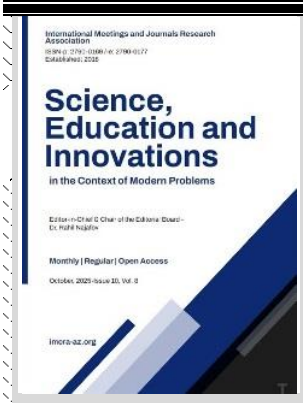

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Title of research article

Expanding the Role of Oncology Nurses in the Identification and Treatment of Depression Among Cancer Patients: Clinical Perspectives, Challenges, and Integrated Care Approaches

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Keywords Cancer Patients; Depression; Oncology Nurses; Psycho-Oncology; Primary Care; Therapy; Interdisciplinary Collaboration

Abstract

Depression is one of the most common psychiatric comorbidities observed in patients with cancer, with prevalence rates ranging between 10% and 50% depending on the severity of illness and clinical setting. It is associated with diminished quality of life, impaired treatment adherence, prolonged hospitalization, and increased healthcare utilization, thus placing a considerable burden on patients, families, and health systems. Despite its clinical importance, depression often remains under recognized in oncology practice, primarily due to overlapping somatic symptoms, time constraints faced by physicians, and persistent stigma surrounding mental health referrals. Consequently, many cancer patients either do not receive adequate treatment or are prescribed subtherapeutic regimens with limited access to evidence-based psychotherapy.

This study addresses these challenges by exploring the possibility of expanding the professional role of oncology nurses to include active involvement in the screening, early identification, and management of depression in cancer patients. Drawing on pilot programs and empirical evidence from psycho-oncology research, the paper highlights how oncology nurses, when appropriately trained, can administer validated screening tools, deliver structured psychosocial support, monitor patient progress, and collaborate effectively within multidisciplinary teams. Such an integrated approach not only reduces the treatment gap but also minimizes the stigmatizing effect of external psychiatric referrals, as patients tend to trust oncology nurses with whom they already share a therapeutic relationship.

Furthermore, the paper discusses practical considerations, including the need for specialized training modules, peer support systems, adequate staffing, and institutional policies that formally recognize mental health care as part of oncology services. The intervention underscores that structural investment in infrastructure must be

complemented by professional engagement and interdepartmental collaboration to achieve meaningful improvements. By broadening the scope of oncology nursing practice, health systems can create sustainable, patient-centered models of care that integrate mental health management into routine oncology practice, ultimately improving survival outcomes, psychosocial well-being, and quality of life for patients living with cancer.

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1. Introduction

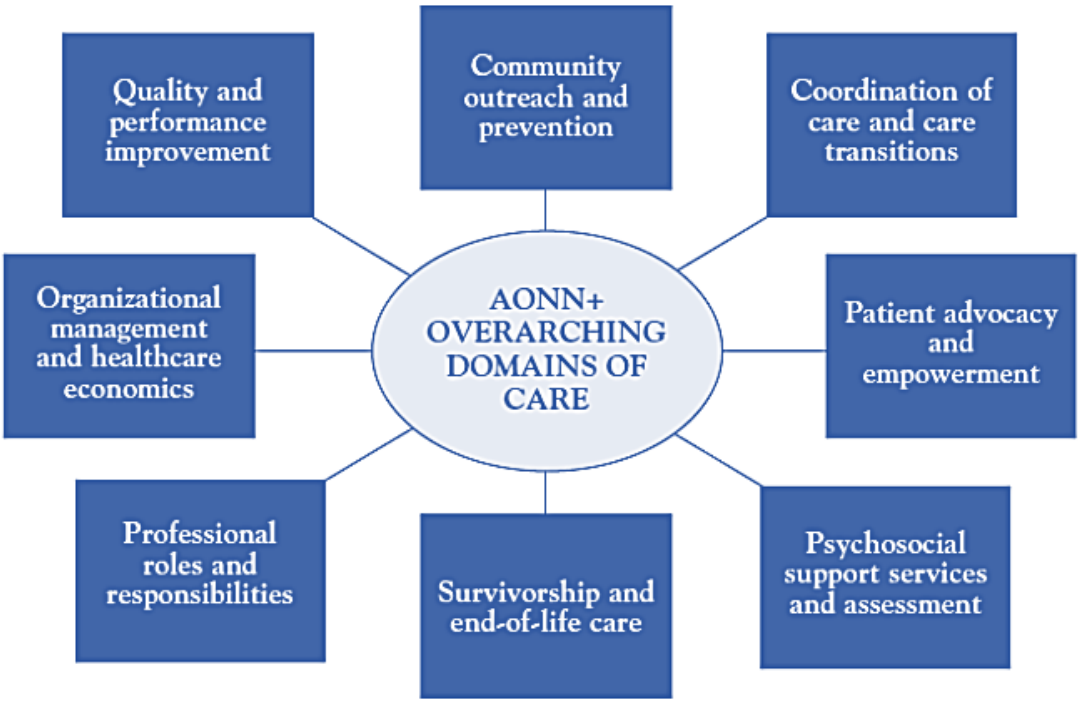
Depression represents one of the most frequent psychological comorbidities among medically ill patients, particularly those diagnosed with cancer. Comorbid depression refers to the onset of depressive symptoms in patients concurrently experiencing another medical condition such as malignancy. Major depressive disorder (MDD), the most severe form of depression, has been recognized by psychiatrists as clinically significant, contributing to heightened somatic symptoms, increased disability, diminished quality of life, and poorer treatment outcomes [1]. The presence of depression has also been linked to greater caregiver burden and increased utilization of hospital resources.

