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Exploratory Controlled Study of the Impact of a Hypnosis-Based Intervention on the Couple's Communication and Coping in the Context of Cancer

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ABSTRACT

Emotional distress, communication, and dyadic coping difficulties are common among cancer patients and their partners. Hypnosis-based interventions can improve emotional distress in patients. We designed a group intervention combining self-hypnosis and self-care techniques. We hypothesized an effect of the intervention on emotional distress, conjugal communication, and dyadic coping, considered in patients and their partners. Our exploratory controlled study included 55 women with cancer and 55 partners. Participants completed questionnaires before and after the intervention, which was delivered to patients only. No significant effect of the intervention was revealed for patients or partners. Positive correlations between patients' and partners' communication and dyadic coping were revealed. However, to address couples' or partners' difficulties, interventions specifically designed for couples or partners must be tested.

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Introduction

Cancer has a lot of consequences for patients and their relatives. A large proportion of cancer patients suffer from emotional distress (Dauchy et al., 2013; Hernández Blázquez & Cruzado, 2016; Mitchell et al., 2011), which has a negative impact on treatment adherence and results, as well as general quality of life (Batty et al., 2017; Dauchy et al., 2013; Satin et al., 2009). In addition, patients' partners often become their main caregiver (Braun et al., 2007; Libert et al., 2006). Indeed, during these last decades, changes in health-care delivery and interventions allowed longer survival among cancer patients, along with a transfer of cancer treatments to outpatient settings. This increases the necessity for informal caregiving at home (Coriat et al., 2012; Vallerand et al., 2007). Because of their responsibilities and the burden of having a loved one suffering from a potentially terminal disease, cancer patients' partners can experience emotional distress as well (Cassidy & McLaughlin, 2015; Lapid et al., 2016; McClure et al., 2012), and both spouses' mood states are known to be associated

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(Paradis et al., 2009; Segrin & Badger, 2014). Indeed, cancer is generally considered to be coped with dyadically, meaning that both spouses are managing one partner's disease (Bodenmann, 2008a; Magsamen-Conrad et al., 2015). Dyadic coping is thus an essential resource within the relationship and helps to prevent psychological difficulties (Bodenmann, 2008a; Traa et al., 2015). An important factor associated with dyadic coping and management of the disease is couples' communication (Arden-Close et al., 2010; Bodenmann, 2008a; Magsamen-Conrad et al., 2015; Manne et al., 2006). Patients' and their spouses' cancer communication openness seem to be correlated (Paradis et al., 2009), but, unfortunately, it is often negatively impacted by cancer, with for example, more reluctance to talk about some emotional or cancer-related subjects (Goldsmith & Miller, 2014; Magsamen-Conrad et al., 2015). The relationship between communication and distress in couples dealing with cancer is not clear (Manne et al., 2010; Normand et al., 2004; Paradis et al., 2009), and clarifying this link seems important to better understand what factors impact emotional distress in couples.

Some studies have shown the efficacy of psychological interventions to decrease patients' emotional distress (Björneklett et al., 2013; De Vries & Stiefel, 2014). Alternative methods such as hypnosis-based interventions are also starting to show their positive effects on cancer patients' distress (Cramer et al., 2015; Grégoire, Bragard et al., 2017; Grégoire et al., 2020; Montgomery et al., 2013, 2017). Hypnosis is often used in combination with cognitive-behavioral therapy or self-care learning (Grégoire, Bragard et al., 2017; Grégoire et al., 2018, 2020; Montgomery et al., 2014) in order to induce changes in patients' daily functioning and dysfunctional cognitions and behaviors, including social and marital behaviors (Grégoire, Faymonville et al., 2017; Vanhau den huysse et al., 2017). However, few of these psychological-interventions studies investigated their indirect impact on the partner's well-being or on the couple's dynamic (Candy et al., 2011). Yet, if they allow positive effects on patients' psychological state, we can hypothesize that this improvement will have different repercussions on partners and the couple. For examples, partners could experience lower distress in response to patients' improved quality of life.

