示すようになり、遺された家族や友人という定義が登場し、さらに自殺で遺されたことで強いストレスを感じたものという定義や、関係性があれば親族関係とは限らないという議論などがあった⁴⁾。医学的には誰が強いストレスを感じたかを同定できることが重要であるが、実際に確度の高い予測は難しく、そこで別のアプローチとして死別による外傷体験に暴露したかどうかとする提案もあったという。誰かの自殺を経験して支援ニーズが必要とした人の、故人との関係性を数え上げると家族・友人をはじめ 28 種の関係性が見出せることからその外延的定義もゆらぐこと、あるいは survivors ということばが自殺未遂者と混同しやすいことなど、カテゴリとしての見直しの必要性を示唆した上で、「A nested model of suicide survivorship= 自死遺族性の入れ子モデル」を提案している。つまり、4 重の円を描き、最も外側には suicide exposed= 自殺に暴露、次に suicide affected= 自殺に影響される、さらに suicide bereaved, short term= 自殺で遺された・短期、最も内側の円は suicide bereaved,

long term= 自殺で遺された・長期と示されている。このモデルは、自殺で遺された者の全体像を支援や健康の側面から適切に捉えることができるのではないかと提案している。たとえば家族は、4 つのどの自死遺族性を示す可能性もある。日本においても、自死遺族とは誰なのか、個々の支援はどこまで届くべきなのか、といった議論が必要だろう。

本特集のテーマが家族支援であり、本稿はその 1 つの領域としての自殺であるから、その意味では自死遺族支援という表現が不適切というわけではない。ただし、より広く自殺で遺された者の支援を考えるうえでは、「遺族」という言葉は使い勝手がよくない場合がある。たとえば、セクシャルマイノリティの方がパートナーを自殺で亡くした場合、法的には自死「遺族」ではない。とすると、ここまで述べてきた問題はより複雑になり、たとえば故人の葬儀に出られない、福祉サービスが申請できないといったことが起こる。これらの問題を整理するためにも、狭義の遺族を包含した、より包括的な言葉が必要となる。

また逆に、自殺問題に関連した家族支援をテーマとするなら、自死遺族だけではなく、自殺未遂者家族の支援についても検討すべきであるが、本稿では紙幅の関係で割愛した。自殺未遂が自殺の最大の危険因子であることは知られており、その点では未遂者家族と遺族の間には、支援の連続性が想定されるべき場合がある。たとえば、地域で支援していた自殺未遂者が再企図をして亡くなった場合、それまでの支援者と家族の関係性が、自死遺族支援を容易にする場合もあるし、逆に困難にする場合もあるだろ

う。つまり自殺対策の現場においては、未遂者家族への支援と自死遺族への支援は、連続しているのである。

さらに、自殺対策は自殺の実態把握から始まる。自死遺族は自殺対策において単に支援される存在ではなく、不幸にして起こってしまった経験から学び、より自殺の起こりにくい社会作りに貢献し得る主体であることも確認しておきたい。

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Reply to B. Gyawali et al

We thank Gyawali et al¹ for their questions and concerns regarding our recent report of a randomized controlled trial (RCT) on communication skills training (CST).² Their first comment is that the percentage of oncologists who wanted to participate in our study is lower (19.6%) than expected; they suggest as reasons for this that Japanese oncologists suffer fewer patient complaints and feel confident in communicating with their patients. As we reviewed previous RCTs on communication skills training, we found participant rates of 15% (81 of 550) for oncologists in the report by Razavi et al³ and Delvaux et al,⁴ and 18% for nurses and 55% for physician trainees in the article by Curtis et al.⁵ However, in our study, 11 of 15 (73%) oncologists assigned to the control group participated in the CST workshop after the study. More than 80% of oncologists in Japan reported some perceived burden when communicating bad news to patients.⁶ Therefore, we disagree with the claim by Gyawali et al¹ that the participant rate is low, owing to that Japanese oncologists feel less difficulty with bad news communication. On the other hand, we agree with their claim that many Japanese oncologists may have no time to study communication skills because they are always busy and do not know what benefit CST will provide. Therefore, we believe that our study published in *Journal of Clinical Oncology* will contribute to the promotion of oncologists' understanding of CST.