Despite these concerns, many patients with comorbid depression attending primary care or oncology clinics remain inadequately treated. This inadequacy is largely attributable to two interrelated challenges: (i) depression is frequently underdiagnosed due to overlapping symptoms with cancer and treatment side effects, and (ii) even when recognized, therapeutic interventions are often insufficient, with only a small proportion of patients receiving antidepressants at therapeutic dosages or referrals to evidence-based psychotherapy [2]. The present study seeks to address these systemic shortcomings by exploring targeted interventions in oncology settings.

Epidemiological research indicates that major depression occurs in approximately 10–50% of cancer patients, with the highest prevalence among inpatients with advanced disease or at end-of-life stages. Ideally, all cancer patients experiencing significant depressive symptoms should have immediate access to specialized mental health services. However, in countries such as the United Kingdom, the provision of counseling psychologists and liaison psychiatry within oncology departments is insufficient to meet clinical needs. Furthermore, referrals to external psychiatric care are often perceived as stigmatizing, leading many patients to reject such support [3].

This context highlights the urgency of developing reliable screening instruments for psychological distress and expanding the role of oncology nurses to incorporate depression management. Properly trained oncology nurses could not only help address shortages of mental health specialists but also contribute to an integrated model of care. This approach minimizes the risk of stigmatization while ensuring continuity of psychosocial support. Figure 1 illustrates the overarching domains of care established by the Association of Oncology Nurse & Patient Navigators (AONN+), underscoring the broad competencies required for delivering high-quality, patient-centered oncology services [JONS].

Figure 1. Oncology Nurse & Patient Navigators (AONN+) overarching domains of care. Oncology nurses must demonstrate competence across multiple care domains to ensure holistic and patient-centered oncology practice.



While some studies have reported benefits of involving non-psychiatric nurses in the psychosocial care of cancer patients, few investigations have systematically examined the feasibility of oncology nurses taking a lead role in the management of depression [4]. Previous research demonstrated that nurse monitoring and counseling could reduce psychological distress, though patients with persistent symptoms were referred to psychiatrists. Nonetheless, oncology nurses were not primary providers of depression therapy in these studies. Moreover, although liaison psychiatric nurses have been involved in supporting oncology patients, evaluations of oncology nurses delivering structured depression management remain limited [5].

The present research therefore explores the feasibility of empowering specially trained oncology nurses to assume a more active role in the treatment of major depression among cancer outpatients. Drawing on reflective practice records and supervisory notes, the study further addresses implications for nursing practice, ethical responsibilities, and systemic integration. Oncology nurses are positioned uniquely to combine medical, psychosocial, and educational roles, including:

- assessing patients' physiological and psychological status,
- obtaining comprehensive nursing histories,
- reviewing laboratory and imaging results,
- ensuring communication of expected outcomes with oncologists, and
- preparing patients physically and psychologically for therapy.