Therefore, the principal aim of this controlled exploratory study is to assess the impact of an 8-week group intervention combining self-care and self-hypnosis, proposed to cancer patients after their treatments, on the patient and their partner's well-being (emotional distress, couple's communication, and dyadic coping). We hypothesized a positive effect on all the variables, for both spouses, with a higher effect on patients. The secondary aim is to explore the correlations between the spouses' respective emotional distress, respective perception of the couple's communication, and respective perception of the dyadic coping, and between communication and emotional distress. The present study is based on planned analyses.

Material and Methods

The complete protocol of the study has previously been published (Grégoire et al., 2018) and displays detailed information about the study design, the recruitment procedures, and the assessment and intervention components. Therefore, we will only summarize these aspects in this section. The data discussed in this paper were collected in the context of a larger study published before (Grégoire et al., 2020) and aiming at assessing the effect of the intervention on patients' quality of life.

Participants

Patients were recruited in the University Hospital of Liège, in the context of a larger study investigating the effect of a hypnosis-based intervention on cancer patients' quality of life. For this study, the inclusion criteria were to be at least 18 years old, to be fluent in French, to present a nonmetastatic invasive cancer (all diagnoses accepted), to have completed all active treatments (surgery, radiotherapy, and/or chemotherapy) for less than a year, and to experience emotional or physical difficulties as established by a score of at least 4 out of 10 on one of the six chosen items of the Edmonton Symptom Evaluation Scale (Chang et al., 2000) (physical fatigue, moral fatigue, depression, anxiety, fear of recurrence, ruminations (Grégoire et al., 2018)). As the impact of the intervention on partners and couples was the secondary aim of a larger research project, having a partner was not an inclusion criterion for the main study.

Materials

Assessments were conducted at two different times for each partner (T1, T2). They had to complete the same questionnaires:

Sociodemographic and Medical Data

Data such as gender, age, education level, employment status, marital situation, and number of children were asked of both partners. Medical information such as type of cancer, time since diagnosis, and treatments received were only asked of the patient.

Hospital Anxiety and Depression Scale (HADS)

This scale measures anxiety and depression (Zigmond & Snaith, 1983). Cutoff scores for these two dimensions are 7 out of 21. A total score is also calculated to assess emotional distress. A higher score suggests more anxiety, depression, or emotional distress. Internal consistency of each scale is high (α range .79 to .90).

Couples' Illness Communication Scale (CICS)

This 4-item scale measures the tendency of each partner to discuss the illness and their comfort in doing so (Arden-Close et al., 2010). Scores range from 4 to 20. A higher score suggests better couple's communication. The scale's internal consistency is high ($\alpha = .80$). As no French translation of this scale existed before our study, we translated it with the agreement of the author (translation/back-translation method, with one the authors [VC] who is bilingual).

Dyadic Coping Inventory (DCI)

This 37-item scale assesses the couple's dyadic coping through a total score and nine subscale scores (stress communicated by oneself [SCO]; supportive dyadic coping by oneself [SDCO]; delegated dyadic coping by oneself [DDCO]; negative dyadic coping by oneself [NDCO]; stress communication of the partner [SCP]; supportive dyadic coping of the partner [SDCP]; delegated dyadic coping of the partner [DDCP]; negative dyadic coping by partner [NDCP]; common dyadic coping [CDC]; Bodenmann, 2008b). Based on this questionnaire, the couple's dyadic coping can be categorized into below average dyadic

coping (total score less than 111), in the normal range dyadic coping (total score from 111 to 145), and above-average dyadic coping (total score more than 145). The subscales have adequate to high internal consistency (α range .50 to .92).

In addition, as we focused on the potential positive impact of our intervention, partners from the experimental group had to answer one open question about the indirect benefits of the intervention they perceived for themselves (*Which personal benefits did you perceive after your partner's participation in the intervention?*). Multiple answers were accepted for this question.

Design

Our main study was a longitudinal, randomized waiting-list, controlled trial with an intention-to-treat (ITT) analytic strategy (Grégoire et al., 2018, 2020). To deal with missing values due to drop-outs, we used the *last observation carried forward* method (Fielding et al., 2008; Gravel et al., 2007) in which participants' missing data are replaced by the value they obtained in the previous measurement time.