Second, Gyawali et al¹ express concern that the oncologists in the intervention group might have had more patients who were receiving good news. In this study, 8.4% of the intervention group consultations were for the communication of bad news, 29.1% were for the delivery of good news, and 62.5% were for sharing neutral news; in contrast, 6.0% of control group consultations were for the communication of bad news, 23.6% for good news, and 70.4% for neutral news. The results showed no significant differences ($\chi^2 = 7.74$; $P = .09$).² Another concern was expressed by Gyawali et al with respect to the contents of the CST workshop; specifically, that the workshop might have addressed only bad news and not good news consultations. Although our developed CST workshop program covered three bad news scenarios (diagnosis of advanced cancer, recurrence, and stopping anticancer treatment), which were based on the results of our previous survey for oncologists regarding difficult communication situations,⁷ the program included not only specific communication skills (based on the results of our previous surveys of patients' preferences),^{8,9} but also many fundamental skills. It is difficult to assess the effect of the CST program on real-life clinical consultations, because many of the desired behaviors are context dependent. For example, an oncologist will have more opportunity to make an empathic response or respond to cues if the patient expresses his/her emotion or psychosocial concerns. However, in this study, no attempt was made to select certain types of consultations or patients. It was impossible to ensure that the context (good/bad news) or reason for consulting (new diagnosis/routine follow-up) was constant for an individual oncologist at each time point. Despite these limitations, the patient outcomes could be assessed well in the real-world practice.

Third, we agree with the claim by Gyawali et al¹ that patients with advanced or newly diagnosed disease might be more prone to anxiety and depression. In this study, the number of patients with recurrence or metastasis in the two groups was not significantly different ($\chi^2 = 2.89$; $P = .236$).² Although the percentage of patients currently receiving treatment was different among the two groups (40.4% in the intervention v 27.5% in the control group),² we do not think this skewed the results. The levels of psychological distress, satisfaction with the oncologist, and trust in the oncologist expressed by patients currently receiving treatment were significantly worse compared with levels expressed by patients not currently undergoing treatment (respectively, $t = -1.97$ and $P = .049$; $t = 3.83$ and $P = .001$; $t = 3.29$ and $P < .001$). We used real-world clinical settings with consecutive and consenting patients because that is likely the realistic approach for identifying effects of a CST program on patient outcomes.

Fourth, we calculated and showed 13 participants in each group as a sample size to detect a significant between-group difference in our study on the basis of the results of difference in empathic behavior in our previous open-label trial.¹⁰ Furthermore, we showed the desired sample size, including missing values, in our study protocol.

Because communication is interaction between persons, and personal reaction and experience are subjective, it is difficult to perform an objective and scientific assessment of communication. Despite these many limitations, many additional efforts in this research area are expected because communication between patients and oncologists is an important issue.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the authors are available with this article at www.jco.org.

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Effect of Communication Skills Training Program for Oncologists Based on Patient Preferences for Communication When Receiving Bad News: A Randomized Controlled Trial

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ABSTRACT

Purpose

The aim of this study was to identify the effects of a communication skills training (CST) program for oncologists, developed based on patient preferences regarding oncologists' communication.

Participants and Methods

Thirty oncologists were randomly assigned to either an intervention group (IG; 2-day CST workshop) or control group (CG). Participants were assessed on their communication performance during simulated consultation and their confidence in communicating with patients at baseline and follow-up. A total of 1,192 patients (response rate, 84.6%) who had consultations with the participating oncologists at baseline and/or follow-up were assessed regarding their distress using the Hospital Anxiety and Depression Scale, satisfaction with the consultation, and trust in their oncologist after the consultation.

Results

At the follow-up survey, the performance scores of the IG had improved significantly, in terms of their emotional support ($P = .011$), setting up a supportive environment ($P = .002$), and ability to deliver information ($P = .001$), compared with those of the CG. Oncologists in the IG were rated higher at follow-up than those in the CG in terms of their confidence in themselves ($P = .001$). Patients who met with oncologists after they had undergone the CST were significantly less depressed than those who met with oncologists in the CG ($P = .027$). However, the CST program did not affect patient satisfaction with oncologists' style of communication.

Conclusion

A CST program based on patient preferences is effective for both oncologists and patients with cancer. Oncologists should consider CST as an approach to enhancing their communication skills.

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INTRODUCTION

A number of studies examining patient-physician communication in cancer consultations have revealed numerous difficulties, because patients with cancer suffer from intense emotional anguish, particularly when they receive bad news about their disease. The ability of physicians to empathize—defined in medical settings as a “cognitive attribute and behavior that involves an understanding of experiences, concerns and perspectives of the patient”^{1(p1183)}—has been effective in helping patients adjust to a life-threatening disease^{2,3} and correlated with a low level of psychological distress.⁴ Therefore, communication between patients and physicians has been viewed as a core clinical skill that merits a considerable investment of time and resources in training.

