


# Aligned and Divergent Perceptions of Support Persons' Role in Triadic Gynecologic Cancer Communication

Qualitative Health Research  
2022, Vol. 32(4) 710–724  
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DOI: 10.1177/10497323211066868  
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## Abstract

Health care providers routinely advise cancer patients to involve support persons in oncology care to fulfill critical support roles. This qualitative descriptive study explored alignment of triadic perceptions of support person involvement in oncology treatment visits and cancer-related care from the perspectives of patients with gynecologic cancer ( $n = 18$ ), regular visit-attending support people ( $n = 16$ ), and health care providers ( $n = 10$ ), including oncologists, nurses, and medical assistants. Semi-structured interviews ( $N = 44$ ) captured perceptions of facilitation and interference of support persons' roles within and outside appointments with oncology providers. Thematic analyses revealed alignment and divergence regarding support persons' instrumental, informational, and emotional support behaviors. Perspectives aligned regarding what support functions companions provide. However, patients and support persons emphasized the significance of instrumental followed by informational and emotional support, whereas oncology providers highlighted informational, followed by emotional and instrumental support. Discussion provides insight into each role's perspective in the triad.

## Keywords

triadic communication, patient-provider communication, social support, cancer communication, instrumental support, informational support, emotional support, facilitation, interference, companion, support person

The American Cancer Society estimates that in 2021, 116,760 women will be diagnosed with new cases of gynecologic cancer in the United States including cervical, ovarian, uterine, vaginal, and vulvar cancers (CDC, 2019). Often, women who receive gynecologic cancer diagnoses experience fear and concern stemming from “biological, psychosocial, emotional, and experiential turmoil” (Thorne et al., 2009, p.1390). In this health context, patients and their loved ones navigate myriad changes in interpersonal roles and responsibilities, emotions, social and sexual relationships, patients' physical bodily changes, and attempts to cope with illness (Akyüz et al., 2008; Maughan et al., 2002). To mitigate gynecologic cancer-related uncertainty, the Mayo Clinic (2021) recommends that patients establish a strong support system and seek information to make informed care-decisions. Specifically, health experts recommend that patients ask a trusted friend or family member to accompany them to oncology appointments to help manage complex information involving interaction with multiple health care professionals (Thorne et al., 2009).

Beginning in the diagnostic period, the cancer journey is, in part, defined by either supportive or compromised communication between patients, support persons who often attend oncology appointments, and health care providers (Thorne et al., 2009). Supportive communication has been previously defined as verbal and nonverbal behavior produced to assist others who require that aid (MacGeorge et al., 2011). The typology of enacted support is commonly comprised of instrumental (i.e., tangible assistance, management of health care, and mundane

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routines and activities), informational (i.e., engagement in seeking and clarifying information and record keeping), and emotionally supportive behaviors (i.e., openness, reassurance, and maintaining positivity about the future) (Bontempo et al., 2020; Goldsmith & Albrecht, 2011; Krieger et al., 2016). Specifically, receiving adequate social support predicts female cancer patients' reports of health-related quality of life three years post diagnosis (Leung et al., 2014). Larger support networks are also associated with women's decreased risk of breast cancer mortality, whereas socially isolated women experience higher rates of mortality at 10 years post diagnosis (Kroenke et al., 2013).

Supportive partners can facilitate patients' illness experiences by providing assistance that aligns with and helps achieve a patient's multiple illness-related goals, tasks, and coping efforts (Brashers et al., 2004). Existing literature has documented relationships between both giving and receiving social support and positive health outcomes for physical health and mental well-being (Brashers et al., 2004). For example, individuals with ample social support resources are more likely to psychologically adjust to stressors (Kawachi & Berkman, 2001) and adhere to medical regimens (DiMatteo, 2004). Social support is linked to health outcomes by providing relevant health information, promoting healthy behavior, encouraging self-care, self-esteem building, and buffering the health impacts of negative emotions and distressing events (MacGeorge et al., 2011).

In the cancer context, support persons commonly include a patient's partner or spouse, family members, and/or friends (Laidsaar-Powell et al., 2013). Although support persons may or may not attend clinical visits, this study focuses on how the presence of a support person within the health care interaction affects the oncology treatment visit. The inclusion of support persons, in addition to patients and health care providers within clinical interactions, influences communication based on the triadic (i.e., three person) versus dyadic (i.e., two-person, patient-provider) level of the interaction scenario (Greene & Adelman, 2013). Triadic communication within oncologic encounters is often complex because triad members engage in discussion, negotiate power dynamics, address challenges, and manage expectations (Greene & Adelman, 2013). Research considering the involvement of support persons in cancer communication suggests that support persons regularly attend appointments, perform helpful support behaviors, and assume many roles related to their participation (Laidsaar-Powell et al., 2013).

Currently, little existing research directly compares patient, support person, and health care provider perspectives in relation to outcomes of communication within treatment visits. Given the highly involved nature of support in the cancer context, research has explored the

experiences, needs, and communication preferences of patients, support persons, and health care providers individually, dyadically, and to a very limited extent triadically. Triadic communication may result in discrepancies between patients' self-efficacy and patients' engagement in independent communication behavior during consultations with health care providers (van Staa & On Your Own Feet Research Group, 2011). Thus, patients who are accompanied by a support person may be less actively involved during treatment consultations as compared to unaccompanied patients (Laidsaar-Powell et al., 2013).