In our main study, once 16 cancer patients were recruited, they were randomized into two groups of 8 participants: the first group received immediate intervention (experimental group; EG), and the second group received it (at the latest) 4 months later (control group; CG). The participants in the experimental group were evaluated before the intervention (T1) and after it (T2, approximately 3 months after T1). The participants in the control group were evaluated at the same time but received the intervention after T2. At the end of the first evaluation (T1), the experimenter asked each participant if they had a spouse and, if so, proposed that they ask their partner to answer a few questionnaires (alone, at home) and to bring them back later. Only the patients who had a partner who agreed to participate (no matter the duration of the relationship) were considered in this paper.

Intervention

The intervention was proposed to cancer patients only. It included eight weekly 2-hour sessions in a group of 8 to 10 participants. This has been developed and was led by one of the authors (MEF), (Charland-Verville et al., 2017; Faymonville et al., 2010). Participants had to complete different self-care tasks at home between sessions and keep a work-related diary to report how they managed it in their daily life. Examples of assignments are: adjusting self-expectation, reinforcing sense of self-esteem, adaptation of social roles, differentiating self from illness, managing ruminations, etc. This intervention is based on self-management and patient empowerment approaches, which aim to strengthen self-esteem, problem-solving skills, assertion, and self-confidence (Te Boveldt et al., 2014; Kim et al., 2017). Concerning hypnosis, a 15-minute hypnosis exercise was conducted under the therapist's supervision at the end of each session, with participants receiving a CD to encourage at-home practice, which is essential to take full advantage of hypnosis without the help of a therapist. It is intended that the practice of self-hypnosis will influence cognition and emotional regulation and therefore facilitate the completion of the assigned tasks. In this way, self-hypnosis is complementary to self-care tasks. Our aim is thus to investigate the effect of this innovative intervention combining two techniques who have been successfully combined in our clinical practice, rather than investigating the effect of each component

separately. More details about the sessions' content can be found in our paper describing the study protocol (Grégoire et al., 2018).

Data Analyses

All statistical analyses were performed using Statistica 13.3 (TIBCO Software Inc.). First, normality of the data was tested with the Shapiro-Wilks test. Then, baseline (T1) demographic, medical, and psychological data were compared between the experimental and control groups of each population (patients and partners) to test initial group equivalency with *t*-tests and Chi-square tests. Group-by-time changes in depression, anxiety, couple's communication, and dyadic coping were processed using multivariate analysis of variance (MANOVA) with repeated measures, which are quite robust tests that can support a violation of normality (Blanca et al., 2017; Mendoza et al., 1974), followed by post hoc comparisons (Tukey's HSD tests). Finally, as most variables were not normally distributed, Spearman rank-order correlations between patients' and partners' data (emotional distress, couple's communication, and dyadic coping) were conducted on data from T1. All tests were two-tailed, and the results were considered to be significant at $p < .05$. Partners' answers to the open question were classified into different general categories according to the themes addressed in their answers.

Results

As stated above, the following analyses were performed on participants whose partner accepted to participate and their spouses. Thus, of the 104 patients included in our study and randomized in the experimental and control groups, 60 had a partner who agreed to participate. As there were only five men in these 60 patients, they were excluded from the analyses, leading to final samples of 55 women with cancer ($n_{EG} = 33$; $n_{CG} = 22$) and 55 male partners ($n_{EG} = 33$; $n_{CG} = 22$). Indeed, if we had considered the male patients in our analyses, it would have been difficult to make conclusions about the impact of the intervention on them, or on a population of men and women with cancer, and the sample would not have been homogenous. Some participants (patients and partners) dropped out before T2. According to the ITT approach, their data were replaced by that obtained at T1. See [Figure 1](#) for more details about the sample's composition and the flow of participants. The average group intervention attendance rate was 6.1/8 sessions.