Communication skills training (CST) is reported to be effective in improving physicians' communication skills, such as using open questions and showing empathy toward patients; it is recommended for medical staff. However, there is no evidence to support a beneficial effect of CST on patients' mental health or patient satisfaction.⁵ One possible reason for this is that findings have been based only on experts' and oncologists' opinions and have not necessarily reflected those of patients.⁶⁻⁹ Oncologists' communication behaviors preferred by patients were linked in a previous study to lower psychological distress and higher satisfaction in patients.¹⁰ Therefore, interventions to enhance oncologists' communication skills that take into account patients' preferences for receiving information are needed.^{7,10}

Our previous quantitative and qualitative surveys revealed that patient preferences regarding the

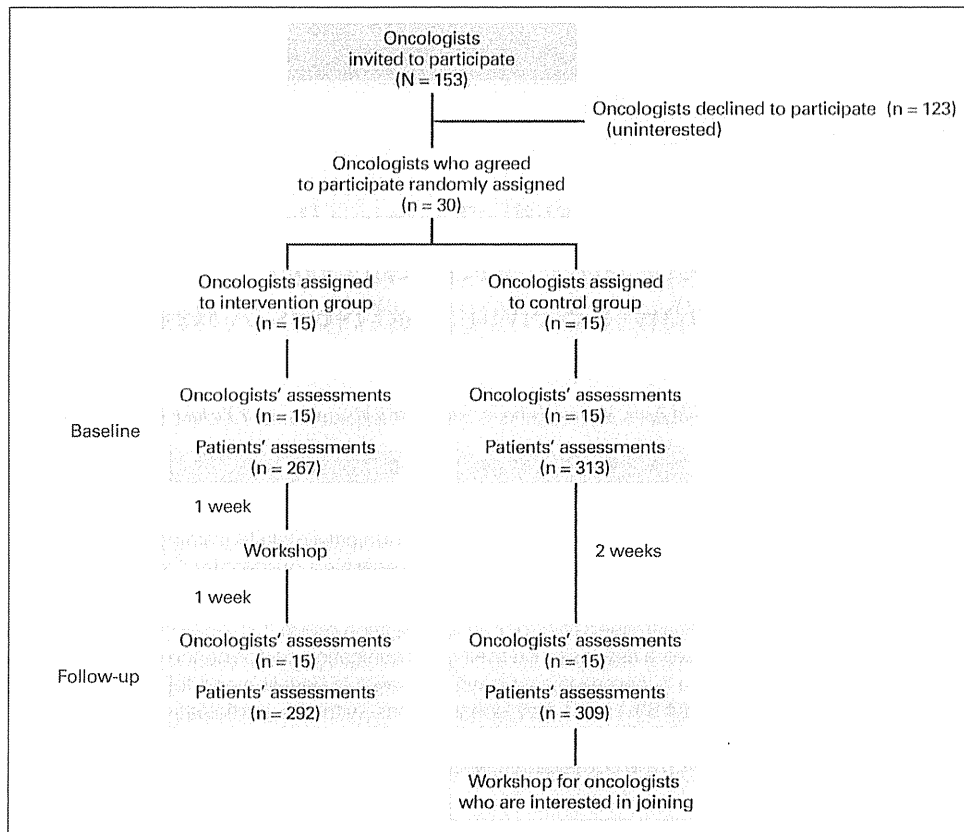


Fig 1. Study flow diagram.

communication of bad news consist of four factors: setting, how the news is delivered, provision of various types of information, and emotional support.¹¹ Emotional support has also been found to be the most important factor for patients.¹² On the basis of these findings, we previously developed a 2-day CST program. This program was intended to improve the empathic communication and effective behaviors of oncologists and their confidence in their ability to communicate with patients.¹³

Building on this work, the aim of this study was to identify the effects of this CST program for oncologists, using patient preferences, by evaluating oncologists' behaviors during simulated consultation, their confidence in communicating with patients, and patients' distress and satisfaction with the consultation.

PARTICIPANTS AND METHODS

Participants

Oncologists. Staff of the National Cancer Center (NCC) Hospital, Tokyo, and Hospital East, Chiba, Japan, were recruited.

Patients. Outpatients who were attending follow-up medical appointments with oncologists at the NCC hospitals were recruited after consultation. The eligibility criteria were as follows: patients who had received a diagnosis of cancer, were age ≥ 20 years, were judged capable of completing the survey physically and cognitively, and were capable of understanding spoken and written Japanese.

All participants were given information about this study and provided written informed consent. The institutional review board and ethics committee of the NCC approved this study.

Procedures

After providing informed consent, oncologists were randomly assigned to an intervention group (IG; 2-day CST workshop) or control group (CG). The study flow diagram is shown in Figure 1.

The baseline survey required oncologists to participate in a simulated consultation, in which they relayed a diagnosis of incurable advanced cancer to a simulated patient (SP), and to complete a questionnaire requesting information about their demographic characteristics (age, sex, and marital status), medical experience (specialty, clinical experience, and clinical experience in oncology), and perceived confidence in communicating with a patient. On days when a participating oncologist had consultations in the outpatient clinic, all eligible outpatients were invited to participate in the study after their follow-up medical visit. Patients who provided written informed consent were asked to complete and return within 1 week a series of questionnaires evaluating their psychological distress (Hospital Anxiety and Depression Scale [HADS]), their satisfaction with their oncologist's communication during the consultation, their trust in the oncologist, and their demographic characteristics. If the questionnaires contained any blanks, a single attempt was made to obtain the missing information by telephone or mail.

