Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This study has been financially supported by National Cancer Institute.

ORCID

Laura S. Porter http://orcid.org/0000-0002-2962-2378

References

[1] Badr H. New frontiers in couple-based interventions in cancer care: refining the prescription for spousal communication. Acta Oncol. 2017;56:139–145.
[2] Lepore SJ, Helgeson VS. Social constraints, intrusive thoughts, and mental health after prostate cancer. J Soc Clin Psychol. 1998;17:89–106.
[3] Baucom DH, Porter LS, Kirby JS, et al. Couple-based interventions for medical problems. Behavior Ther. 2012;43:61–76.
[4] Baucom DH, Porter LS, Kirby JS, et al. A couple-based intervention for female breast cancer. Psycho-Oncol. 2009;18:276–283.
[5] Porter LS, Keefe FJ, Baucom DH, et al. Partner-assisted emotional disclosure for patients with gastrointestinal cancer: results from a randomized controlled trial. Cancer. 2009; 115(S18):4326–4338.
[6] Porter LS, Keefe FJ, Garst J, et al. Caregiver-assisted coping skills training for lung cancer: results of a randomized clinical trial. J Pain Symptom Manage. 2011;41:1–13.
[7] Reese JB, Porter LS, Regan KR, et al. A randomized pilot trial of a telephone-based couples intervention for physical intimacy and sexual concerns in colorectal cancer. Psychooncology. 2014;23:1005–1013.
[8] Porter LS, Keefe FJ, Baucom DH, et al. A randomized pilot trial of a videoconference couples communication intervention for advanced GI cancer. Psycho-oncol. 2017;26:1027–1035.
[9] Porter LS, Keefe FJ, Baucom DH, et al. Partner-Assisted Emotional Disclosure for Patients with GI Cancer: Eight-week follow up and processes associated with change. Support Care Cancer. 2012;20:1755–1762.
[10] Baucom BR, Saxbe DE, Ramos MC, et al. Correlates and characteristics of adolescents' encoded emotional arousal during family conflict. Emotion. 2012;12:1281–1291.
[11] Weusthoff S, Baucom BR, Hahlweg K. Fundamental frequency during couple conflict: an analysis of physiological, behavioral, and sex-linked information encoded in vocal expression. J Family Psychol. 2013;27:212–220.
[12] Juslin PN, Scherer KR. Vocal expression of affect. In: Harrigan JA, Rosenthal R, Scherer KR, editors. The new handbook of methods in nonverbal behavior research. New York: Oxford University Press; 2005. p. 65–135.
[13] Fischer M, Baucom D, Baucom B, et al. Emotional arousal and social support in German and American couples talking about breast cancer. J Family Psychol. 2015;29:744–754.

LETTER TO THE EDITOR

Author's response to Porter and Keefe letter to the editor regarding 'new frontiers in couple-based interventions in cancer care: refining the prescription for spousal communication'

Hoda Badr

Department of Medicine, Section of Health Services Research, Baylor College of Medicine, Houston, TX, USA

Sir,

Recently, Drs. Porter and Keefe wrote a letter to the editor [1] regarding my 2017 review article, 'New Frontiers in couple-based Interventions in Cancer Care: Refining the Prescription for Spousal Communication' [2]. While some concerns were raised, a number of areas of potential consensus were also highlighted. Below, I will directly respond to the concerns that were raised, summarize areas of consensus and propose future research directions.

The main concern relates to how a 2009 study that Porter and colleagues conducted in gastrointestinal cancer [3] was characterized in the review. The study examined the effects of a four-session partner-assisted emotional disclosure intervention versus an attention control condition on three outcomes – psychological distress, relationship quality and intimacy. In the intervention, the therapist trained couples in 'skills designed to help the patient disclose his/her concerns related to the cancer experience' (p. 5). All couples were instructed that their goal was for the patient to focus on the expression of his/her feelings and for the partner to facilitate disclosure and communicate acceptance and understanding. While it is entirely possible that the authors tried to address couples' motivations for the avoidance of cancer-related discussions and provide individualized skills training in the intervention as stated in their letter [1], this was not explicitly stated in the article [3]. Furthermore, when describing their intent-to-treat (ITT) analyses, the authors stated (p. 7) that the time X treatment effect for relationship quality was significant, but that the analyses for intimacy and mood disturbance were not significant [3]. Despite this, Porter and Keefe describe their intervention as showing positive effects for both relationship quality and intimacy [1]. While this

CONTACT Hoda Badr hoda.badr@bcm.edu Department of Medicine, Section of Health Services Research, Baylor College of Medicine, Houston, TX, USA

https://doi.org/10.1080/0284186X.2017.1413249

statement is presumably based on findings from a subsequent completers analysis, it is important to point out that even though ITT analyses are more conservative than completers analyses, they avoid overoptimistic estimates of intervention efficacy resulting from the removal of non-completers by accepting that noncompliance and protocol deviations are likely to occur in actual clinical practice [4]. Thus, the focus on relationship quality in my review was not a mischaracterization [2]. Furthermore, while there is no dispute that a significant time X treatment effect for relationship quality was described in the original article, tests of the simple slopes were not reported and a graph showing estimated trajectories of change in patients' and partners' scores (logged values) for relationship quality by treatment condition (Figure 2) showed an approximate post-test difference of .01 between study conditions [3]. The extremely small magnitude of this difference coupled with the absence of any statistical tests to indicate that it was significant suggests that even though the change between pre- and post-test was not the same in the two treatment conditions, post-test values for marital quality were not significantly greater in the intervention condition.