Description of the Sample

Sociodemographic and medical data of the participants and their partners are displayed in [Tables 1 and 2](#). Experimental and control groups in each population (patients and partners) were equivalent at baseline on demographics and medical data, except for whether they had children or not in the partners population ($p = .034$). Patients and their partners did not significantly differ at baseline on demographics except for employment status ($p < .001$). Indeed, a majority of patients were unable to work (incapacitated/invalided) or unemployed, while most of their partners were employed full time. More details about the medical data of the sample can be found in our previous article (Grégoire et al., 2020). Breast cancer was the most represented cancer in the sample (79.18%), followed by digestive

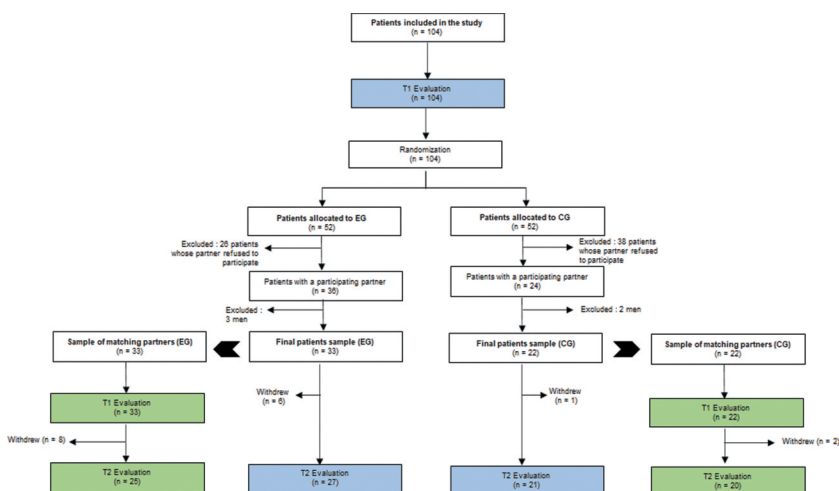


Figure 1. Flow of Participants and Sample Composition

cancers (5.45%). The majority of participants received surgery (98.18%), radiation therapy (70.91%), endocrine therapy (60%), and/or chemotherapy (54.55%).

Main Objective: Assessing the Impact of the Intervention on Patients' and Partners' Emotional Distress, Couple's Communication, and Dyadic Coping

In the patients' population, our results revealed a significant time effect, $F(3,51) = 9.34$; $p < .001$. Post hoc comparisons showed a significant improvement of dyadic coping (total score) between T1 and T2 for all patients ($p < .001$). No significant group-by-time effect was revealed, $F(3,51) = 2.09$; $p = .113$. However, our previously published results (Grégoire et al., 2020) already underlined the positive impact of the intervention on patients' emotional distress when considering the whole sample (anxiety: $p < .001$; depression: $p < .001$).

Concerning partners' emotional distress, perception of couple communication, and perception of dyadic coping, our results showed no significant effect of time, $F(3,49) = 0.142$; $p = .934$; and no significant group-by-time effect, $F(3,49) = 1.11$; $p = .354$. Finally, analysis of partners' answers to the open question about the benefits they perceived for themselves after the intervention revealed different categories (see Table 3). Only 36% ($n = 9$) of them did not experienced any indirect positive benefit after the intervention; 32% of partners noted a change in their couple relationship, with effects on proximity, understanding, coping, or communication for example; 20% of them were simply happy to see their spouse being well and evolve in a positive way; while 12% noted a decrease in their own anxiety.

Secondary Objective: Exploring the Differences and Associations between Patients' and Partners' Data

Differences in Psychological State at Baseline

Experimental and control groups (in each population: patients and partners) were similar at baseline on all psychological variables. However, there were some differences when

Table 1. Baseline Patients' Demographics and Medical Data in Each Group

	Total Sample (n = 55)	Experimental Group (n = 33)	Control Group (n = 22)	p
Demographics				
<i>Age (years)</i>				
Mean (SD)	51.93 (12.88)	50.58 (13.94)	53.95 (11.09)	.319
Range	24–78	24–78	30–74	
<i>Cultural origin, n (%)</i>				
Western Europe	52 (94.55)	30 (90.91)	22 (100)	.146
Eastern Europe	3 (5.45)	3 (9.09)	0 (0.00)	
<i>Marital status, n (%)</i>				
Married/living with partner	48 (87.27)	30 (90.91)	18 (81.81)	.322
In a relationship but not living together	7 (12.73)	3 (9.09)	4 (18.18)	
<i>Education level, n (%)</i>				
Elementary school, lower and upper	19 (34.55)	10 (30.30)	9 (40.91)	.692
Secondary school				
Bachelor's degree	22 (40.00)	13 (39.39)	9 (40.91)	
Master's degree or more	14 (25.45)	10 (30.30)	4 (18.18)	
<i>Employment status, n (%)</i>				
Employed full-time	4 (7.27)	2 (6.06)	2 (9.09)	
Employed part-time	11 (20.00)	5 (15.15)	6 (27.27)	.568
Incapacity of work/invalidity	23 (41.82)	16 (48.48)	7 (31.82)	
Unemployed/student/housewife/house-husband/retired/other	17 (30.91)	10 (30.30)	7 (31.82)	
<i>Children, n (%)</i>				
Yes	50 (90.91)	28 (84.85)	22 (100)	.056
No	5 (9.09)	5 (15.15)	0 (0.00)	
Patient medical history				
<i>Cancer diagnosis</i>				
Breast cancer	43 (78.18)	26 (78.79)	17 (77.27)	.144
Others	12 (21.82)	7 (21.21)	5 (22.73)	
<i>Time since diagnosis (months)</i>				
Mean (SD)	11.78 (10.30)	10.12 (5.42)	14.27 (14.74)	.438
Range	1–72	2–24	1–72	