After the CST workshop in the IG or 2 weeks after baseline in the CG, the same variables collected at baseline were collected as follow-up data. After the follow-up survey, the oncologists assigned to the CG were allowed to participate in the workshop if they desired.

Workshop

Table 1 lists components of the CST program based on the SHARE model. In accordance with our previous surveys of the preferences of Japanese patients with cancer regarding the disclosure of bad news,^{11,12,14,15} the CST program adopted the conceptual communication skills model consisting of four dimensions, referred to as SHARE: S, setting up a supportive environment for the interview; H, considering how to deliver the bad news; A,

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Table 1. Components of CST Program Based on SHARE Model

Component	Description
Conceptual communication skills model: SHARE	
S	Setting up supportive environment for interview (eg, greeting patient cordially, looking at patient's eyes and face)
H	Considering how to deliver bad news (eg, not beginning bad news without preamble, checking to see whether talk is fast paced)
A	Discussing additional information that patient would like to know (eg, answering patient's questions fully, explaining second opinion)
RE	Providing reassurance and addressing patient's emotions with empathic responses (eg, remaining silent out of concern for patient's feelings, accepting patient's expression of emotions)
Module	
Lecture	Introduction, communication skills model, evidence of preferences of patients with cancer regarding communication
Video trigger	Delivering bad news using communication skills
Role playing	Delivering bad news using communication skills with scenarios
Peer discussion	Solving problems occurring in role playing, final summary
Scenarios for breaking bad news	Diagnosis of advanced cancer Recurrence Stopping anticancer treatment
Small-group setting	Four participants Two facilitators One simulated patient
Schedule	
Day 1	Orientation (10 minutes) Icebreaking (20 minutes) Lecture (30 minutes) Video trigger (30 minutes) Role playing with peer discussion (60 minutes × 4)
Day 2	Role playing with peer discussion (60 minutes × 4) Summary (30 minutes)

Abbreviation: CST, communication skills training.

discussing various additional information that patients would like to know; and RE, providing reassurance and addressing patients' emotions with empathic responses. The program particularly emphasized the RE component, because it has been shown to be the most important for patients^{11,15} and also to be one of the most difficult communication skills for oncologists.¹⁵ The face validity of the conceptual model in the CST program and the feasibility of the CST program were confirmed by two psychiatrists, one psychologist, and two oncologists who were experienced attending staff in clinical oncology, with knowledge about communication between patients and oncologists; this was achieved using the Delphi method¹⁶ after reviewing previous studies and by holding preliminary workshops before this study.

The program was a participant-centered approach and consisted of an icebreaking discussion, a 1-hour computer-aided didactic lecture with text and video, 8 hours of role playing with SPs, and discussions on this role playing. It lasted a total of 2 days and was based on previous studies.^{5,17,18} The lecture provided during this program cited evidence of the most important and common patient preferences regarding the communication of bad news, such as empathic responses and encouragement to ask questions, as well as variability of patients' preferences, such as discussion of prognosis and being dispassionate, and showed how to check and elicit patient preferences. After this lecture, the oncologists were divided into groups of four, with two facilitators each, for role playing and discussion. During the role playing and discussion, the participants were required to consider a patient's emotions and concerns caused by bad news, cognition of his or her disease, social situation, and information that he or she would want to know, by empathizing with the patient. Facilitators led the role playing and discussion on the potential communication-related preferences and emotions of the patient. The facilitators were psychiatrists, psychologists, and oncologists, all of whom had ≥ 3 years of clinical experience in oncology and had participated in specialized 30-hour training workshops for facilitating communication skills in oncology. The SPs, individuals who had

≥ 3 years of experience in medical school, also participated in the 30-hour training workshops. For the role playing, many scenarios were drawn up tailored to each oncologist's specialty, presenting three different situations that required the sharing of bad news with a patient: diagnosis of advanced cancer, recurrence of cancer, and cessation of anticancer treatment. In a previous study, these situations were found to be difficult to deal with in practice by oncologists.¹⁸

Oncologists' Outcome Measure

Objective performance of communication skills. We videotaped the oncologists' performance during simulated consultations at baseline and follow-up. Each simulation involved a total of four SPs, who had ≥ 3 years of experience in medical school and had been trained in simulating the standard reactions of patients for ≥ 60 hours via a manual. On the basis of previous study methods,^{13,19} the frequencies of each type of performance and utterance during their consultations were assessed using the 27 SHARE categories for analyzing the impressions of oncologists' performance (Table 2). Each video was coded in terms of SHARE category in a random order by two blinded coders, who had been trained for 30 hours for this task independently on two occasions with a rating manual. The averages of the intracoder correlation coefficients for each group of categories were 0.79 (range, 0.72 to 0.92) and 0.76 (range, 0.70 to 0.94), and the average of the intercoder correlation coefficient was 0.78 (range, 0.58 to 1.00).