Based on the above, an issue where I hope we can agree is that the methodological strength of reporting standards for couple-based interventions in cancer must improve. Authors of several recent reviews have noted that dyadic interventions often do not include information on refusal and attrition, acceptability, barriers to participation and randomization techniques [5–7]. The reporting of pre- and post-test means as opposed to change scores would greatly enhance interpretation of findings and facilitate the calculation of effect sizes. Studies could greatly benefit from discussion of clinical significance in addition to statistical significance. More detailed descriptions of intervention content and procedures are also needed to foster transparency and facilitate replication.

Another area of potential consensus is that more work is needed to clarify for whom and under which circumstances emotional disclosure is beneficial. Given that encouraging patients not to hold back and openly express their emotions to their partners is a common recommendation in the cancer literature [8–10], it is not surprising that couple-based interventions routinely include emotional disclosure as a key component [3,11–16]. Despite this, several scholars (myself included) have noted that research in cancer provides little empirical support for the unilateral benefits of talking about feelings [17–19]. Indeed, while Drs. Porter and Keefe [1] rightly point out that many couples lack the skills to communicate effectively (and may thus benefit from emotional disclosure skills training), there are numerous individual (e.g., cultural background, gender, age, need for emotional expression), relationship (e.g., length, pre-existing communication patterns) and medical factors (e.g., type, severity, trajectory of illness) that could potentially attenuate or strengthen the effects of disclosure on the couple. More work is needed to specify these factors. By the same token, disclosing to someone other than the spouse [20] and teaching spouses problem-solving skills [21] are potentially effective methods for reducing patient distress that do not involve emotional disclosure to a partner. Our science can only benefit from investigating and testing these alternative strategies so that clinicians can have more tools in their toolboxes to offer to couples in need.

Finally, I want to reiterate that it is imperative that our field move beyond couple-based interventions that take a 'one size fits all approach.' This means clarifying how best to involve partners in interventions and developing more targeted interventions. Indeed, Porter et al [22] noted that one limitation of their intervention was that the application of communication training focused on patient disclosure to the partner without providing opportunities for the partner to disclose. In a subsequent intervention that was delivered via videoconferencing that was published after my review, both patients and partners were encouraged to talk about their cancer-related concerns [22]. Despite this more balanced approach, there were limited positive effects of the intervention for partners. Future research may thus benefit from identifying both individual and couple-level factors that might influence when it is more appropriate to conceptualize the partner's role in the intervention as either supportive or active. On a related note, several studies conducting moderator analyses of the effects of couple-based interventions have found that the interventions only benefited a subset of couples – specifically, those who had poorer functioning relationships, greater cancer-related distress or poor communication skills at the outset [3,13,16]. There is also increasing recognition that psychosocial interventions should be targeted to those at greatest risk for poor outcomes [23,24], and it is heartening to see that couple-based interventions have begun to follow suit [22]. However, more work is needed to determine whether there are profiles of at-risk couples who may benefit from such interventions, and whether it is necessary to screen for distress (marital and/or psychological) or communication difficulties in both the patient and partner (or just one member of the couple).

In conclusion, I am pleased that my review has ignited some healthy academic discourse and hope that the small but growing number of researchers interested in couple-based interventions in cancer will benefit from the perspectives that were presented. Ultimately, however, the success of this debate will be measured by its impact on the direction and conduct of future trials. I hope the dialog between Drs. Porter, Keefe, and myself encourages researchers to critically review and question the couple-based intervention literature in cancer and tackle the issues raised here in innovative new ways. To the extent that future research can address these issues, the scientific quality of couple-based interventions as well as their clinical relevance, uptake and dissemination will continue to improve.

Disclosure statement

No potential conflict of interest was reported by the author.