By integrating these competencies, oncology nurses can strengthen patient understanding, adherence, comfort, and long-term outcomes.

Findings

The study highlights that trained oncology nurses can effectively identify depressive symptoms and initiate supportive interventions, reducing the treatment gap for cancer patients. Their involvement leads to earlier referrals, improved patient engagement, and reduced stigma compared to external psychiatric referrals. However, barriers include high workloads, lack of ongoing supervision, and limited institutional recognition of psycho-oncology roles.

Actuality

Integrating mental health support into oncology care is increasingly urgent. With limited numbers of psychiatrists and psychologists in many health systems, oncology nurses represent a critical workforce to bridge the gap between cancer treatment and psychosocial support. Expanding their scope aligns with global trends in holistic and patient-centered cancer care.

1.1 Nurse-Delivered Intervention

The study examined the feasibility and potential effectiveness of a nurse-delivered intervention for depression among cancer patients. Ethical approval was secured, and all patients provided written informed consent. The protocol sought to educate patients about depression as a legitimate medical condition requiring treatment, while simultaneously encouraging them to take an active role in their care [6].

The intervention employed multiple therapeutic strategies, including:

- provision of accurate information about depression,
- reinforcement of active problem-solving approaches,
- guided evaluation of benefits and risks associated with antidepressant therapy, and
- coordination of care with general practitioners (GPs) and oncology specialists to ensure integrated management of depression.

The intervention consisted of up to ten individual sessions (approximately 40 minutes each) delivered across three months. The oncology nurse implementing the intervention received regular supervision from a liaison psychiatrist, who was available for consultation on a continuous basis. While the nurse was responsible for the day-to-day therapeutic engagement, the supervising psychiatrist retained overall clinical responsibility for patient outcomes.

This structured approach demonstrated promising results in terms of patient engagement, adherence, and self-perceived well-being. Figure 2 illustrates the multiple professional practices involved in oncology, emphasizing the comprehensive skill set required for oncology nurses to deliver holistic care [ONCOLOGYNURSE].

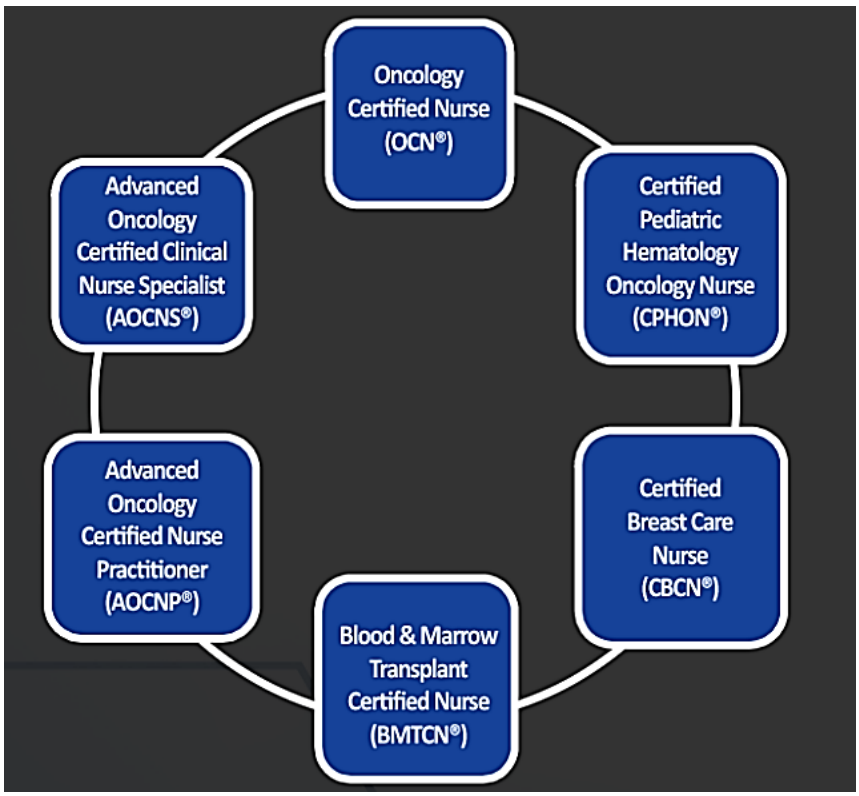


Figure 2. Key professional practices in oncology nursing. Oncology nurses are expected to integrate technical expertise, psychosocial support, and patient education into routine cancer care.