Confidence in communication with patients. Confidence in communicating with patients was assessed using two questionnaires consisting of 32 items related to SHARE^{11,13,19} and 21 items established by Baile et al.^{13,17,20} All items were rated on a 10-point Likert scale, ranging from "not at all" to "extremely." The total scores (SHARE: range, 32 to 320; confidence questionnaire: range, 21 to 210) were used to rate oncologists' confidence in communicating with patients.

Table 2. Comparison of Mean Total Performance Score for Physicians During Consultation Over Time and Between Groups

Communication Skill	Baseline				Follow-Up				F	P	Bonferroni Correction*
	IG		CG		IG		CG				
	Mean	SD	Mean	SD	Mean	SD	Mean	SD			
Setting up supportive environment for interview	8.73	1.83	7.87	2.00	10.93	2.09	8.13	1.92	11.98	.002	X
Greeting patient cordially	1.00	1.73	0.53	1.41	3.20	1.66	0.67	1.45	18.14	< .001	X
Looking at patient's eyes and face	3.73	0.59	3.73	0.59	3.87	0.52	3.73	0.46	2.06	.163	
Taking sufficient time	4.00	0.00	3.60	1.06	3.87	0.35	3.73	0.80	0.08	.775	
Considering how to deliver bad news	18.53	5.24	15.73	7.40	25.93	8.57	14.67	7.01	13.18	.001	X
Encouraging patient to ask questions	3.33	1.11	2.20	1.82	3.27	1.44	2.13	1.88	0.41	.528	
Not beginning bad news without preamble	2.13	2.07	2.00	1.77	4.20	1.08	1.73	1.98	20.50	< .001	X
Asking how much patient knows about his or her illness before breaking bad news	0.00	0.00	0.47	1.25	2.13	2.07	0.73	1.53	5.76	.024	
Not using technical words	2.93	1.49	2.73	1.58	3.60	1.30	3.07	1.22	1.23	.278	
Using actual images and test data	3.47	1.41	2.13	2.07	3.20	2.24	2.33	1.99	0.24	.629	
Writing on paper to explain	3.20	1.66	3.20	1.66	2.93	1.83	3.20	1.66	0.23	.636	
Checking to see that patient understands	2.27	1.83	2.13	1.81	3.13	1.92	1.20	1.70	8.33	0.008	
Checking to see whether talk is fast paced	0.53	1.13	0.33	0.90	1.67	2.29	0.00	0.00	9.29	.005	X
Communicating clearly main points of bad news	0.67	1.45	0.53	1.41	1.80	1.90	0.27	1.03	7.52	.011	
Discussing additional information	17.00	3.27	16.67	4.69	18.93	5.04	15.67	4.65	4.11	.053	
Answering patient's questions fully	4.00	0.00	3.60	0.91	4.07	0.26	3.73	0.59	0.98	.331	
Explaining status of patient's illness	3.73	0.46	3.73	0.46	3.80	0.41	3.47	1.06	2.32	.139	
Telling prospects of cancer cure	3.13	1.55	2.93	1.53	3.47	1.81	2.67	1.45	1.64	.211	
Providing information on services and support	0.33	1.05	0.53	1.41	0.27	1.03	0.27	1.03	11.15	.002	X
Discussing patient's everyday life and work in future	1.67	1.68	1.87	1.92	1.87	1.92	1.87	1.64	0.02	.963	
Explaining second opinion	0.27	1.03	0.27	1.03	1.33	1.95	0.00	0.00	7.27	.012	
Checking questions	3.87	0.52	3.73	0.70	4.13	0.52	3.67	0.72	4.40	.045	
Providing reassurance and addressing patient's emotions with empathic responses	18.67	5.91	15.33	7.19	22.53	7.81	13.80	7.17	7.45	.011	X
Asking about patient's worries and concerns	1.33	1.72	1.60	1.76	1.07	1.71	1.27	1.58	0.07	.796	
Using words to mentally prepare patient	3.53	1.13	1.07	1.67	3.47	1.41	0.80	1.42	0.32	.575	
Remaining silent out of concern for patient's feelings	0.47	1.13	1.27	1.53	2.20	1.78	0.67	1.45	9.59	.005	X
Accepting patient's expression of emotions	2.40	1.68	1.73	1.83	3.53	0.83	1.40	1.92	17.64	< .001	X
Using words that soothe patient	1.60	2.03	2.00	1.89	2.80	2.21	1.67	1.99	9.29	.005	X
Explaining in way that incorporates hope	3.93	0.26	3.13	1.55	3.60	1.12	3.27	1.22	1.11	.300	
Explaining what patient can hope for	4.00	0.00	3.07	1.33	3.87	0.52	3.40	1.18	0.78	.389	
Assuming responsibility for patient's care until end	1.40	1.50	1.47	1.64	2.00	2.17	1.33	1.76	1.40	.247	

Abbreviations: CG, control group; IG, intervention group; SD, standard deviation.

