

A Case Study of Telephone Interpersonal Counseling for Women With Breast Cancer and Their Partners

Terry Badger, PhD, APRN, BC, Chris Segrin, PhD, Paula Meek, RN, PhD, Ana Maria Lopez, MD, and Elizabeth Bonham, MS, APRN, BC

Purpose/Objectives: To present a case study of one woman with breast cancer and her partner to provide a firsthand account of an innovative telephone interpersonal counseling intervention.

Data Sources: Journal articles, book chapters, research data, and transcriptions of telephone counseling sessions.

Data Synthesis: Substantial evidence exists that face-to-face psychosocial interventions improve psychological adjustment and health-related quality of life for patients with cancer. Yet psychosocial interventions are not offered routinely, and many patients with cancer do not use face-to-face counseling mechanisms. The telephone may be an innovative and effective method of delivering interventions, and telephone-delivered interpersonal counseling may be an especially effective intervention for women with breast cancer and their partners.

Conclusions: Despite the fact that the telephone counseling occurred over a brief period of time, the woman and her partner in this case study reported substantial positive changes in their own distress (e.g., symptoms such as depression and anxiety) and the nature of their relationships with each other and their children. This is precisely the effect that would be predicted by interpersonal theories of psychological distress. These results were not atypical for other women and their partners who participated in the study.

Implications for Nursing: Family members play a significant role in supporting women through the breast cancer experience; thus, nurses should assess the emotional distress of both partners during the course of treatment and, if needed, provide critical education and referral to psychosocial interventions. This woman and her partner clearly benefited from the intervention, resulting in improved symptom management and quality of life. Although this intervention requires additional training in the advanced practice nursing role, some techniques of the intervention can be used by all nurses, regardless of specialty training.

In 2004, more than 200,000 women will be diagnosed with breast cancer (Jemal et al., 2004), and the majority will have treatment-related side effects associated with their cancer experience (Badger, Braden, & Mishel, 2001; Lewis, Zahlis, Shands, Sinsheimer, & Hammond, 1996; Winningham et al., 1994). Of the side effects experienced, treatment-related fatigue is the most common, and its incidence is estimated to be 40%–100% (Meek et al., 2000; Nail, 1996; Winningham et al.). The most common psychological symptom for women with breast cancer is depression, with incidence estimates ranging from 4.5%–50% (Newport & Nemeroff, 1998). Women often rate depression and fatigue among the top five most distressing side effects of the cancer experience (Badger,

Key Points . . .

- ▶ Brief, focused psychosocial interventions delivered over the telephone may be a solution to improve symptom management and quality of life for women receiving adjuvant therapy for breast cancer and their partners.
- ▶ Telephone interpersonal counseling with women and their partners may be an effective method to intervene early with women with cancer and their partners to improve symptom management and quality of life.
- ▶ Advanced practice nurses can learn to conduct interpersonal counseling interventions to help women with breast cancer and their partners with the cancer experience.

Braden, et al., 2001; Nail). These side effects significantly influence cancer recovery, quality of life (QOL), and long-term survival (Badger, Braden, Longman, & Mishel, 1999; Giese-Davis & Spiegel, 2003; Newport & Nemeroff; Paraska & Bender, 2003; Pasacreta, 1997).

Substantial evidence exists that psychosocial interventions improve patients' psychological adjustment and health-related QOL (Bottomley, 1997; Bultz, Specia, Brasher, Geggie, & Page, 2000; Fawzy, Fawzy, Arndt, & Pasnau, 1995; Meyer & Mark, 1995; Newport & Nemeroff, 1998). Psychosocial interventions can influence daily activities such as diet, exercise, sleep, ability

Terry Badger, PhD, APRN, BC, is a professor in the College of Nursing, and Chris Segrin, PhD, is a professor in the Department of Communication, both at the University of Arizona in Tucson; Paula Meek, RN, PhD, is a professor in the School of Nursing at the University of New Mexico in Albuquerque; Ana Maria Lopez, MD, is an assistant professor of clinical medicine and pathology at the Arizona Cancer Center of the Arizona Health Science Center in Tucson; and Elizabeth Bonham, MS, APRN, BC, is a doctoral student in the College of Nursing at the University of Arizona in Tucson. This research was funded by an ONS Foundation Symptom Management Research Grant. (Submitted July 2003. Accepted for publication October 13, 2003.)

Digital Object Identifier: 10.1188/04.ONF.997-1003

to handle side effects associated with cancer treatment, adherence to medical treatment, and social support and can have positive effects on psychological distress (Spiegel, 1997). Yet psychosocial interventions are not offered routinely to patients with cancer or their family members.