1.2 Selection of Nurse

The purpose of this research was to determine whether an oncology nurse without prior training in psychological support could be educated to deliver a structured intervention while maintaining a high standard of patient care. To accomplish this, the selection process prioritized a nurse with extensive clinical oncology experience and a strong interest in psychiatric care. It was recognized that not all oncology nurses would either be willing or capable of assuming such a role, and this limitation was addressed explicitly during recruitment.

The selection criteria emphasized three competencies: (i) familiarity with the psychological challenges faced by cancer patients, (ii) effective communication skills for engaging patients in sensitive discussions, and (iii) the capacity to encourage patients to assume an active role in managing psychological distress. Ultimately, a senior nurse (VS) with considerable oncology nursing experience but without specialized mental health training beyond the standard UK nurse education curriculum was appointed to the role [6].

1.3 Nurse Education and Training

Following the selection, a structured education and training protocol was implemented to equip the nurse with essential skills. Three core competencies were identified as central to the intervention:

1. Communication and interpersonal skills. Training was undertaken through a recognized program led by Professor Peter Maguire at Christie Hospital, Manchester, UK. This well-established course on communication in cancer care provided targeted instruction in recognizing and addressing patient concerns. Over three months, the supervising psychiatrist (MS) conducted weekly audio–video assessments of competency, offering feedback and guidance for improvement.

2. Recognition and management of depressive disorders, including antidepressant therapy and suicide risk. The supervising psychiatrist provided one-to-one training using printed materials, role-playing exercises, and supervised patient assessments. Although nurses were not authorized to prescribe antidepressants, they were trained to explain the purpose, benefits, and side effects of such medications to patients. Additionally, principles of suicidality assessment were introduced, with clear directives on when to seek immediate psychiatric consultation [7].

3. Cognitive–behavioral therapy (CBT) principles. The nurse completed an intensive two-day workshop on problem-solving psychotherapy, facilitated by an experienced trainer who also acted as a nursing advisor. This was followed by supervised application of CBT-based strategies, with regular evaluations from the supervising psychiatrist and psychologist.

1.4 Identifying Fundamental Abilities

Over four months, the nurse delivered the intervention to 18 cancer patients with coexisting depression. Treatment sessions adhered to the draft intervention protocol and were closely monitored. Competence was assessed using six randomly selected audio–video recordings of therapy sessions, independently reviewed by the supervisory team. Following this evaluation, the nurse demonstrated adequate proficiency in communication, problem-solving facilitation, and depression management within the defined scope of practice.

1.5 Modifications to the Intervention Programme

During training and implementation, two primary issues emerged: (i) lack of social support networks among patients, and (ii) difficulty in addressing existential concerns about mortality.

To address the first issue, structured problem-solving strategies were introduced by the third session to help patients identify and strengthen external sources of support. Patients were encouraged to generate their own solutions for building social connections and to implement these incrementally during the therapy period [8].

The second issue, reluctance to confront mortality, was addressed by integrating realistic discussions about prognosis and end-of-life planning into problem-solving sessions. Patients were encouraged to focus on achievable goals and meaningful arrangements within the context of their life expectancy. Following these modifications, a subsequent cohort of 30 cancer patients with depression was treated under the revised protocol [9].