*Level of significance of each factor, $P < .013$; categories are as follows: setting up supportive environment for interview, $P < .017$; considering how to deliver bad news, $P < .006$; discussing additional information, $P < .007$; providing reassurance and addressing patient's emotions with empathic responses, $P < .006$.

Patients' Outcome Measure

Patients' distress. The Japanese version of HADS²¹ was used to measure patients' distress.²² The HADS is a self-administered and standardized instrument for evaluating patients' distress. It consists of 14 items grouped into two factors: anxiety (HADS-A, seven items) and depression (HADS-D, seven items). Each item is rated on a 4-point (0 to 3) Likert scale.

Patient satisfaction with consultation. Patient satisfaction with their oncologist's performance during consultation was assessed using an 11-point (0 to 10) numeric rating scale.

Patient trust in oncologist. Patient trust in their oncologist was assessed using an 11-point (0 to 10) numeric rating scale.

Statistical Analysis

The demographic characteristics of the oncologists and patients were compared among groups using the χ^2 or t test as required. Time change in the baseline and follow-up surveys of the factors and items related to oncologists' performance and the total score of oncologists' confidence questionnaires were analyzed using one-way analysis of variance (ANOVA) with controlled baseline data. Before ANOVA, Levene's test for equality of variances between groups (IG and CG) was used. Bonferroni correction was used to determine which items of oncologists' performance differed among the groups. For

patients' outcome data (each factor of HADS, satisfaction, and trust) at the follow-up survey, we used generalized linear mixed models. The models included fixed effects for group (IG and CG) and the intercept and a random effect for clustering of patients within oncologists. The sample size was computed based on the main outcome: total RE scores (range, 8 to 80) of the SHARE model. On the basis of our previous study,¹³ 13 oncologists per group were needed to detect a 6.2-point (standard deviation [SD], 5.5) change with power of 80% at $\alpha = 0.05$. Statistical significance was set at $P < .05$ for all analyses. The statistical analysis was performed using SPSS version 21.0 software (SPSS, Chicago, IL).

RESULTS

Oncologist Characteristics

Thirty (19.6%) of 153 oncologist candidates returned the consent form, whereas the others chose not to participate. Although there was no significant difference in specialty between the participants and nonparticipants ($\chi^2 = 0.76$; $P = .859$), there was a significant

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Table 3. Participant Characteristics

Characteristic	IG (n = 15)		CG (n = 15)		t	P
	Median ± SD	Range	Median ± SD	Range		
Age, years	38 ± 5.4	33-54	38 ± 5.5	35-50	-1.34	.192
Clinical experience, years	15 ± 5.3	9.3-30.3	14.5 ± 5.4	9.5-25.0	-1.17	.252
Clinical experience in oncology, years	10 ± 5.5	3.0-22.3	13.3 ± 6.1	6.1-25.0	-1.82	.080
	IG (n = 15)		CG (n = 15)		χ ²	P
	No.	%	No.	%		
Sex					0.00	1.000
Male	13	86.7	13	86.7		
Female	2	13.3	2	13.3		
Oncology specialty					1.06	.589
Surgical	9	60.0	8	53.3		
Medical	6	40.0	6	40.0		
Radiation	0	0.0	1	6.7		

Abbreviations: CG, control group; IG, intervention group; SD, standard deviation.

difference in sex ($\chi^2 = 6.31$; $P = .012$). The rate of participation among women (five of 11; 46%) was significantly higher than that among men. There was no significant difference in any participant characteristics between IG and CG (Table 3).

Performance of communication skills. For the 30 oncologists, we obtained evaluable videos of consultations in which bad news was relayed to an SP at baseline and follow-up. One-way ANOVA revealed significant differences in three of four factors and seven of 27 categories of SHARE (Table 2).

Confidence in communication with patients. There were significant differences by one-way ANOVA in the mean scores (\pm SD) of confidence in SHARE communication between the groups (IG: $\Delta = 22.5 \pm 34.4$; CG: $\Delta = -17.1 \pm 26.1$; $F = 13.7$; $P = .001$) and communication of bad news between the groups (IG: $\Delta = 19.2 \pm 19.6$; CG: $\Delta = -2.4 \pm 15.4$; $F = 11.2$; $P = .002$).