The purpose of this article is to present a case study of one woman with breast cancer and her partner to provide a firsthand account of an innovative telephone interpersonal counseling (TIP-C) intervention. This novel intervention was used in a larger behavioral clinical trial with 48 women and their partners to test the effectiveness of a counseling intervention for symptom management (depression and fatigue) and QOL for women with breast cancer and their partners (Badger, Meek, & Segrin, 2001). Preliminary results of the study indicated improved symptom management and QOL for women and their partners in the intervention group (Badger et al., in press). The authors believed that a more detailed discussion of the counseling session was important to understanding the usefulness of the intervention.

Interpersonal psychotherapy has well-documented effectiveness for patients with emotional distress (Rounsaville, Klerman, Weissman, & Chevron, 1985; Weissman & Markowitz, 2000; Weissman, Markowitz, & Klerman, 2000). Interpersonal psychotherapy is based on the assumption that problems such as depression affect and are affected by the nature of a person's interpersonal relationships (Weissman et al.). Regardless of its etiology in any given case, depression can be maintained, alleviated, or exacerbated through interpersonal interactions. Consequently, the focus of interpersonal psychotherapy is on examining the nature of current interpersonal relationships and how they influence and are influenced by psychological distress. The role of counseling is to assist a patient in decreasing interpersonal strains and stresses to improve health. A brief version of interpersonal therapy known as interpersonal counseling has been offered by nurse practitioners and other healthcare professionals with positive results (Weissman & Klerman, 1993). Clinical trials have provided favorable data supporting its efficacy as an acute treatment in various primary care contexts and suggest that it would be equally effective in cancer care (Schulberg & Scott, 1991; Weissman & Markowitz).

Donnelly et al. (2000) presented the first published results of telephone interpersonal psychotherapy with patients with cancer. An innovative feature of the design involved the active participation of each patient's close companion. Patients ($n = 14$) and their partners ($n = 10$) received weekly telephone sessions in concert with the first chemotherapy and ended four weeks after the final chemotherapy. On average, patients participated in 16 sessions and partners in 11 sessions. By the end of the trial, 33% of the patients showed "marked improvement" in their psychological well-being, and another 33% showed minor improvement or a stable symptom profile over the course of the investigation. Conversely, only 25% of the sample exhibited a "marked worsening" of symptoms from baseline to final assessment. Despite the chemotherapy that was concomitant to the interpersonal psychotherapy, two-thirds of the patients experienced stable to markedly improved symptom profiles. Patients and partners also reported high levels of satisfaction with the telephone interpersonal psychotherapy.

Donnelly et al.'s (2000) findings suggested that interpersonal psychotherapy is capable of decreasing the psychological distress that often accompanies chemotherapy for patients

and their partners. It had direct positive effects on the patients' psychosocial and physical well-being and indirect positive effects by assisting their partners. During the course of the treatment, patients and partners expressed anxiety and uncertainty about the details of cancer treatment; these were addressed to improve QOL for both. The authors of the current study also provided information about cancer and chemotherapy in their intervention as a natural extension of the psychoeducational component of interpersonal psychotherapy.

Reports have suggested that telephone counseling has become a standard means of providing education and advice to patients (Greenberg, 2000; Ridsdale et al., 2001). Hunkeler et al. (2000) found that telephone counseling by nurses with depressed patients reduced depressive symptoms when compared to patients without telephone contact. Similarly, Braden, Mishel, and Longman (1998) found significant improvements in psychological adjustment and QOL among women with breast cancer who received telephone case management. Telephone intervention eliminates the visual channel of communication, offering greater anonymity to patients and their partners. Some patients undergoing chemotherapy experience extreme self-consciousness about their appearance, and the use of the telephone allows for interaction without concern about image. Use of the telephone also allows for the delivery of counseling to people living in rural areas who might not otherwise have access to the same range of medical and psychological services as those in urban settings. The telephone may be a cost-effective method for delivering interventions and also may be an especially effective method for delivering interpersonal psychotherapy to women with breast cancer and their partners.

Study Methods

The current study used a repeated measures experimental design to test the effectiveness of TIP-C compared to a usual care attentional control group on symptom management and QOL for women with breast cancer and their partners. Forty-eight women and their partners participated in the study and were matched for stage and treatment. The majority of the women, regardless of group assignment, were stage 2 and received chemotherapy or chemotherapy plus hormonal treatment. Most were middle-aged white women who were married, had greater than a high school education, and were employed. The case presented in this article represents a typical example of the subjects who participated in this study, although details have been altered to protect confidentiality of the patient and her partner.