References

[1] Porter L, Keefe F. Couple-based communication interventions for cancer: moving beyond a "one size fits all" approach. Acta Oncol.
[2] Badr H. New frontiers in couple-based interventions in cancer care: refining the prescription for spousal communication. Acta Oncol. 2017;56:139–145.
[3] Porter LS, Keefe FJ, Baucom DH, et al. Partner assisted emotional disclosure for patients with gastrointestinal cancer. Cancer. 2009;115:4326–4338.
[4] Heritier SR, Gebski VJ, Keech AC. Inclusion of patients in clinical trial analysis: the intention-to-treat principle. Med J Aust. 2003;179:438–440.
[5] Regan T, Lambert S, Girgis A, et al. Do couple-based interventions make a difference for couples affected by cancer? a systematic review. BMC Cancer. 2012;12:279. DOI:10.1186/1471-2407-12-279.
[6] Badr H, Krebs P. A systematic review and meta-analysis of psychosocial interventions for couples coping with cancer. Psychooncology. 2013;22:1688–1704.
[7] Hopkinson JB, Brown JC, Okamoto I, et al. The effectiveness of patient-family carer (Couple) intervention for the management of symptoms and other health-related problems in people affected by cancer: a systematic literature search and narrative review. J Pain Symptom Manage. 2012;43:111–142.
[8] Cordova M, Cunningham LL, Carlson C, et al. Posttraumatic growth following breast cancer: a controlled comparison study. Health Psychol. 2001;20:176–185.
[9] Figueiredo M, Fries E, Ingram K. The role of disclosure patterns and unsupportive social interactions in the well-being of breast cancer patients. Psychooncology. 2004;13:96–105.
[10] Iwamitsu Y, Shimoda K, Abe H, et al. Differences in emotional distress between breast tumor patients with emotional inhibition and those with emotional expression. Psychiatry Clin Neurosci. 2003;57:289–294.
[11] Baucom DH, Porter LS, Kirby JS, et al. A couple-based intervention for female breast cancer. Psychooncology. 2009;18:276–283.
[12] Porter LS, Keefe FJ, Garst J, et al. Caregiver-assisted coping skills training for lung cancer: results of a randomized clinical trial. J Pain Symptom Manage. 2011;41:1–13.
[13] Manne S, Nelson C, Kissane D, et al. Intimacy enhancing psychological intervention for men diagnosed with prostate cancer and their partners: a pilot study. J Sex Med. 2011;8:1197–1209.
[14] Lewis FM, Cochrane BB, Fletcher KA, et al. Helping her heal: a pilot study of an educational counseling intervention for spouses of women with breast cancer. Psychooncology. 2008;17:131–137.
[15] Scott J, Halford W, Ward B. United we stand? the effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer. J Consult Clin Psychol. 2004;72:1122–1135.
[16] Manne S, Ostroff JS, Winkel G, et al. Couple-focused group intervention for women with early stage breast cancer. J Consult Clin Psychol. 2005;73: 634–646.
[17] Goldsmith DJ, Miller LE, Caughlin JP. Openness and avoidance in couples communicating about cancer. Ann Int Commun Assoc. 2007;31:62–115.
[18] Hagedoorn M, Puterman E, Sanderman R, et al. Is self-disclosure in couples coping with cancer associated with improvement in depressive symptoms?. Health Psychol. 2011;30:753.
[19] Dagan M, Sanderman R, Hoff C, et al. The interplay between partners' responsiveness and patients' need for emotional expression in couples coping with cancer. J Behav Med. 2014;37: 828–838.
[20] Bultz BD, Speca M, Brasher PM, et al. A randomized controlled trial of a brief psychoeducational support group for partners of early stage breast cancer patients. Psychooncology. 2000;9: 303–313.
[21] Blanchard C, Toseland R, McCallion P. The effects of a problem-solving intervention with spouses of cancer patients. J Psychosoc Oncol. 1996;14:1–21.
[22] Porter LS, Keefe FJ, Baucom DH, et al. A randomized pilot trial of a videoconference couples communication intervention for advanced GI cancer. Psychooncology. 2017;26:1027–1035.
[23] Schneider S, Moyer A, Knapp-Oliver S, et al. Pre-intervention distress moderates the efficacy of psychosocial treatment for cancer patients: a meta-analysis. J Behav Med. 2010;33:1–14.
[24] Jacobsen PB. Lost in translation: the need for clinically relevant research on psychological interventions for distress in cancer patients. Ann Behav Med. 2006;32:119–120.

LETTER TO THE EDITOR

Pain relief after a short course of palliative radiotherapy in pancreatic cancer, the Academic Medical Center (AMC) experience

Gati Ebrahimi[a], Coen R. N. Rasch[a] and Geertjan van Tienhoven[a]

Department of radiation oncology, Academic Medical Center, Amsterdam, The Netherlands

Introduction

Pancreatic ductal adenocarcinoma (PDAC) is the fourth cause of cancer death and has a poor overall survival, with a five-year survival rate of 7% [1]. The majority of patients (approximately 80%) have locally advanced and/or metastatic disease at diagnosis and are treated with palliative intent [2–4].

At time of diagnosis, 30–40% of the patients report pain as a dominant symptom, which rises to 90% shortly before death [5,6]. Hence, successful pain management is often viewed as the key management in patients with advanced PDAC. In addition to neurolytic celiac plexus block (NCPB) [7,8] treatment with radiotherapy has shown to give improvement in pain control [9–13]. However, in part of these studies the radiation is meant to improve

CONTACT Gati Ebrahimi g.ebrahimi@amc.uva.nl Academic Medical Center, Department of radiation oncology, Meibergdreef 9, 1105 AZ Amsterdam, The Netherlands

Supplemental data for this article can be accessed here.

https://doi.org/10.1080/0284186X.2017.1400692