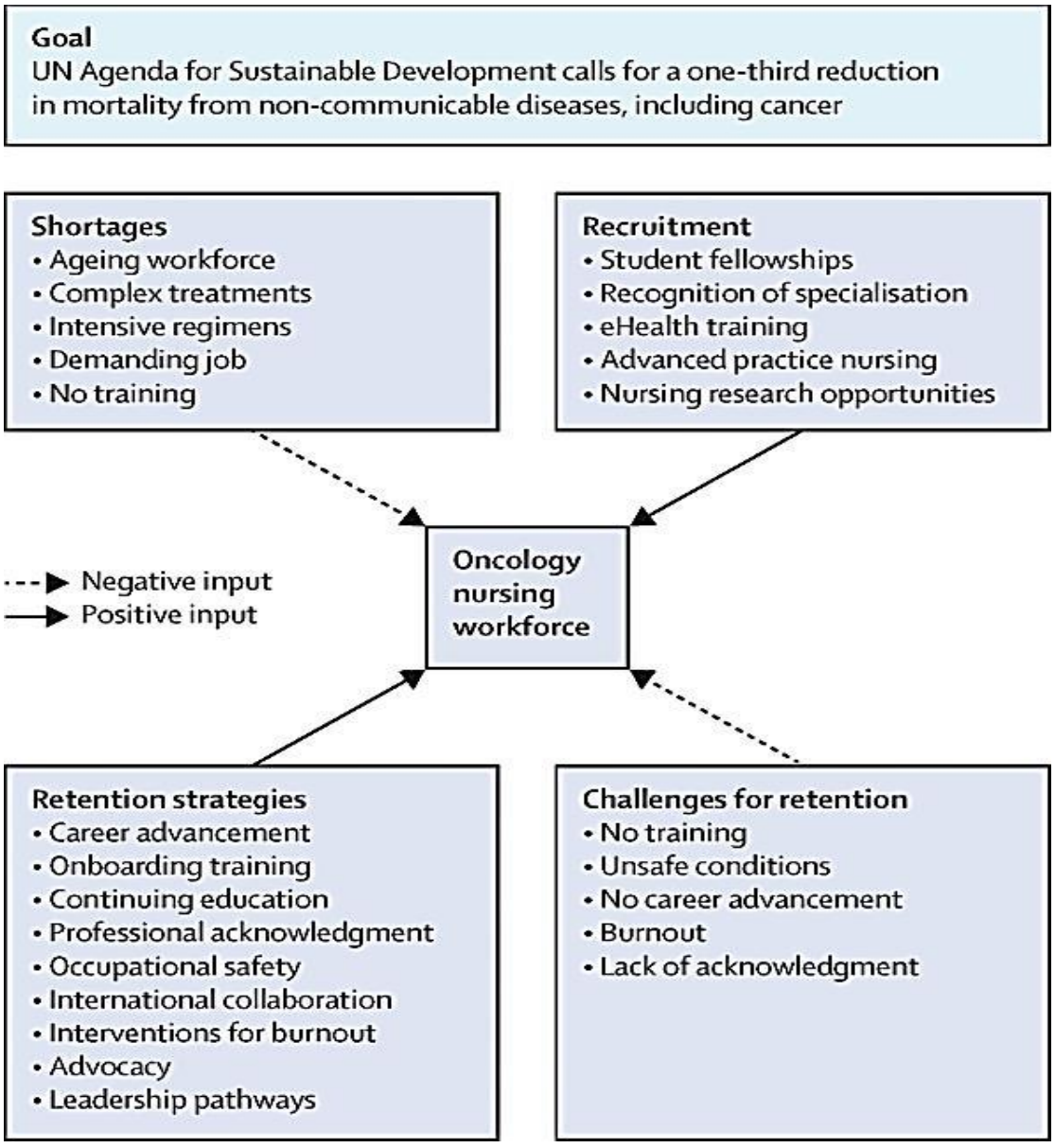


Figure 3. Challenges, solutions, and future strategies for the oncology nursing workforce. Expanding the global oncology nursing workforce is central to achieving the United Nations Sustainable Development Goals [LANCET].

1.6 Concerns Arising

1.6.1 Difficulties in Providing the Intervention

The nurse identified three key challenges: (i) managing patient refusal and non-adherence, (ii) preventing and managing suicide risk, and (iii) ensuring effective coordination between oncology and primary care providers.