After informed consent, participants were asked to complete questionnaires at baseline, at completion of the intervention, and one month later. Participants were assigned to the TIP-C intervention or the attention control group. The TIP-C group received a modified version of traditional interpersonal psychotherapy supplemented with cancer education. Counseling was provided by master's-prepared clinical nurse specialists in psychiatric mental health nursing who had additional oncology expertise. Total training in interpersonal psychotherapy techniques and oncology was 34 hours of didactic content plus supervised counseling practice (i.e., analysis and discussion of taped sessions with experienced counselors). The training program included discussion of the intervention protocol, theoretical aspects of the

intervention, and cancer treatment information supplemented with reading assignments from the scientific literature.

TIP-C is a brief, focused psychosocial intervention that allows the women and their partners, along with the counselor, to set the focus of each session within the TIP-C protocol. TIP-C retains a focus on current relationships and sources of stress and dissatisfaction in life from work, family, and friends, with the addition of cancer information. TIP-C focuses on the four key relationship issues of grief, interpersonal role disputes, role transitions, and interpersonal deficits. Ongoing supervision provided quality control of the sessions. Women assigned to TIP-C received six weeks of counseling, and their partners received three weeks of counseling. Partners received counseling every other week during the women's six weeks of counseling.

Women assigned to the attention control also received six phone calls, but for about 10 minutes each, and their partners received three 10-minute phone calls. All interventions and assessments were conducted over the telephone. Ms. and Mr. A, the subjects of the case study, received the TIP-C intervention.

Case Presentation

Case

Ms. A is a 54-year-old, white, married woman who learned of her breast cancer diagnosis about four months before the initiation of counseling. Within a month of her diagnosis, Ms. A had a double mastectomy with reconstruction. At the time of her first counseling session, she had received the second of four rounds of scheduled chemotherapy. In the first telephone session, Ms. A indicated that she was very willing to participate and was scheduled for six sessions of weekly interpersonal counseling. The initial session focused on her medical complications, including her need for injections to treat low white blood cell counts and the adverse reactions she had to the injections. She expressed concern that she was unable to administer her own injections and had to have family members administer them. A review of her psychological symptoms documented significant anxiety related to receiving chemotherapy and injections. Ms. A initially denied a history of or current depression, although on clinical interview she was diagnosed as depressed. She became tearful over her physical appearance, stating that she did not feel like a woman. She explained that she was not able to find a bra that fit properly because her breasts were oddly shaped. Ms. A could not stand for people to see her bald; her hair loss was immediate after her first round of chemotherapy. Ms. A indicated that she was having some difficulty with her children but did not elaborate. She stated that she had good communication with her husband; however, when he first was called, he had not even heard about their participation in the counseling. Ms. A recently had missed work because of her decreased white blood cell count and was very concerned about missing work because she never missed prior to her illness.

Interpretation

In the first session of TIP-C, counselors rapidly assess the interpersonal issues that confront participants to determine which one of four areas (grief, interpersonal role disputes, role transitions, or interpersonal deficits) to focus on in the remaining sessions. Ms. A was struggling with a number of challenges such as reliance on family members for injections, a strained relationship with her children, poor body image, and concern

about maintaining her professional teaching role. The counselor offered an interpersonal formulation of role transitions that fit with Ms. A's many personal and professional challenges. Role transitions involve the exploration of the changes brought about by illness, evaluation of the roles changed or lost, exploration of emotional reactions to role changes, identification of positive and negative aspects of role changes, skills helpful with role transitions, and key relationships affected by transitions. Role transitions identified were (a) change of appearance and transition to a new body, (b) difficulty with the sick role and adapting to the changes required by the cancer treatment, and (c) issues in key relationships (stress and lack of support from family members). These role transitions were Ms. A's primary concerns and were the focus during the next sessions. The counselor also provided education about coping with the injections, side effects from chemotherapy, and current psychological stressors.

Case

In the next two telephone sessions, Ms. A reported feeling more depressed. Symptoms were poor memory, difficulty concentrating, anxiety and depression, and some fatigue. She denied suicidal ideation. Ms. A revealed that she was having problems making the transition from the role of mother of little children to mother of adult children. She talked about the difficulty she had in giving up control over her children's lives now that they were young adults and about her communication difficulties with them. Despite severe side effects from the cancer treatment, she did all the cooking and cleaning because her children would not help. Furthermore, her children had no guilt about their lack of support; she believed that her children were tired of her being sick and that they just did not want to hear about her symptoms anymore. Her primary strategy to deal with her children's behaviors was to shame them into doing household chores, but she had no success. The conversation shifted to the sick role and the fact that Ms. A tended to behave as if she was not receiving treatment for cancer nor experiencing such severe side effects. Ms. A did everything she did before she became ill, and her family accepted this as her normal behavior. She said that being in the sick role was not negotiable because her husband does everything on the outside of the house and she does everything inside. She reported that her husband believed that if the children did not help around the house, that was not his fault because she did not bring them up properly.