considering the two whole samples: patients and partners differed at baseline on several psychological variables (see Table 4).

The results revealed a quite high score for couple's communication. However, partners seemed to consider it of significantly higher quality than patients. Concerning dyadic coping, the total scores indicated a normal range of dyadic coping for both partners. However, their perceptions of several dyadic coping dimensions seem to differ: SCO (expression of a need for help or support) and DDCP (the partner takes on tasks that the patient is unable to do, they give a hand) were significantly higher in patients, while DDCO (taking on tasks to support the other) and SCP (perception that the other is expressing a need for help or support) are higher in partners. These results also revealed the existence of emotional distress (especially anxiety) in patients, which is significantly different than the partners' psychological state. Indeed, the three HADS scores are below cutoffs for partners, meaning that they do not seem to suffer from emotional distress.

Associations between Patients' and Partners' Data at Baseline

Spearman correlations showed that patients' and partners' perception of their couple's communication were positively associated ($r_s = .47, p < .001$), as well as their perception of their dyadic coping (total score, $r_s = .56, p < .001$). Several dimensions of dyadic coping

Table 2. Baseline Partners' Demographics Data in Each Group

	Total Sample (n = 55)	Experimental Group (n = 33)	Control Group (n =22)	p
Demographics				
<i>Age (years)</i>	54.09 (13.01)	52.03 (13.28)	57.18 (12.23)	.180
Mean (SD)	22–80	22–79	31–80	
Range				
<i>Marital status, n (%)</i>				
Married/living with partner	49 (89.09)	30 (90.91)	19 (86.36)	.596
In a relationship but not living together	6 (10.91)	3 (9.09)	3 (13.64)	
<i>Education level, n (%)</i>				
Elementary school, lower and upper	22 (40.00)	11 (33.33)	11 (50.00)	.748
Secondary school				
Bachelor's degree	19 (34.55)	11 (33.33)	8 (36.36)	
Master's degree or more	12 (21.82)	9 (27.27)	3 (13.64)	
Missing data	2 (3.64)	2 (6.06)	0 (0.00)	
<i>Employment status, n (%)</i>				
Employed full-time	38 (69.09)	24 (72.73)	14 (63.63)	.457
Employed part-time	1 (1.82)	1 (3.03)	0 (0.00)	
Incapacity of work/invalidity	1 (1.82)	1 (3.03)	0 (0.00)	
Unemployed/student/housewife/ house-husband/retired/other	15 (27.27)	7 (21.21)	8 (36.36)	
<i>Children, n (%)</i>				
Yes	49 (89.09)	27 (81.82)	21 (100)	.034
No	6 (10.91)	6 (18.18)	0 (0.00)	

Table 3. Partners' Indirect Benefits after the Intervention (Experimental Group Only; N =25)

Indirect Benefits	Experimental Group (n =25)
Impact on the relationship (n, %)	8 (32%)
Being closer, more solidary, better understanding, more love, more dyadic coping, better communication ...	
Happiness to see their partner evolve positively (n, %)	5 (20%)
More energy (n, %)	2 (8%)
Learning of new techniques through their partner (n, %)	1 (4%)
Anxiety decrease (n, %)	3 (12%)
Negative impact on the partner (n, %)	1 (4%)
No benefit perceived (n, %)	2 (8%)
Did not know/Did not answer (n, %)	6 (24%)

were also positively associated: NDCO ($r_s = .31, p = .21$), SDCP ($r_s = .32, p = .018$), NDCP ($r_s = .36, p = .007$), CDC ($r_s = .56, p < .001$), and EDC ($r_s = .50, p < .001$). There was no significant correlation between both spouses' emotional distress.