Patient Characteristics

In total, 1,181 of the 1,397 candidates who visited outpatient clinics were recruited to participate in the survey after consultation; 44 were excluded because of a physical or psychological problem, and 120 were not contacted because of refusal to participate or an inability to contact them. Of these 1,181, at baseline, 267 patients in the IG and 313 patients in the CG participated in the questionnaire survey; at follow-up, there were 292 patients in the IG and 309 patients in the CG (response rate, 84.6%). Thirteen to 32 patients were surveyed for each oncologist at baseline and follow-up. The correlation coefficient of the numbers at baseline and follow-up was $r = 0.60$ ($P < .001$). Patient characteristics at baseline and follow-up surveys, except for cancer type and current treatment status, were not significantly different between the IG and CG (Table 4).

Patient distress, satisfaction with consultation, and trust in oncologist. At the baseline survey, no score (\pm SD) was significantly different between the groups (HADS-A: mean, 5.48 ± 3.77 in IG; mean, 5.20 ± 3.79 in CG; HADS-D: mean, 5.20 ± 3.64 in IG; mean, 5.44 ± 4.30 in CG; HADS total: mean, 10.67 ± 6.82 in IG; mean, 10.65 ± 7.58 in CG; satisfaction with oncologist's communication: mean, 8.56 ± 1.68 in IG; mean, 8.44 ± 1.94 in CG; trust in oncologist: mean, 9.14 ± 1.40 in IG; and mean, 9.06 ± 1.64 in CG).

At the follow-up survey, the HADS-D score was significantly lower and the rating score of trust in oncologists was significantly higher for patients who met with oncologists from the IG compared with those of patients who met with oncologists from the CG. Conversely, there was no significant difference between these two groups regarding the HADS-A score, the HADS-total score, or patient satisfaction (Table 5).

DISCUSSION

To our knowledge, this is the first report to demonstrate the effect of CST on breaking bad news for oncologists in improving the psycho-

Table 4. Patient Characteristics at Follow-Up

Characteristic	IG (n = 292)		CG (n = 309)		χ ²	P
	No.	%	No.	%		
Age, years					0.29	.769
Median	64		64			
SD	10		10			
Male sex	179	61.3	190	61.5	0.00	.962
Employed	109	38.3	115	38.1	1.11	.576
Married	237	83.2	251	83.1	0.00	.979
Living alone	21	7.4	20	6.6	0.14	.714
Educational level ≤ 9 years	46	16.2	59	19.4	1.11	.293
Type of oncology specialist					21.47	< .001*
Surgical	193	66.1	175	56.6		
Medical	99	33.9	114	36.9		
Radiation	0	0.0	20	6.5		
Experience of bad news					2.89	.236
Cancer diagnosis	292	100.0	309	100.0		
Recurrence or metastasis	66	22.6	87	28.2		
Stopping anticancer treatment	0	0.0	0	0.0		
Currently receiving treatment	118	40.4	85	27.5	11.17	.001*
Consultation to deliver bad news	24	8.4	18	6.0	4.75	.093

Abbreviations: CG, control group; IG, intervention group; SD, standard deviation.
* $P < .01$.

Table 5. Comparison of Patient Psychological Distress, Perceived Communication, and Satisfaction Between Groups at Follow-Up

Factor	IG		CG		F	P
	Mean	SD	Mean	SD		
HADS						
Anxiety	4.83	3.75	5.17	3.42	0.94	.333
Depression	4.59	3.75	5.32	4.04	4.94	.027*
Total distress	9.36	6.93	10.50	6.90	3.85	.050
Satisfaction with oncologist communication	8.58	1.62	8.35	1.74	2.80	.095
Trust in oncologist	9.15	1.28	8.87	1.54	6.89	.009*

Abbreviations: CG, control group; HADS, Hospital Anxiety and Depression Scale; IG, intervention group; SD, standard deviation.

* $P < .05$.

logical distress of patients with cancer, as well as oncologist performance and confidence in communicating with patients, using a randomized design. Reasons for our positive results might include that the CST program had been developed based on patient preferences regarding the communication of bad news^{11,12} and oncologists' needs.¹⁷ Health professionals benefit by learning valuable communication strategies and reviewing the application of their skills in simulated clinical situations.²³ Hence, our study might have met these oncologists' needs and effectively helped them to provide more culturally appropriate support for their patients.

The results of the oncologists' performance and confidence showed that they had acquired emotional support skills after the CST, as in previous studies. Significant learning of new empathic skills occurred, including the use of silence and accepting a patient's expression of emotions, in contrast to the already well-established practices of offering hope, explaining the clinical findings, maintaining eye contact, and avoiding jargon. All communication skills dealt with in the CST program, such as the additional use of a preamble, checking the patient's current understanding of the illness, checking how well the news has been assimilated, and offering a second opinion, became new skills that enhanced oncologists' repertoire for dealing with difficult situations clinically. Interestingly, these increased performance skills did not prolong the consultation time. This result suggests the possibility that a patient's psychological distress can be reduced without increasing demands on oncologists in busy clinical practice.