Interpretation

After the counselor provided education about cancer treatment side effects, assurance that some side effects would dissipate in time after completion of chemotherapy, and strategies to deal with specific symptoms, the focus shifted to Ms. A's relationship with her adult children. Because of the nature and seriousness of the interpersonal issues that surfaced, the counselor postponed discussing physical appearance and focused on role transitions, including Ms. A's associated depression. These early sessions brought into sharp focus how Ms. A's relationship problems were compounded by her illness. The counselor discussed the role transition from being a caretaker of young children to being a parent of adult children. Ms. A was urged to consider the role transition regarding her health, specifically the transition to the sick role. In interpersonal counseling, the counselor discusses the sick role and

gives the participant license to cut back on some responsibilities without guilt or feeling like a failure.

At this point, and in the context of what appeared to be worsening symptoms of depression for Ms. A, the counselor had the daunting task of sorting through a collection of substantial interpersonal strains that were concomitant to her treatment. Ms. A was encouraged to state clearly what behavior she expected from herself and others and then use positive reinforcement when the expected behavior occurred. The negative reinforcement strategy that Ms. A. typically used was not effective. She was asked to reconsider the implications of nonparticipation in various household tasks. For example, if she was unable to bake cookies for her children because of her cancer treatment-related fatigue and depression, Ms. A was asked to consider what would happen realistically. Alternative strategies were that her children would bake or purchase cookies or do without. In either case, nothing tragic would occur. Ms. A was encouraged to realize that she does not need to function as if she were not experiencing side effects but could adopt the sick role without guilt or feeling like a failure. The counselor reviewed strategies for handling interactions with family members and role-played using clear communication about her needs and desires. In interpersonal counseling, role-playing sometimes is used to allow participants the opportunity to practice their communication skills in a supportive context in which they can be given feedback and encouragement.

By the end of the third session, the counselor had made considerable progress in identifying relationship issues, most of which were entwined in role transitions and role disputes (i.e., conflicts with others). These added to the stress that Ms. A experienced secondary to her cancer treatment and influenced her recovery and QOL. The challenge continued to be that of trying to help Ms. A to create meaningful progress in these areas in the few short remaining sessions. The goal is not to bring resolution to problems but rather to initiate strategies and dialogues that will put in motion positive and ongoing changes. In the case of Ms. A, management of her depressive symptoms was complicated not only by her interpersonal issues but also by the physical side effects of cancer treatment. Strategies to deal with these side effects must be part of counseling because physical difficulties often exacerbate interpersonal difficulties, and vice versa.

Case

The fourth session covered strategies to deal with the side effects of chemotherapy (nausea, diarrhea, fatigue) and with adopting the sick role, including asking for help immediately after chemotherapy to relieve her of the household task burden. Several friends offered to cook, for example, but Ms. A refused their help. She tried some new strategies discussed in previous sessions with her children that were successful. Ms. A reported feeling better and that she and her children were talking about their communication problems. One child actually asked for some advice, and Ms. A was very pleased about the increased communication. Although Ms. A did not report changes as far as more help around the house, she seemed less concerned about this issue and generally less stressed about her children.

Interpretation

The fourth session, five days postchemotherapy, focused on role transitions, specifically Ms. A's reluctance to adopt the sick role. The counselor role-played how to ask for what she

needs, including suggesting that friends may want to show their tangible support by helping her. The counselor gave an assignment to "be nice to herself" by allowing herself to be excused from and to ask for help with at least one task.

By this session, some tangible progress had become evident. Despite being somewhat set in her ways with managing relationships with her children and spouse, Ms. A was acting on the counselor's advice and beginning to recognize positive consequences as a result. These consequences were evident not only in Ms. A's reports of improved communication with her family members but also in her overall mood. At this juncture, the counselor carefully had to identify those interpersonal strategies that were working for Ms. A (e.g., abdicating what she thought were parental roles by having her children assume responsibilities) and encourage her to continue those in earnest. The counselor, in an effort to manage Ms. A's depressive symptoms by permitting her the sick role, used the interpersonal psychotherapy technique of homework assignments, together with a promise to discuss the assignments at the next session, to increase the probability of compliance.

Case

By the fifth session, Ms. A reported that her side effects from the previous week had subsided. Ms. A was learning to delegate to others and realized that nothing horrible happened by delegating some tasks. Ms. A was laughing as she reported the outcomes of her homework (i.e., being nice to herself by delegating), demonstrating less depression. Ms. A's husband bought her an expensive present, and Ms. A saw it as a tangible symbol of his love and caring. Ms. A discussed her physical appearance and the role transition to a new body—a body still healing. She talked about things that were stressful and strategies to reduce the stress. For example, she reported telling her children she could not do the arrangements for their party. She reported that this behavior was different for her and that Mr. A was supporting her totally. Ms. A also reported that she was proud of the way she handled the situation and believed that her relationships with her children had improved. She talked about her job performance and about rearranging her work to accommodate her cancer-related fatigue. She worried that she was not doing as good a job as she did in previous years, although her coworkers had complimented her. Ms. A was encouraged to use reframing to turn negative statements and thoughts into more positive statements. As requested by Ms. A, the counselor reviewed symptoms of depression and menopausal symptoms secondary to cancer treatment and the strategies to handle symptoms. Ms. A returned to the topic of stressors. Her main stress was at work, and specific strategies were discussed to handle work stress. The session ended with homework related to increasing her pleasurable activities and reducing stress. Ms. A was encouraged to do something pleasurable with her spouse.

