



Does emotional talk vary with fears of cancer recurrence trajectory? A content analysis of interactions between women with breast cancer and their therapeutic radiographers

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A B S T R A C T

Fears of cancer recurrence (FCR) in patients with breast cancer are hypothesised to develop over the period from diagnosis, through treatment and thereafter. A crucial point may be the contact that patients have with their therapeutic radiographer in review appointments. The study aimed to (1) describe and categorise the content of the identified emotional talk, and (2) consider the evidence for an association of content with FCR trajectory.

Methods: A concurrent mixed methods approach was applied as part of a larger investigation (FORECAST) of breast cancer patients (n = 87). Patients completed a daily diary during their radiotherapy treatment. Audio recordings were collected of review appointments. The Verona Coding Definitions of Emotional Sequences (VR-CoDES) system was used to code patient emotional cues and concerns (CCs). Purposeful sampling of the daily diary ratings identified 12 patients (30 consultations) with an increasing (n = 6) or decreasing (n = 6) FCR trajectory. The emotional talk of these patients at their weekly reviews was content analysed.

Results: Four themes were identified from 185 CCs: Physical Symptoms, Factors External to Hospital, Treatment, and Labelling Cancer. FCR decreasing trajectory group consultations were longer ($p < 0.02$), expressed twice as many CCs as the increasing trajectory group ($p < 0.001$), and were more likely to refer to cancer directly ($p < 0.05$).

Conclusions: The emotional content expressed matched features outlined in the Lee-Jones et al. (1997) FCR model, and showed evidence of avoidance in increasing FCR trajectory patients.

1. Introduction

Persons treated for breast cancer often experience raised levels of anxiety and depression [1–3]. However a recent review has found that an increased prevalence at 5 years post diagnosis was confirmed for depression but not for anxiety [4]. The focus on depression and anxiety has tended to ignore some pressing additional psychological needs of patients with cancer. The strongest priority as rated by patients with breast cancer, recently found that 62% wished to speak with their clinician, at the out-patient clinic, about their fears of cancer recurrence (FCR) [5]. The number of articles that document fears of recurrence is increasing and there has been an extensive review to show associations with anxiety and depression [6]. It is clear that FCR is a stable construct that is aversive to the individual at high levels. To reduce extensive FCR that has developed, through specialist intervention, is complex and resource intensive [7–9]. A preventive approach is therefore indicated.

Our group has investigated the factors that may exacerbate FCR [10,11]. As part of this work we are researching (FORECAST study) the interactions that clinicians have with their patients during the course of their treatment [12]. For oncology patients there is time taken in clinical appointments to discuss treatment options. Information delivered at this early stage is considered important to enable patients to adjust to their changed circumstances [13]. Patients who lack information report more anxiety [14]. Halkert et al. surveyed 123 women longitudinally at four time points during, and immediately after treatment to enquire of their information needs and anxiety levels [15]. Information was sought throughout the treatment period and anxiety was found to be maintained until the treatment finished. However, this survey relied solely on structured questionnaires and patient self-reports. Another approach that the authors prefer is to record (via audio or video) the clinical interactions between health providers and the patient. This methodology as the advantage is that the data collected

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are objective and not so easily subject to social-desirability responding by patients.

Some articles report systematic methods to analyse the communication features of the clinical/patient interaction [16–18]. The Verona Coding Definitions of Emotional Sequences (VR-CoDES) is a coding scheme that is especially suited to explore, in exquisite detail, the hidden emotional cues that are presented by patients, including those treated for serious diseases including cancer [19–22]. The system has been validated [23] and has already been employed in over 40 studies since its development [24]. The link between patient self-report of their concerns about cancer returning and clinical contact with their health care team has yet to be studied in detail. We are aware from one model of FCR development in patients [25] that the understanding and ‘representation’ of a disease such as cancer is constructed by vital information sources including staff contacts. Not only is the cognitive aspect (e.g. information) of the disease important but also the emotional response that patients have to these relevant stimuli. The self-regulation model outlined by Lee-Jones et al. incorporates the parallel-processing of cognition and emotion [25]. Hence our approach has been to examine closely the interactions at a key stage of treatment, specifically the review appointments, when patients are encouraged to describe their current state of health during the radiotherapy treatment process. We are aware of no other investigation that has investigated sequential interactions in the review appointments of patients with breast cancer receiving radiotherapy.

2. Aims

1. Present and critically analyse the content of female breast cancer patients' emotional talk (cues and concerns) through the course of radiotherapy, in the weekly review consultations with therapeutic radiotherapists.
2. Investigate the association of emotional talk content to patients' fears of cancer recurrence trajectories (increasing or decreasing) assessed during treatment.