Other Spearman correlations were conducted to investigate the links between a couple's communication and emotional distress. When considering each population separately (patients and partners), we found no correlation between one's emotional distress and one's perception of couple's communication. Same results were observed when considering the links between one partner's emotional distress and their spouse's couple's communication.

Discussion

The primary aim of this paper was to assess the effect of a hypnosis-based intervention on emotional distress, perception of the couple's communication, and perception of the dyadic

Table 4. Psychological Variables at Baseline for Patients and Partners (Whole Sample)

	Patients (<i>n</i> = 55)	Partners (<i>n</i> = 55)	Wilcoxon <i>t</i> -test
	Mean (SD)	Mean (SD)	<i>p</i>
Couple Illness Communication Scale	13.64 (3.96)	14.65 (3.10)	.043
Dyadic Coping Inventory			
Stress Communicated by Oneself (SCO)	12.24 (3.24)	9.37 (3.49)	<.001
Supportive Dyadic Coping by Oneself (SDC)	18.27 (3.31)	18.11 (3.47)	.959
Delegated Dyadic Coping by Oneself (DDCO)	6.53 (1.81)	7.33 (1.40)	.009
Negative Dyadic Coping by Oneself (NDCO)	16.85 (2.50)	16.79 (3.10)	.990
Stress Communication of the Partner (SCP)	9.04 (3.40)	13.54 (3.10)	<.001
Supportive Dyadic Coping of the Partner (SDCP)	16.56 (5.22)	17.13 (4.51)	.184
Delegated Dyadic Coping of the Partner (DDCP)	7.04 (1.86)	6.02 (1.93)	.012
Negative Dyadic Coping by Partner (NDCP)	16.38 (3.25)	16.93 (3.00)	.328
Common Dyadic Coping (CDC)	15.53 (4.68)	16.24 (3.90)	.185
Evaluation of Dyadic Coping (EDC)	6.69 (2.09)	6.96 (1.94)	.217
Total score	118.44 (20.38)	121.44 (18.09)	.190
Hospital Anxiety and Depression Scale			
Anxiety	10.84 (4.04)	6.82 (3.92)	<.001
Depression	6.58 (3.95)	4.20 (3.43)	<.001
Total score	17.42 (6.72)	10.99 (6.75)	<.001

coping of cancer patients and their partners. The secondary aim was to explore the differences and associations between these variables considered in each partner.

First, we did not show any significant effect of the intervention on patients' or partners' data. However, positive results of this intervention on patients' distress have already been highlighted in our previous article analyzing the whole sample ($N = 95$) (Grégoire et al., 2020). This is in line with other studies showing the efficacy of hypnosis-based intervention to improve emotional distress (Grégoire, Bragard et al., 2017; Montgomery et al., 2017). Concerning partners, they generally reported indirect effects of the intervention in an informal way. Our intervention addressed some topics that could have had an impact on patients' behaviors and relationships, and we hypothesized that this would have impacted the conjugal relationship. However, it is possible that the second measurement time was too close from the last group session to allow the participants to take full advantage of the sessions. Another possible explanation of this lack of impact on partners and the conjugal relationship is that indirect interventions for the caregivers (such as interventions provided to the patient) are less likely to have a high impact on their well-being (Candy et al., 2011). Our results are in accordance with other authors, underlining that if an intervention aims at improving partners' well-being, it should be specifically designed for them and not for their ill spouses (Lapid et al., 2016; Li & Loke, 2014; Northouse et al., 2012).