These positive results might also have been influenced by the culture and attitude of Japanese patients and the basically poor support system for patients with cancer that currently exists in Japan. Although Japanese patients with cancer do not typically seek professional assistance for psychological problems caused by their cancer experience and usually repress their emotions about having cancer,²⁶ they need emotional support from their oncologists.^{11,12,14} Improved communication behaviors among oncologists could thus alleviate the psychological distress of patients. This interpretation can be confirmed by the results of the oncologists' improved performance; that is, oncologists who participated in CST were more empathic.

This study showed that patients in the IG demonstrated less psychological distress and more trust in oncologists than those in the CG. However, we found no significant difference in the level of satisfaction of patients as a result of CST for oncologists.^{27,28} The absence

of such an effect suggests that a ceiling effect occurred for satisfaction scores in this study. Specifically, 61% of patients gave the maximum satisfaction score. Patient satisfaction studies generally report a high level of satisfaction,²⁶ which is taken to indicate a high quality of service. However, some patients may be afraid of hurting their oncologists' feelings if they express dissatisfaction with their health care. This can be a particular concern for patients with cancer in view of the potentially life-threatening nature of their illness.²⁸ Another problem has also been suggested regarding the validity of tools used to measure satisfaction.²⁹ In particular, few questionnaires are visit specific or deal with just one physician rather than the entire experience of visiting a hospital.⁵

Some limitations of this study should be noted. First, the rate of participation here was only approximately 20% of recruited senior oncologists from two institutions, both comprehensive cancer center hospitals. However, this is not particularly low, because recruitment for this kind of intervention study is difficult, as described in previous studies.^{23,30,31} Although there was a sex difference in the rate of participation, women numbered only 11 (7.2%) of the 153 oncologists. We could also not obtain any other data on the oncologists who declined to participate, besides their specialty and sex. The identification of oncologists' demographic factors associated with participation in the CST might be important when applying the CST program to a medical education setting. Furthermore, this study has only shown the positive effects of the CST on subjective and objective measurements of oncologists' communication skills for experienced attendees with extensive experience of oncology in a comprehensive cancer center. However, medical students or residents might be expected to benefit more from participation in CST than highly skilled oncologists, such as those in this study. Second, this study showed only short-term effects and did not evaluate the long-term effects on oncologists. However, previous studies have shown that oncologists who participated in a CST workshop maintained their communication skills at a high level 1 year later, but future studies need to evaluate the long-term effects. Third, this study included patients who were newly diagnosed as well as patients participating in follow-up visits; however, this is realistic for identifying the effects of a CST program on actual patient outcomes in a clinical context.

Although additional studies are needed to resolve these limitations, this work shows that communication skills that comply with patient preferences can be taught to oncologists, and their use decreases patient distress. Our study might thus provide encouragement and a direction for future research in the application of CST for more health professionals in oncologic practice to help oncologists deal with unrecognized distress among patients diagnosed with cancer.

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The author(s) indicated no potential conflicts of interest.

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Development and preliminary evaluation of communication skills training program for oncologists based on patient preferences for communicating bad news

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ABSTRACT

Objective: The purposes of this study were to develop a communication skills training (CST) workshop program based on patient preferences, and to evaluate preliminary feasibility of the CST program on the objective performances of physicians and the subjective ratings of their confidence about the communication with patients at the pre- and post-CST.

Methods: The CST program was developed, based on the previous surveys on patient preferences (setting up the supporting environment of the interview, making consideration for how to deliver bad news, discussing about additional information, and provision of reassurance and emotional support) and addressing the patient's emotion with empathic responses, and stressing the oncologists' emotional support. The program was participants' centered approach, consisted a didactic lecture, role plays with simulated patients, discussions and an ice-breaking; a total of 2-days. To evaluate feasibility of the newly developed CST program, oncologists who participated it were assessed their communication performances (behaviors and utterances) during simulated consultation at the pre- and post-CST. Participants also rated their confidence communicating with patients at the pre-, post-, and 3-months after CST, burnout at pre and 3 months after CST, and the helpfulness of the program at post-CST.

Results: Sixteen oncologists attended a newly developed CST. A comparison of pre-post measures showed improvement of oncologists' communication performances, especially skills of emotional support and consideration for how to deliver information. Their confidence in communicating bad news was rated higher score at post-CST than at pre-CST and was persisted at 3-months after the CST. Emotional exhaustion scores decreased at 3-months after CST. In addition, oncologists rated high satisfaction with all components of the program.

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