Interpretation

In this session, the counselor reinforced Ms. A's successes in delegating tasks, both at home and at work, and for feeling okay about it. When Ms. A. talked about how she did not feel like a woman, the counselor reframed the issue as one about her own image, not the image that others may have of her. The counselor reinforced that she still had two more reconstructive surgeries and that perhaps her family and friends do not focus on her breast shape as much as she does. The counselor and Ms. A discussed how Mr. A treats her as still attractive and

that she might want to discuss further with Mr. A about what he thinks about her appearance. Ms. A changed the topic because it was addressed to the capacity that Ms. A was able to deal with it at the time.

The counselor provided education about menopausal symptoms, fuzzy thinking, pronounced mood swings, depressive symptoms, hormonal therapy and side effects, and the various treatments available. The counselor complimented her on how she handled a difficult work situation and used reframing to suggest that she is doing the best job possible given the circumstances and that, from an outsider's perspective, she was doing marvelously. The counselor encouraged her to use the social support of her coworkers and the communication and other strategies discussed for work and home stressors. She denied any other stressors at the time.

The fifth telephone session illustrates several staple techniques of interpersonal counseling: positive reframing, positive reinforcement, positive regard for the participant, additional homework assignments, and identification of sources of social support. The counselor combined these techniques with cancer education to minimize Ms. A's anxiety and encourage her continued pursuit of pleasurable activities and reduced responsibility for her children's needs.

Case

The sixth session focused on termination. Ms. A reported fewer side effects from her last chemotherapy treatment. Her family celebrated the last treatment as part of recognizing her milestones and increasing pleasurable activities. Ms. A continued to voice anxiety about her lack of hair and future reconstructive surgery but discussed some strategies that she had learned to deal with her appearance issues. Ms. A talked about her mood swings and history of depression (something she denied at baseline assessment) and requested information about medications or other coping strategies. She reported feeling more supported by her family and less stressed at work. Ms. A was better able to handle her symptoms and had improved her QOL at the conclusion of counseling.

Interpretation

In response to Ms. A's questions, the counselor provided education about hormonal therapy, its possible side effects, strategies for dealing with the side effects, antidepressants, and strategies to deal with depression, including being her own advocate with her primary care physician. Ms. A's family encouraged her to start some medication for her mood swings and crying spells, and the counselor reinforced that Ms. A might benefit from treatment. Various community mental health resources were provided. The counselor reinforced Ms. A's past successes in reducing stress, bolstering her social support, communicating with others about her needs, and allowing others to assume responsibilities because of her health issues. The principle goals of the final session of TIP-C were to summarize the participant's accomplishments over the course of counseling, identify potential sources of future stress and mechanisms for dealing with it, and identify primary sources of social support with encouragement to diligently maintain those relationships.

The Partner

A staple part of TIP-C is inclusion of the partner because partners are key in supporting women with breast cancer

through the experience. The following presents the counseling sessions of Mr. A.

Case

Mr. A is a 57-year-old, white man who asked whether he was a typical participant because he was religious. After the counselor talked about the role of faith and prayer as coping strategies, Mr. A agreed that he and his wife were right for the program. The session started with an overview of TIP-C and education about depression and fatigue. Mr. A believed that his wife had both of the side effects, along with significant anxiety. Mr. A talked about her use of an antianxiety medication and expressed concern about possible dependence on it. Mr. A talked openly about his disappointment with his children and how his children's behaviors generated stress for him and his wife. He believed that the stress impeded his wife's recovery. Mr. A said that next time he wanted to talk about symptoms of depression, fatigue, and possibly his relationships with Ms. A and their children if time allowed.

Interpretation

In TIP-C, the goal is to bolster the partner's ability to support the woman with breast cancer by answering questions and providing education and supportive counseling for the partner. The assumption is that if the partner is unable to deal with his or her own anxiety and stress, he or she will not be able to assist the woman with breast cancer. Mr. A received education about the antianxiety medication Ms. A was taking and about other medications that might help her with depression and anxiety. Mr. A was encouraged to allow Ms. A to take medications as prescribed during chemotherapy and reconstruction. The sick role was explained to Mr. A, and the importance of helping Ms. A adopt the sick role was stressed. The counselor discussed the role of the father in making sure his actions and overseeing his children would help Ms. A. In this session, the counselor essentially recruited Mr. A as an ally for Ms. A in her efforts to cope with depression and other cancer treatment-related side effects.