1.6.2 Patient Refusal and Non-Adherence

Out of 64 patients screened and offered treatment, 34 (53%) declined participation. This high refusal rate was attributed to the recruitment strategy, which relied on telephone invitations rather than direct physician referrals. Evidence suggests that face-to-face recruitment by oncologists may have yielded higher acceptance rates. Once enrolled, most patients complied with the intervention, though three participants demonstrated poor engagement. Non-adherence was influenced by external discouragement from family physicians or caregivers regarding depression diagnosis and treatment [10].

1.6.3 Responsibility and Suicide Risk

Assessing suicidality in cancer patients presents unique challenges, as thoughts of death may reflect both depression and rational end-of-life concerns. Approximately 25% of participants were prescribed antidepressants, and four disclosed suicidal ideation requiring enhanced monitoring. Although these cases were safely managed within the study framework, they demanded additional supervision and inter-institutional collaboration. The experience underscored the necessity of clear practice guidelines, ongoing retraining, rapid access to psychiatric support, and integration within a psycho-oncology team [11].

1.6.4 Coordination with Primary Care Services

Coordination between oncology and primary care was inconsistent. Several patients reported being advised by general practitioners (GPs) against antidepressant use during cancer treatment. In eight cases, disagreements arose over diagnosis, treatment options, or nurse-led interventions. This may reflect resistance to novel nursing roles and limited time for establishing credibility with GPs. Sustained integration of such services within oncology practice is essential for improved communication and patient acceptance [12].

2. Discussion

The findings of this study highlight both the potential and challenges of expanding oncology nursing roles to include depression management. Nurses undertaking these responsibilities face emotional, organizational, and professional challenges. Feelings of isolation were reported when nurses adopted perspectives that diverged from those of physicians or colleagues. Repeated exposure to patients' psychological suffering also heightened risks of emotional exhaustion and burnout [13].

To mitigate these challenges, structured support systems must be implemented. Options include part-time deployment of nurses in psycho-oncology roles, integration within multidisciplinary teams, and regular peer supervision. Evidence suggests that shared responsibility and team-based approaches reduce caregiver burnout and enhance sustainability of such programs [14].

In this study, the nurse received weekly supervision from a psychiatrist, with additional support available for crisis situations, particularly suicide risk. This oversight was critical in ensuring patient safety and in strengthening the nurse's confidence in addressing complex psychological needs [15].

However, barriers remain in terms of professional hierarchy and acceptance. Some GPs were reluctant to acknowledge or act upon nurse-led assessments or recommendations, creating tension in continuity of care. This resistance may stem from entrenched medical hierarchies, unfamiliarity with advanced nursing roles, or differences in practice culture between oncology and primary care. Future success depends on building trust, demonstrating clinical efficacy, and embedding nurse-led interventions into institutional protocols [16–21].

The central question of this research was whether oncology nurses can be adequately trained to deliver structured interventions for the treatment of major depression in cancer patients. The findings indicate that oncology nurses, even without prior specialist training in mental health, can be equipped with the necessary competencies to identify, monitor, and provide supportive care for patients experiencing depression. The pilot intervention demonstrated that such training is feasible, cost-effective, and has the potential to complement conventional oncology care by integrating psychosocial and physical treatment components.

However, the effectiveness of nurse-delivered depression care must be established through large-scale randomized controlled trials (RCTs) before it can be widely implemented. Preliminary results suggest that patients value the continuity, trust, and accessibility provided by oncology nurses, and that such interventions can help reduce stigma compared with traditional psychiatric referrals. Yet, sustainability, workload balance, and adequate supervision remain critical concerns.

It is evident that not all nurses will be willing or suited to undertake this role. Providing depression management in oncology is emotionally taxing, requiring resilience, specialized training, and consistent peer support. Therefore, such roles should be reserved for motivated oncology nurses with both aptitude and interest, while ensuring safeguards to prevent burnout. Structured supervision, integration into multidisciplinary psycho-oncology teams, and institutional recognition are essential to ensure both patient safety and nurse well-being.

Beyond oncology, the integration of nurse-delivered psychosocial care has broader implications for chronic disease management. Similar models could be adapted to address comorbid depression in patients with other long-term conditions such as cardiovascular disease, diabetes, and neurodegenerative disorders. By embedding psychosocial interventions into routine medical care, health systems can move closer to the goal of delivering holistic, patient-centered services.