3. Methods

3.1. Participants

Data were collected from an observational cohort study of adult female breast cancer patients and radiotherapists, in which their one-on-one consultations at a specialist breast cancer centre in Scotland, were audio recorded. One of two radiotherapists led review consultations held with patients receiving radiotherapy as primary or adjunctive treatment for their cancer. Patients self-rated their fears of cancer recurrence (FCR) pre-radiotherapy, and daily throughout their two to three-week treatment period (ranging 15 to 25 days). The rating consisted of a 3 item scale (FCR3) that assessed FCR. The reliability of this scale has been shown to be high (0.92) with a mixed sample of breast and colorectal cancer patients, and some evidence of validity has been indicated through confirmation of unidimensionality and relatedness with associated psychological constructs [26]. Those in rank order with the most positive or negative overall change in their FCR from baseline to the end of their therapy were selected. The principle of “maximum variation” sampling, a form of purposeful qualitative sampling, was applied to enable the greatest chance of demonstrating an effect [27]. In total, 12 patients, with a repeated set resulting in thirty consultations, were regarded as sufficient to provide a corpus of data establishing support for the hypothesised association of content to FCR change [27,28]. The number of participants selected were identical to a similar study using maximum variation sampling in cancer patients [29]. Hence, six patients with the largest FCR increases from baseline, and six with the largest decreases, were selected. Participants were volunteers, communicated in English and had no known psychiatric conditions. The radiotherapy regime was the final primary treatment

element for these patients at the centre, before a conventional out-patient follow-up protocol with the necessary occasional check-up. Ethical approval was granted by NRES (reference number: 13/ES/0015).

3.2. Design, procedure & analyses

A concurrent mixed-methods explorative design was used [30] (p22). This approach ‘mixes’ both the quantitative and qualitative data corpuses as defined in a recent review [31]. Quantitative (trajectories from diary ratings) and qualitative (audio tape transcripts) methodologies were applied. A content analysis [32] using a stepwise deductive-inductive procedure [33], was conducted on patients' emotional talk. This involved both theory and data-driven coding, and therefore combines deduction and induction. The initial step involved deductively identifying topics of interest, based on theory. This step was achieved by coding the audiotapes for emotional events (cues and/or concerns; or “CCs”) with the widely used VR-CoDES system, using the event logging software Observer XTv12. Two researchers coded the tapes following training from GH and an inter-rater reliability analysis was conducted to assess general agreement [34]. Any discrepancy or difficulty in assigning the cues' or concerns' utterances was discussed with the principle investigator (GH), and consensus achieved to ensure a complete identification of these crucial events. The next step involved induction, and every identified emotional “cue” and “concern” uttered by the patient, was rewritten into a shorter phrase or a few words conveying the content onto an index card. This procedure is similar to “systematic text condensation” [28], which forms condensates or artificial quotes from actual quotes. These condensed descriptors were then inductively grouped according to their main content, and finally grouped into over-arching final themes. This grouping was conducted blindly, so that the specific patient and their FCR trajectory (increasing or decreasing) was unknown. This procedure adopted to enhance validity and trustworthiness [35] was undertaken separately by two of the authors (LB and GH), who then deliberated and decided on the final themes summarising the content of patients' emotional talk. Once the overarching themes were agreed upon, an inter-rater reliability analysis determined the level of agreement in allocating the descriptors throughout these themes, as followed by Moretti et al. [36] Any remaining disparities in descriptor allocation were discussed and mutually reallocated, resulting in the final themes and membership of each CC. We present quotes in tabular form (Table 4) and within the results text.

Statistical analyses (alpha set to 0.05, 2 sided) included z , t and likelihood ratio tests, where appropriate, to supplement the findings of the content analysis, particularly comparing CC frequency, duration of consultation and theme allocation across relevant groupings.

4. Results

4.1. Demographics

Participants were all married and lived with at least one other person, apart from one (8%) patient. She was single and lived alone, and was situated in the increasing FCR group. Only two (17%) were educated to degree level, both in the increasing group. Seven (58%) were employed and five were retired or unemployed (42%). Six (50%) had chemotherapy prior to radiotherapy, four of these being in the decreasing FCR group (see Table 1).

4.2. Consultations

There were 30 consultations in total, and the average number per patient was identical for both FCR trajectory groups ($M = 2.5$, $SD = 0.52$). The maximum number of consultations per patient was three. One radiotherapist conducted 17 (57%) consultations and the other, 13 (43%). There were equal number of consultations in the

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