Case

The second session began with a discussion of the emotional distress of breast cancer and how the distress affects both parties. Mr. and Ms. A had experienced increased depression, anxiety, fear, uncertainty, and stress. Mr. A talked at length about his own anxiety, indicating that both he and Ms. A experienced severe anxiety the day before and day of chemotherapy administration. They often made each other's anxiety worse. Another issue is that he became anxious when family and friends shared materials regarding cancer treatment. Reading these materials made him fearful about how they were dealing with his wife's illness and about his role in supporting her. The counselor reinforced how they had used the scientific evidence provided by her physician to support their decisions about treatment and reinforced the idea that correct choices were made. The counselor gave him permission to dispose of any such materials without reading them to reduce anxiety. Mr. A expressed gratitude for putting his mind at ease. The session then shifted focus to the interpersonal context of getting and giving support. The counselor reminded Mr. A about communicating openly about anxiety without dwelling on it to the extent that he would transmit it to Ms. A. They reviewed strategies to cope with this anxiety. Mr. A also talked about fatigue as a problem and his concern over his wife's "fuzzy thinking" and forgetfulness, and he recognized that Ms.

A had issues about not feeling feminine. Ms. A had begun to discuss her feelings with Mr. A. The session concluded with a brief discussion of menopausal symptoms and Mr. A's need to talk with his children about helping around the house.

Interpretation

The counselor discussed strategies for handling stressors, such as soliciting social support, taking prescribed medications, and maintaining important interpersonal relationships. The counselor provided education about effective relaxation exercises and more general approaches to reducing the ill effects of stressors in life, such as increasing pleasurable activities as a couple. Rather than discuss their mutual anxiety at length, the counselor recommended listening to music or books while driving to chemotherapy appointments and taking a portable compact disc player to listen to pleasurable music or books. The counselor talked about the importance of reducing stress because it interacts with and perhaps intensifies side effects. The counselor provided education about cognitive problems with cancer treatment and the importance of memory aids such as writing things down. Furthermore, the counselor explained how the problem was exacerbated by anxiety. The counselor recommended the use of a social calendar posted on the refrigerator to write down all appointments and social events. The calendar would remind family members when Ms. A was having chemotherapy so that the family could plan the division of labor accordingly, especially for the days immediately after treatment.

The second session with the partner was packed with practical tips and suggestions for easing the burden experienced by both Ms. and Mr. A. After assessing Mr. A's reaction to his wife's illness, aided by some information already provided by Ms. A, the counselor rapidly disseminated strategies for managing anxiety, forgetfulness, and depression, with the hope of enhancing the quality of social support available to Ms. A.

Case

The final session began with a discussion of general cancer information but quickly focused on Ms. A's mood swings, fatigue, and symptoms of depression by which Mr. A was greatly bothered. Mr. A recognized the self-esteem issue related to Ms. A's breast shape and was going to try to increase her self-esteem by rephrasing things and being more positive. Mr. A discussed the children planning their own party as an example of Ms. A assuming the sick role and how he was totally supportive of his wife. He worried about her doing too much. He reported that things were better now that he and Ms. A were letting the children handle more responsibility for their own lives. The session refocused on the different expectations about how much Ms. A does on a daily basis and how to support each other.

Interpretation

The counselor discussed different strategies to deal with mood swings such as walking away, getting out of the house, or perhaps rephrasing things. The counselor normalized the mood swings and suggested that perhaps Mr. A. might talk with Ms. A about how best to handle them. The counselor discussed Mr. A's own strategies to handle stress and the anxiety associated with chemotherapy. The strategies suggested in the previous sessions were helpful. The counselor and Mr. A. discussed some strategies that he could use to reinforce Ms. A. not overdoing and getting too fatigued and stressed. The counselor suggested that they talk to each other about expecta-

tations and how to best support each other through the cancer experience. Education was provided about menopausal symptoms related to chemotherapy and hormonal therapy, specifically hot flashes, mood swings, depression, and strategies to handle various symptoms. The counselor also suggested that an antidepressant might be appropriate if the mood swings continued or if depression symptoms worsened. Mr. A was encouraged to support Ms. A exploring these various options with her physician. The session ended with the counselor complimenting Mr. A for his support and care of Ms. A.