3. Conclusion

The pilot study also highlights the need for system-level change. Nurse-delivered depression care requires strong collaboration with general practitioners, psychiatrists, and other oncology specialists. Clear communication channels, shared treatment guidelines, and recognition of expanded nursing responsibilities must be institutionalized to ensure continuity of care. Future work should therefore focus not only on demonstrating efficacy but also on developing policies and frameworks that support the integration of psycho-oncology practices into standard cancer treatment pathways.

In conclusion, the expansion of oncology nurses' roles to include depression management represents both an opportunity and a challenge. It is an opportunity to improve patient outcomes, reduce stigma, and make mental health care more accessible within oncology. At the same time, it poses challenges in terms of training, supervision, workload, and interprofessional collaboration. The success of this approach will ultimately depend on ongoing research, policy support, and the development of sustainable models of nurse-led psycho-oncology care. If implemented thoughtfully, this model has the potential to transform not only oncology nursing but also the broader landscape of integrated medical and mental health care.

Clinical nurse specialists in oncology frequently report feeling underprepared to manage the psychological distress, anguish, and sadness experienced by their patients. This gap in training is significant, as unmanaged depressive symptoms not only affect patients' quality of life but also place additional stress on healthcare providers. Evidence suggests that equipping nurses with adequate training, sufficient time allocation, and structured psychosocial protocols can substantially reduce patient distress, improve treatment adherence, and enhance the therapeutic environment. Importantly, such interventions may also contribute to improved job satisfaction among nurses, who often derive professional fulfillment from providing comprehensive, patient-centered care.

Holistic care for individuals with cancer requires nursing staff to take a more active and sustained role in addressing comorbid depression, despite the considerable challenges this responsibility entails. Traditionally, oncology nurses have focused on physiological management, treatment monitoring, and symptom relief. However, the increasing recognition of psychological well-being as a determinant of health outcomes has expanded their scope of practice. By integrating depression care into their daily roles, nurses can help bridge the gap between oncology and mental health services, thereby ensuring that patients receive truly comprehensive care.

The nursing profession has undergone a substantial transformation in recent decades, with an expansion of advanced practice roles and specialized responsibilities. This evolution reflects both professional recognition of nursing as a distinct discipline and the growing complexity of healthcare delivery. Specialized roles in areas such as oncology, palliative care, and mental health have proliferated, signaling a shift toward interdisciplinary and integrative care models. In this context, the extension of nursing skills to encompass the direct management of depression represents a logical and necessary progression.

The present research explored whether specialized oncology nurses could be trained to deliver hands-on, structured interventions for major depression in cancer patients. The findings from this pilot work demonstrate that such an intervention is both feasible and cost-effective. Specifically, the model of nurse-delivered depression care required an average of one hour of medical consultation time and approximately ten hours of nurse-led care per patient. This allocation of resources is modest when compared to the potential benefits, which include earlier detection of depressive symptoms, improved patient engagement, and reduced reliance on already overburdened psychiatric services.

Preliminary results indicate that patient acceptance of nurse-delivered depression therapy was high once patients became actively engaged in the intervention. This suggests that oncology nurses, by virtue of their existing therapeutic relationships with patients, are uniquely positioned to address sensitive psychological issues in a non-stigmatizing manner. Compared to external psychiatric referrals, which some patients perceive as alienating, the involvement of oncology nurses may foster a sense of trust and continuity in care.

These findings provide promising evidence that nurse-delivered depression treatment has the potential to improve outcomes beyond the standard level of care currently available through the National Health Service (NHS) in the United Kingdom. While the pilot data are encouraging, randomized controlled trials are required to formally evaluate the efficacy, scalability, and long-term sustainability of this intervention. Such research will be critical in establishing the evidence base necessary to guide policy, education, and practice frameworks for integrating nurse-delivered psychosocial care into oncology services.

Ethical Considerations

All clinical interventions must safeguard patient confidentiality, respect autonomy, and ensure informed consent. Training oncology nurses requires not only technical skills but also ethical awareness to handle sensitive disclosures and to provide culturally appropriate care.

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Conflict of Interest

The authors declare no conflict of interest.

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