



Communication study

What to listen for in the consultation. Breast cancer patients' own focus on talking about acceptance-based psychological coping predicts decreased psychological distress and depression



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ABSTRACT

Objective: To analyze whether qualitative themes in breast cancer patients' self-presentations predicted symptoms of psychological distress and depression in order to improve the consultation process.

Methods: Ninety-seven breast cancer patients gave unstructured, 10-min self-presentations at their first consultation in a clinical registered trial (CRT identifier: NCT00990977). Self-presentations were categorized thematically and the most prevalent themes investigated as predictors for scores on the symptom check-list 90-revised (SCL-90-R) and the center for epidemiological studies depression scale (CES-D).

Results: Among the qualitative themes, only the percentage of words spent on talking about 'Acceptance-based psychological coping' was related to symptoms. In regression models controlling for age, education and time since diagnosis, a stronger focus on acceptance-based coping predicted less psychological distress and depression, respectively. A cross-validation including only the first few minutes of speech per patient confirmed these results and supported their practical utility in health consultations.

Conclusion: Patients' focus on acceptance-based coping significantly predicted decreased psychological distress and depression, respectively. No other qualitative themes predicted symptoms. Doctor–patient studies may benefit from combined qualitative–quantitative methods.

Practice implications: While quantitative symptom assessment is important for a consultation, health care providers may improve their understanding of patients by attending to patients' presentations of acceptance-based psychological coping.

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1. Introduction

An important aim for the health consultation is to listen to patients' illness narratives to help them cope with their illnesses. But the time-limited consultation makes it difficult for health professionals to understand how a patient copes with her unique situation. An often-used method for narrowing the consultation

focus is to administer questionnaires before the consultation as part of a screening procedure. However, little knowledge exists about how patients' unstructured self-presentations relate to structured scales measuring e.g. symptoms of psychological distress or quality of life. What should health professionals listen for in the brief time available? Which themes of patients' self-presentations might be most relevant in a consultation assessment of the patients' degree of psychological distress or depression and their ability to cope with their illness? In the present study, we examined these questions in a sample of breast cancer patients.

Breast cancer affects women's perception of themselves and represents a highly stressful life event requiring extensive coping. It is well documented that psychological perceptions of an illness

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and ways of coping with the illness are significantly related to rating scales measuring quality of life or psychological distress for different patient groups [1–4] and also for breast cancer patients [5–13].

Cancer patients' representations of themselves and their illness have mostly been studied by using standardized questionnaires, rather than qualitative methods such as semi-structured or unstructured interviews. Some of the most applied questionnaires are the illness perception questionnaire-revised (IPQ-R) [14–16] or the COPE [17], both of which have been linked to emotional distress in breast cancer patients [6,18] and to quality of life [19]. Similarly, questionnaire studies of illness perceptions show that patients who report more adaptive coping behaviors are also more likely to engage in adaptive health practices [19–21].

A review of 477 studies examining factors related to psychological wellbeing and quality of life for breast cancer patients such as illness representation and coping style concluded that quantitative studies had contributed with important insights into coping and wellbeing in breast cancer [10]. However, the review concluded: "There were few qualitative studies. Since these could provide more insight into quality of life in breast cancer patients, we need more such studies" (p. 29).

Coping refers to strategies or attempts to manage stressful events [22]. The coping literature distinguishes between especially coping processes marked by approach toward the stressor, such as acceptance or confrontation of emotional stressors, and avoidant coping, such as withdrawal, repression, or denial [23]. Avoidant coping has generally been related to increased levels of psychopathology and distress, also within cancer patients [24], although more studies on coping styles and cancer patients are needed [24].

The few qualitative studies available in this area have yielded interesting findings. For example, one study indicated that cancer patients' statements in a focus group could be mapped onto the coping and appraisal components of the IPQ-R [21], supporting the combination of qualitative and quantitative studies in this area. Similarly, a qualitative study revealed that personal experiences of positive thinking helped breast cancer patients to cope with their illness [25], which was supported by a quantitative study [26]. Other qualitative studies have provided informative descriptions of changes in cancer patients' self-perceptions [27], spirituality [28], or investigated how psychosocial care might be tailored to breast cancer survivors' coping strategies [29].