During the course of Ms. A's and Mr. A's counseling, the counselor provided education about depression, anxiety, stress, side effects of cancer treatment, the sick role, and strategies to deal with these issues. The counselor used role-play, reframing, discussion of communication with significant others, and assigned homework to increase pleasurable activities. The counselor provided practical tips that would help Ms. A cope with the side effects of cancer treatment and her changing appearance (e.g., wigs, scarves, bras). The counselor also tried to ease Mr. A's anxiety by normalizing the sometimes distressing experiences that his wife was undergoing, with assurances that things would improve over time.

Discussion and Conclusions

The case of Ms. A represents a rather typical scenario for patients receiving treatment for breast cancer: a middle-aged woman experiencing adverse physical and psychological side effects from treatment and stress in her interpersonal relationships. Understanding, much less remedying, Ms. A's depressive symptoms is not possible without careful consideration of their association with the key interpersonal relationships in her life. In some cases, Ms. A's treatment-related side effects magnified existing interpersonal issues (e.g., with children) that varied in functionality during times of good health. In other cases, treatment-related side effects interrupted those relationships (e.g., with coworkers), with Ms. A simply wanting to resume them as she normally would.

To help Ms. A with the management of her symptoms, the counselor deployed a range of interpersonal counseling techniques, including encouraging expression of affect, frequently reviewing symptoms of depression, giving the client the sick role, decision analysis, role-play, homework assignments, and consistently showing positive regard for the client (Weissman et al., 2000). The researchers supplemented these interpersonal counseling techniques with cancer education to help Ms. A with her understanding and uncertainty surrounding the course of her illness and its treatment. Because most people in this situation experience substantial anxiety about the illness and its treatment, cancer education is a vital adjunct to traditional interpersonal counseling techniques for the management of distress.

The counselor also worked carefully with Ms. A's husband during her counseling. Like many husbands of patients with breast cancer, Mr. A was unsure about his participation in the counseling. However, after establishing a rapport with the counselor, he readily admitted that he had substantial anxiety about his wife's condition and her reaction to the chemotherapy. The counselor's task with Mr. A was to address his concerns while enhancing his potential as a vital source of social support to Ms. A.

Despite the fact that telephone counseling with this couple occurred over a brief period of time, both reported substantial

positive changes in their own psychological distress and the nature of their relationships with each other and their children. This is precisely the effect that would be predicted by interpersonal theories of psychological distress. These results were not atypical of other women and their partners who participated in the intervention in this study.

Implications for Nursing

Family members play a significant role in supporting women through breast cancer diagnosis and treatment; thus, nurses should assess the emotional distress of both partners during the course of treatment and, if needed, provide referral to psychosocial interventions. By initiating positive solutions to existing interpersonal strains and mobilizing social support and understanding from significant others during treatment for cancer, the

negative psychosocial side effects of cancer treatment can be managed effectively and minimized. Although this intervention requires additional training in the advanced practice nursing role, some techniques in the intervention can be used by all nurses, regardless of specialty training, to provide critical education and support to women with breast cancer and their partners. For example, nurses can provide education to both partners to reduce anxiety or refer to supportive interventions in face-to-face, telephone, or electronic formats. Brief, focused psychosocial interventions delivered over the telephone may be a solution to improve symptom management and QOL for women receiving adjuvant therapy for breast cancer and their partners.

Author Contact: Terry Badger, PhD, APRN, BC, can be reached at tbadger@nursing.arizona.edu, with copy to editor at rose_mary@earthlink.net.