Second, some differences and associations between both spouses' psychological variables were noted. Concerning dyadic coping, SCO and DDCP are significantly higher in patients, while DDCO and SCP are higher in partners, which is understandable in the context of cancer. Indeed, it is frequent that patients are not able to perform all the tasks they used to do and need to ask their partner for help and support (Kuijjer et al., 2004, 2001). On the contrary, during this period, partners often try not to burden their ill spouse with tasks to do or their own difficulties and carry out the daily tasks. Patients and partners also differ in terms of emotional distress: while it was high in patients, especially for anxiety, partners' scores are below cutoffs, suggesting that they did not suffer from emotional distress. These

results were not expected as several studies showed the high distress levels of partners in the context of cancer (Cassidy & McLaughlin, 2015; Lapid et al., 2016; McClure et al., 2012; Schmid-Büchi et al., 2011). However, as they are not suffering from cancer themselves, their distress level could be lower than patients. Plus, our partners' sample was composed of men only, and it is known that men often report less emotional distress than women (Linden et al., 2012; McLean et al., 2011; Stapleton et al., 2017). Our results also highlighted some significant correlations between patients and their partners' data. First, their perceptions of their couple's communication were positively correlated, meaning that when one partner considers the couple's communication as good and comfortable or as restrained and difficult, the other spouse does too. This is in line with another study showing a link between both partners' communication (Paradis et al., 2009). Then, we also found several positive correlations between their respective scores on different dyadic coping dimensions. The positive correlation between both spouses' evaluation of dyadic (EDC) coping is particularly interesting as it suggested that no matter the daily coping strategies implemented by the couple, both spouses agree on their effectiveness and are satisfied in the same way. Surprisingly, no correlation was found between the emotional distress of both spouses. Indeed, several studies showed the existence of such a link (Litzelman & Yabroff, 2015; Paradis et al., 2009; Segrin & Badger, 2014). However, as our intervention took place after the cancer treatment completion, it is likely that partners' distress was lower than during treatments, while patients, who were experiencing treatment's adverse effects, were still highly distressed. Finally, no significant correlation was shown between emotional distress and couple's communication. These results are not really surprising, as the literature did not provide clear conclusions about the link these two variables (Manne et al., 2010; Normand et al., 2004; Paradis et al., 2009).

Our study has several limitations. First, the samples are small, and it is possible that larger samples would impact our results. In addition, our patient sample was composed of women only, most of them suffering from breast cancer, which was unexpected and certainly impacted our results. Indeed, the intervention was offered to a lot of men as well, but they seemed not to be interested in it. Second, the intervention was proposed to the patients only, which increased the difficulty to have a significant indirect effect on their partners. In addition, the second measurement time was scheduled right after the group intervention, which could have had an influence on the evolution of our variables, which are likely to need more time to improve. Finally, partners had to complete their questionnaires at home, with the potential presence of their ill spouse. It is possible, in these conditions, that the partner did not answer absolutely frankly in order not to show their distress to their spouse. However, our study opens new research perspectives. First, it could be interesting to conduct the same study with larger and more representative samples. Samples with more men and with more types of cancer could be more representative of the cancer patient population and lead to more robust results. Second, it could be interesting to test the effect of the same intervention proposed to both partners, together or separately. It is likely that effects on conjugal variables and partners' distress will be higher if both spouses benefit from the intervention. Finally, measuring the same variables later after the intervention could be useful, as some changes in behaviors and relationships can take longer to be implemented. For example, we could conduct a 3-month or 1-year follow-up to investigate long-term changes in both partners.

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Authors' Contributions

CG participated in the conception and design of the study, collecting and analyzing the data, and drafting the manuscript. IB participated in the conception and design of the study, and in drafting the manuscript. AV, VC, GJ, and MEF participated in the conception and design of the study, and in revising the manuscript critically for important intellectual content. SW participated in revising the manuscript. All authors read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Disclosure Statement

All authors declare that they have no conflict of interest.

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Registration

ClinicalTrials.gov (NCT03144154). Retrospectively registered on the 1st of May 2017.

Ethics Approval and Consent to Participate

All procedures performed in this study were in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The study was approved by the Ethics Committee of the Faculty of Medicine of the University of Liège in Belgium (N°B707201630321), with each participant providing written consent. All modifications in the protocol will be transmitted to the Ethics Board.

Availability of Data and Material

The full protocol and dataset of this study are available upon request. Please contact the corresponding author (ch.gregoire@uliege.be).