Such studies warrant further investigations of relationships between patients' representations of themselves and their illness, their coping strategies, and the widely used assessment of patients via self-report scales. In particular, studies with transferability to the time-limited health consultation are needed. Therefore, our purpose was to listen to breast cancer patients', unstructured presentations of 'themselves and their illness' with the hypothesis that the focus on psychological coping would be negatively related to symptom scales of psychological distress and depression. We wanted to expand research on structured questionnaires with a perspective on the unstructured self-presentations patients give during consultations.

2. Methods

2.1. Participants

Participants took part in a clinical registered trial approved by the Danish Ethical Committee System (www.clinicaltrials.gov, identifier: NCT00990977) of the effect of a standardized mindfulness-based stress reduction program [30]. Exclusion criteria involved other cancer diagnoses within 10 years, former or current treatment of major psychiatric illnesses, substance abuse or musculoskeletal conditions. Patients were identified from surgical

lists at hospitals and a review of charts. Participants signed informed, written consent forms. The participants included here aged 28–72 years (Mean = 54.2 years, 1st Qu–3rd Qu = 28–62). The time since their breast cancer was diagnosed ranged from 1 to 22 months (Mean = 8.6 months, 1st Qu–3rd Qu = 3.7–13.0). Concerning professional education, 16% completed <3 years ($n = 15$, e.g. a manual education), 70% completed 3–4 years ($n = 68$, e.g. a bachelor-degree), and 12% completed >4 years ($n = 12$, e.g. a master-degree), while 2% ($n = 2$) did not provide educational data.

2.2. Interviewing procedures

The first 100 patients randomized for the MBSR-intervention were invited for the present study and 97 were interviewed (97% participation rate). Authors CGJ and LN conducted all interviews on the first face-to-face meeting with each patient in a hospital office. Self-presentations were initiated by a standardized instruction: "I would ask you to tell about yourself and the disease you had. You are welcome to tell what ever you want. You will have 10 minutes. I am not going to ask questions during these 10 minutes, but if you have difficulties with this task I will help you by repeating this instruction or by repeating your last sentences." If participants stated to have nothing more to say before the ten minutes had passed, the instruction was repeated once and they were encouraged to 'take their time'. Of ethical significance, patients went to the first session with their authorized mindfulness psychologist in the clinical registered trial immediately after the self-presentation, giving them the opportunity to talk more extensively in a therapeutic setting.

2.3. Analytic steps

We used a mixed method of qualitative and quantitative analyses. (1) *Derivation of the qualitative categories.* First, we used qualitative analyses to identify thematic categories in the self-presentations. (2) *Relationships between self-presentation and questionnaires.* Quantitatively, we initially calculated the prevalence of each self-presentation category to identify the most used themes. We then tested correlations between the most prevalent categories and the background factors of age, education, and time since diagnosis, respectively. Thereafter, we conducted multiple regression analyses to examine if any qualitative themes predicted symptoms of distress after controlling for these background factors. (3) *Cross-validation: The three first categories.* We finally examined whether the three first categories in the presentations also predicted symptom scales. We thereby conducted a cross-validation of our overall findings and also aimed to test if they were of practical utility in the time-limited health consultation.

2.4. Self-presentations

Self-presentations were recorded and transcribed and contained on average 715 words (Standard Deviation = $SD = 338$) per patient. Transcriptions were analyzed and interpreted using content analysis. Transcripts were read multiple times and discussed in detail by five researchers (CGJ, LN, TB, SK, PE). In this way, themes and sub-themes were formed by condensation of the patients' presentations and a scoring manual was completed. Sentences were then scored independently by two researchers (TB and SK). Finally, scorings were compared and discussed among three researchers (TB, SK, and PE) until full agreement on all single scorings was achieved.

2.5. Applied questionnaires

2.5.1. The symptom checklist-90-revised (SCL-90-R)

SCL-90-R is a validated instrument of psychological distress for clinical populations [31]. Participants indicated on

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