References

- Badger, T.A., Braden, C.J., Longman, A.J., & Mishel, M.H. (1999). Depression burden, self-help interventions and social support among women receiving treatment for breast cancer. *Journal of Psychosocial Oncology, 17*(2), 17–35.
- Badger, T.A., Braden, C.J., & Mishel, M.H. (2001). Depression burden, self-help interventions, and side effect experience in women receiving treatment for breast cancer. *Oncology Nursing Forum, 28*, 567–574.
- Badger, T.A., Meek, P., & Segrin, C. (2001). [Telephone intervention project: Rural women with cancer and their partners]. Unpublished raw data.
- Badger, T.A., Segrin, C., Meek, P., Lopez, A., Bonham, E., & Sieger, A. (in press). Telephone interpersonal counseling to improve symptom management and quality of life for women with breast cancer. *Oncology Nursing Forum*.
- Bottomley, A. (1997). Where are we now? Evaluating two decades of group interventions with adult cancer patients. *Journal of Psychiatric and Mental Health Nursing, 4*, 251–265.
- Braden, C.J., Mishel, M.H., & Longman, A.J. (1998). Self-help intervention project: Women receiving breast cancer treatment. *Cancer Practice, 6*, 87–98.
- Bultz, B.D., Specia, M., Brasher, P.M., Geggie, P.H., & Page, S.A. (2000). A randomized controlled trial of a brief psychoeducational support group for partners of early stage breast cancer patients. *Psycho-Oncology, 9*, 303–313.
- Donnelly, J.M., Kornblith, A.B., Fleishman, S., Zuckerman, E., Raptis, G., Hudis, C.A., et al. (2000). A pilot study of interpersonal psychotherapy by telephone with cancer patients and their partners. *Psycho-Oncology, 9*, 44–56.
- Fawzy, F.I., Fawzy, N.W., Arndt, L.A., & Pasnau, R.O. (1995). Critical review of psychosocial interventions in cancer care. *Archives of General Psychiatry, 52*, 100–113.
- Giese-Davis, J., & Spiegel, D. (2003). Emotional expression and cancer progression. In R.J. Davidson, K.R. Scherer, & H.H. Goldsmith (Eds.), *Handbook of affective sciences* (pp. 1053–1082). New York: Oxford University Press.
- Greenberg, M.E. (2000). Telephone nursing: Evidence of client and organizational benefits. *Nursing Economics, 18*, 117–123.
- Hunkeler, E.M., Meresman, J.F., Hargreaves, W.A., Fireman, B., Berman, W.H., Kirsch, A.J., et al. (2000). Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Archives of Family Medicine, 9*, 700–708.
- Jemal, A., Tiwari, R.C., Murray, T., Ghafoor, A., Samuels, A., Ward, E., et al. (2004). Cancer statistics, 2004. *CA: A Cancer Journal for Clinicians, 54*, 8–29.
- Lewis, F.M., Zahlis, E.H., Shands, M.E., Sinsheimer, J.A., & Hammond, M.A. (1996). The functioning of single women with breast cancer and their school-aged children. *Cancer Practice, 4*, 15–24.
- Meek, P.M., Nail, L.M., Barsevick, A., Schwartz, A.L., Stephen, S., Whitmer, K., et al. (2000). Psychometric testing of fatigue instruments for use with cancer patients. *Nursing Research, 49*, 181–190.
- Meyer, T.J., & Mark, M.M. (1995). Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments. *Health Psychology, 4*, 101–108.
- Nail, L.M. (1996). Differentiating fatigue and depression in cancer patients. In C.M. Hogan & R. Wickham (Eds.), *Issues in managing the cancer patient: A current reference and bibliography* (pp. 36–42). New York: Phillips Healthcare Communications.
- Newport, D.J., & Nemeroff, C.B. (1998). Assessment and treatment of depression in the cancer patient. *Journal of Psychosomatic Research, 45*, 215–237.
- Paraska, K., & Bender, C.M. (2003). Cognitive dysfunction following adjuvant chemotherapy for breast cancer: Two case studies. *Oncology Nursing Forum, 30*, 473–478.
- Pasacreta, J.V. (1997). Depressive phenomenon, physical symptom distress, and functional status among women with breast cancer. *Nursing Research, 46*, 214–221.
- Ridsdale, L., Godfrey, E., Chalder, T., Seed, P., King, M., Wallace, P., et al. (2001). Chronic fatigue in general practice: Is counseling as good as cognitive behaviour therapy? A UK randomised trial. *British Journal of General Practice, 51*(462), 19–24.
- Rounsaville, B.J., Klerman, G.L., Weissman, M.M., & Chevron, E.S. (1985). Short-term interpersonal psychotherapy (IPT) for depression. In E.E. Beckham & W.R. Leber (Eds.), *Handbook of depression: Treatment, assessment, and research* (pp. 124–150). Homewood, IL: Dorsey Press.
- Schulberg, H.C., & Scott, C.P. (1991). Depression in primary care: Treating depression with interpersonal psychotherapy. In C.S. Austad & W.H. Berman (Eds.), *Psychotherapy in managed health care: The optimal use of time and resources* (pp. 153–170). Washington, DC: American Psychological Association.
- Spiegel, D. (1997). Psychological aspects of breast cancer treatment. *Seminars in Oncology, 24*(1, Suppl. 1), S1–36–S1–47.
- Weissman, M.M., & Klerman, G.L. (1993). Interpersonal counseling for stress and distress in primary care settings. In G.L. Klerman & M.M. Weissman (Eds.), *New applications of interpersonal psychotherapy* (pp. 295–318). Washington, DC: American Psychiatric Association.
- Weissman, M.M., & Markowitz, J.C. (2000). An overview of interpersonal psychotherapy. In M.M. Weissman, J.C. Markowitz, & G.L. Klerman (Eds.), *A comprehensive guide to interpersonal psychotherapy* (pp. 1–11). New York: Basic Books.
- Weissman, M.M., Markowitz, J.C., & Klerman, G.L. (2000). *A comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.
- Winningham, M.L., Nail, L.M., Burke, M.B., Brophy, L., Cimprich, B., Jones, L.S., et al. (1994). Fatigue and the cancer experience: The state of the knowledge. *Oncology Nursing Forum, 21*, 23–36.