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Explorative kontrollierte Studie zum Einfluss einer auf Hypnose basierenden Intervention auf die Kommunikation und das Coping von Paaren in Zusammenhang mit Krebs.

CHARLOTTE GRÉGOIRE, MARIE-ELISABETH FAYMONVILLE, AUDREY VANHAUDENHUYSE, VANESSA CHARLAND-VERVILLE, GUY JERUSALEM, SYLVIE WILLEMS, UND ISABELLE BRAGARD

Zusammenfassung: Emotionaler Stress und Schwierigkeiten in Kommunikation und Coping sind üblich unter Krebspatient*innen und deren Partner*innen. Auf Hypnose gründende Interventionen können den emotionalen Stress der Patient*innen lindern. Wir entwickelten eine Gruppenintervention und kombinierten Selbsthypnose und Techniken der Selbstfürsorge. Unsere Hypothesen bezog sich auf eine Wirkung der Intervention auf den emotionalen Stress, die Kommunikation der Partner*innen und das gemeinsame Coping, sowohl bei den Patient*innen als auch bei deren Partner*innen. Unsere explorative kontrollierte Untersuchung umfasste 55 krebsskranke Frauen und 55 Partner*innen. Die Teilnehmenden füllten vor und nach der Intervention, an welcher lediglich die Patientinnen teilnahmen, Fragebögen aus. Es ergab sich kein signifikanter Effekt der Intervention, weder für die Patientinnen noch für deren Partner*innen. Für die partnerschaftliche Kommunikation und deren Coping zeigten sich bei Patientinnen und Partnern positive Korrelationen. Indessen müssen speziell für Paare oder Partner*innen entwickelte Interventionen getestet werden, um die Paar- und Partnerschaftsschwierigkeiten anzugehen.

ALIDA IOST-PETER

Dipl.-Psych.

Étude exploratoire contrôlée de l'impact d'une intervention basée sur l'hypnose sur la communication et la capacité à faire face des couples dans le contexte du cancer

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Résumé: La détresse émotionnelle, la communication et les difficultés d'adaptation dyadiques sont corantes chez les patients atteints de cancer et leurs partenaires. Les interventions basées sur l'hypnose peuvent améliorer la détresse émotionnelle des patients. Nous avons conçu une intervention de groupe combinant l'auto-hypnose et les techniques d'auto-soins. Nous avons émis l'hypothèse d'un effet de l'intervention sur la détresse émotionnelle, la communication conjugale et l'adaptation dyadique, chez les patients et leurs partenaires. Notre étude exploratoire contrôlée a inclus 55 femmes atteintes de cancer et 55 partenaires. Les participants ont rempli des questionnaires avant et après l'intervention, qui a été effectuée sur les patients uniquement. Aucun effet significatif de l'intervention n'a été mis en évidence chez les patients ou les partenaires. Des corrélations positives sur la communication des patients et des partenaires et l'adaptation dyadique ont été mises en évidence. Cependant, pour faire face aux difficultés des couples ou des partenaires, des interventions spécialement conçues pour les couples ou partenaires doivent être testées.

GERARD FITOUSSI, M.D.
Président of the European Society of Hypnosis

Estudio controlado exploratorio sobre el impacto de una intervención basada en hipnosis sobre la comunicación de pareja y el afrontamiento en un contexto de cáncer.

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Resumen: La tensión emocional y las dificultades de comunicación y afrontamiento diádico son comunes entre pacientes con cáncer y sus parejas. Las intervenciones basadas en hipnosis pueden mejorar la tensión emocional en pacientes. Diseñamos una intervención grupal combinando autohipnosis y técnicas de autocuidado. Hipotetizamos que la intervención surtiría efecto en la tensión emocional, comunicación conyugal, afrontamiento diádico tanto en pacientes como en sus parejas. Nuestro estudio exploratorio controlado incluyó 55 mujeres con cáncer y sus 55 parejas. Los participantes completaron cuestionarios antes y después de la intervención, que solo fue administrada a los pacientes. No se encontró ningún efecto de la intervención en los pacientes o sus parejas. Se encontraron correlaciones positivas entre la comunicación de pacientes y parejas y el afrontamiento diádico. Sin embargo, para abordar problemáticas de pareja o de la pareja, se deben evaluar intervenciones diseñadas específicamente para este propósito.

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