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Men's use of networks to manage communication tensions related to a potential diagnosis of prostate cancer

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ABSTRACT

Purpose: This study used relational dialectics theory to explore the communication tensions experienced by men who were on a prostate biopsy waiting list and how they managed these tensions using their communication networks.
Method: The study utilised dialectical analysis of 36 semi-structured interviews conducted from July to September 2012 in a city in the North Island of New Zealand.
Results: Dialectical analysis revealed men experienced four tensions; a) obligation to disclose/autonomy not to disclose; b) confident to help others/vulnerable and needing help from others; c) accept support/not accept support and d) desire for normality/need to tolerate uncertainty. These tensions were predominantly managed by vacillation. Specifically, the men used their communication network to select one pole with some people and the other pole with others to maintain balance between the poles of the dialectical tensions.
Conclusions: Health care professionals can help men in this situation by having a conversation about disclosure and support prior to them being diagnosed, educating men to reframe or connect as a more effective form of tension management, and linking men who have small or ineffective networks to other resources such as social support networks to facilitate tension management.

The worldwide incidence of prostate cancer is increasing significantly (Center et al., 2012) and will continue to do so for the foreseeable future; a trend also reflected in New Zealand (Ministry of Health (2008)). This rise of prostate cancer is due in part to the increasing age of the population but also more cancers are detected with improved diagnostic testing (Sneyd et al., 2007). More men are faced with the prospect of living with and managing prostate cancer and the psychosocial challenges that come with it than in the past. Occurring in several areas of life and often simultaneously, these challenges include the psychological adjustment to the diagnosis, the social challenge of communicating and interacting with others, and the physical management of the symptoms and treatment.

Men with prostate issues and at the pre-diagnosis stage are at a unique juncture in their medical journey. Sufficient clinical or medical evidence warrants a biopsy which signals a serious intervention. However, the accuracy of prostate biopsies to detect cancer remains equivocal with a wide variation in detection rates reported in part due to various diagnostic technologies (Pokorny et al., 2014; Zeliadt et al., 2013). In a recent review of 15 studies, Valerio et al. (2014, in press) found a median detection rate of 33%. Receiving a diagnosis of cancer has been recognised as a highly stressful part of a patient's medical journey (Edwards and Clarke, 2004) and even though approximately a third will be a positive diagnosis (Valerio et al., 2014, in press) the uncertainty results in worry, fear, and anxiety (Greene et al., 2012).

Given their underlying emotional state, communication for men around the time of a diagnosis of cancer is fraught with difficulties and tensions (Bisson et al., 2002; George and Fleming, 2004; Gray et al., 2000). The need for a biopsy has the potential to create a tension between being perceived as on the verge of a serious illness but not feeling or looking ill with few if any symptoms. Men experience a dilemma concerning how to pitch the biopsy in communicating with others (Lepore and Revenson, 2007). Some may choose to ignore the current situation and potential diagnosis until they have more information by not telling anyone; others may reveal the need for a biopsy and the appointment time to a select few; yet others may be open with everyone (Bloch et al., 2007).

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Furthermore, as prostate cancer is perceived as a stigmatising disease, shame and humiliation can inhibit disclosure especially among the elderly who are more likely than younger men to acquire prostate cancer (Else-Quest et al., 2009).

Communication networks provide a platform for individuals to interact with supportive people who offer help and resources such as information to be disseminated (Granovetter, 1982; Haythornthwaite, 1996; Heaney and Israel, 2002; Petronio, 2002). Networks are the "patterns of contact between communication partners" (Monge and Contractor, 2001, p. 440) in which relationships and ties between individuals are fundamental to the functioning of individuals in their personal networks (Wellman, 2007). Networks become even more important in significant life events (e.g., cancer) which have the potential to cause disruption not only to individuals but also to their networks. While communication networks can provide solutions to help men manage prostate cancer, they can also be a place where communication tensions are created, enacted, and resolved (Arrington, 2005; Grunfeld et al., 2013). This study aims to identify the communication tensions men experienced in communicating with others in their networks prior to a prostate biopsy and to examine how they use their networks to manage these tensions. Understanding these tensions and their management has implications for these men's psychosocial health by increasing their ability to cope, reduce stress, and create positive interactions with others in their networks.

1. Literature review

Tensions exist in the transition from good health to the possibility of poor health. Tensions are opposing forces existing in a struggle, at once pushing and pulling against each other (Putnam et al., 2014). Relational dialectical theory (RDT) (Baxter and Montgomery, 1996) is a well-established theoretical framework for exploring communication tensions and how to manage them. Four fundamental features underpin RDT: contradiction, totality, process, and praxis. Contradiction is the dialectical nature of tensions in which they are "the dynamic interplay of unified opposites" (Baxter and Braithwaite, 2007, p. 276). Tensions create inconsistencies leading to contradictions over time (Putnam et al., 2014). Totality exists in which each pole interacts with, opposes and depends on the other, in juxtaposition at any point in time. Totality also expresses the combination of contradictions in a unique situation (Baxter and Montgomery, 1996). Process refers to dialectical tensions existing within a social context and are constantly in a state of flux and change (Baxter and Montgomery, 1996). Praxis describes the notion that "people are at once actors and objects of their own actions" (Baxter and Montgomery, 1996, p. 13). Individuals are affected by the choices they make.

Dialectical tensions have been studied in various aspects of health care settings including nurses' management of contradictions of their role in health care teams (Apker et al., 2005), radiologists use of informed consent to treatment and patient autonomy (Olufowote, 2011), and spouses whose partner had dementia (Baxter et al., 2002) or a stroke (Brann et al., 2010). For example, Dean and Oetzel (2014) used RDT in a study on emergency department physicians. Two physicians were shadowed and 17 physicians were interviewed about their communication rules and tensions with the patients of an emergency department. Researchers identified tensions between efficiency and rapport and efficiency and comprehension in which the physicians felt the need to be efficient with limited time, but on the other hand needed to develop some rapport with the patients and to ensure they comprehended the information provided. Further, there was a tension between patient and provider perspectives about clarity and relevance of information. These tensions arose from the demanding context of the emergency department and illustrate challenges to effective communication between patients and providers.

Men with prostate cancer experience tensions in communicating with others. Despite prostate cancer being perceived as a disease of couples (Galbraith et al., 2011; Song et al., 2012), husbands and wives have different expectations leading to tensions in the relationship. For example, in information gathering and decision making around the benefits of screening versus side-effects of treatment, wives prefer their husbands to be screened but men prefer not to be screened (Arrington, 2005). Tensions occur between couples in their attitude to disclosure; wives are likely to disclose more, whereas men tend towards non-disclosure (Gray et al., 2000). Further, unsupportive wives create cognitive tensions leading to poorer mental health in men (Lepore and Helgeson, 1998). Arrington (2005) found tensions also existed with adult children between men's desire to share their concerns about prostate cancer but not wanting to be perceived as being more vulnerable or dependant. Beyond the family, disclosing prostate issues in the workplace brought considerable tensions in both social and professional interactions at work (Grunfeld et al., 2013).

As tensions arise, people are faced with various strategies for managing them. Prior research has identified multiple ways to manage tensions (Baxter and Montgomery, 1996; Putnam et al., 2014). For example, Putnam et al. (2014) identified five approaches for managing tensions in the workplace. First, selection occurs when one pole is chosen and the other is ignored. Second, vacillation is a movement back and forwards at different times or in different contexts between the poles making neither redundant. Third, integration facilitates a merger between poles neutralising the tension. The fourth way to manage tensions is to reframe or to transcend the tensions to find a new way of viewing them which facilitates a resolution in the situation. The fifth solution aims for connection-holding together of the poles acknowledging the equal importance of both.

Management strategies have been specifically examined in health care contexts. In an interview and ethnographic study of 42 palliative care workers (including nurses, social workers, care aides and volunteer coordinators), Considine and Miller (2010) identified two tensions experienced by hospice workers when discussing spiritual matters with patients. First, hospice workers were followers when patients and families were viewed as care experts, knowing how to care for their loved ones, and therefore needed to provide direction for the staff. Second, hospice workers were leaders when they were perceived as experts in death and the dying process. The follower/leader tension was managed primarily by selection of one pole thus denial of the other. For example, one hospice volunteer chose the "leader" pole by always offering to pray with patients but another care provider preferred the "following" pole allowing each patient the opportunity to express themselves as they wanted. Vacillation (defined as segmentation by Baxter and Montgomery (1996)) was also evidenced by some workers in choosing to lead the family but to follow the patient. Hospice relationships, in which "the future [of the patient] is tenuous at best" (Considine and Miller, 2010, p. 170), were in a state of flux and so the hospice workers constantly moved between the poles of the tensions according to the variable state of the patient.

The management of dialectical tensions has been applied at both organisational (Seo et al., 2004) and interpersonal (Brann et al., 2010) levels of communication but tensions can also be managed at the level of networks. Communication networks contain a variety of people who can be mobilized to supply resources such as support or information. Individuals with health conditions have the ability to access these resources by choosing the people from their networks they consider will be most effective to fulfil their needs. The tensions can be managed strategically by

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