Support persons are typically perceived as facilitative in the cancer context (e.g., sharing information related to the patient's medical history, symptoms, and medications); however, health care providers and patients may also perceive that support person involvement complicates the health care interaction (Laidsaar-Powell et al., 2013; Petronio et al., 2004). Patients may perceive that support persons interfere with patients' illness and uncertainty management processes (Checton et al., 2012). Support person or "partner" interference is the perception that a partner who the patient depends on may be undermining the patient's personal actions, goals, or outcomes (see Solomon & Knobloch, 2001, relational turbulence theory). From patient perspectives, support persons' interference may result from misalignment between support needs and the types of assistance provided (Linden & Vodermaier, 2012). It is also important to consider that not all support persons are equally prepared, knowledgeable, willing, or able to engage in these support responsibilities (Mastel-Smith & Stanley-Hermanns, 2012).

Members of patient, support person, health care provider triads may hold dissonant perceptions of and preferences for cancer treatment, decision-making processes, or other triad-members' roles in decision-making, which contributes to high levels of decisional conflict (LeBlanc et al., 2018). For example, patients may recall a limited number of available treatment options whereas oncologists report consideration and discussion of multiple treatment options (LeBlanc et al., 2018). Visit participants can also disagree about topics including a patient's prognosis, metastasis, side effects (Eggly et al., 2013), or the correctness of various potential treatment choices (LeBlanc et al., 2018). Patients, support persons, and health care providers are equally likely to be the source of disagreements, but triadic agreement tends to be higher regarding what topics were discussed in treatment interactions than what was said by the health care provider (Eggly et al., 2013).

Patients and health care providers also may experience competing needs or expectations (e.g., coordinating shared decision-making) that contribute to patients'

experiences of stress or frustration (Hsieh et al., 2016). Gynecologic oncologists often engage in patient-centered communication that emphasizes patients' perspectives, respects patients' decisions, and minimizes the health care provider's influence over decision-making processes (Hsieh et al., 2016). However, these patient-centered approaches can be problematic if patients and support persons prefer to engage with health care providers by deferring to the oncologist's expert knowledge when facing complex decisions about treatment choices (Hsieh et al., 2016; LeBlanc et al., 2018). Despite uncertainty regarding patients' or support persons' preferences for engaging in decision-making processes, in one prior study none of the participating oncologists reported directly assessing patient or support person preferences (LeBlanc et al., 2018). Research suggests that support persons prefer to engage with health care providers who communicate in attentive and genuine ways, consider both patient and support person experiences, address unsatisfied information needs, and manage potential discrepancies between patient and support person preferences (Washington et al., 2019). During triadic communication, health care providers should communicate with both patients and support persons (Washington et al., 2019), highlight helpful companion behaviors, and clarify patient and support person roles by agreeing upon interaction preferences (Laidsaar-Powell et al., 2013). However, patients' preferences for support persons' involvement in cancer communication vary widely and are often based on patients' individual level of needs (Laidsaar-Powell et al., 2013).

The present study focuses specifically on gynecologic cancer due to the potential severity of survivors' prognoses, the sensitive nature of communication surrounding women's cancer-related experiences, and patients' dependence on both support persons and health care providers to fulfill a variety of post-surgery and treatment support needs. Because patients are regularly advised to involve support persons within the cancer trajectory, the present research seeks to address a gap in empirical knowledge by considering the ways that support persons influence how and what tasks are accomplished within triadic communication about gynecologic cancer during treatment visits. The specific aim of the present research is to explore the potential facilitation and interference of support persons' involvement in triadic communication about gynecologic cancer from the perspectives of patients, support persons, and health care providers. The project is guided by the following research questions:

RQ1: How do perceptions of support persons' facilitation/interference in gynecologic cancer treatment visits align/diverge across patient, support person, and health care provider perspectives?

RQ2: How do patient, support person, and health care provider perspectives align/diverge regarding which specific support person behaviors would best facilitate patients' gynecologic cancer treatment visits?

## Methods

### Participants

The 44 individuals (18 gynecologic cancer patients, 16 support persons, and 10 health care providers) who participated in this qualitative descriptive study completed in-depth semi-structured interviews, primarily via telephone. All patients were female and actively receiving chemotherapy treatment for the first diagnosis of gynecologic cancer. These patients had previously met their oncology teams, completed surgery and/or radiation, and were between cycles two and five of chemotherapy treatment. Patients identified support persons who regularly attended their oncology treatment appointments with them. All participants were English speakers over the age of 18. For all groups, acceptance rates among eligible participants were high. Interviews exceeded theme saturation within each group.

Table 1 presents demographic data for each group. *Patients* were women receiving treatment for their diagnoses of endometrial ( $n = 9$ , 50%), ovarian ( $n = 9$ , 50%), or uterine ( $n = 2$ , 11%) cancer and could have had multiple cancer diagnoses. *Support persons* regularly accompanied target patients to appointments and included seven women (44%) and nine men (56%). *Health care providers* routinely interacted with patients and support persons during treatment visits and included oncologists ( $n = 4$ ), nurse practitioners/registered nurses ( $n = 3$ ), and medical technicians/medical assistants ( $n = 3$ ).

### Procedure

Participants were recruited through a National Cancer Institute comprehensive cancer center in the northeastern United States. After identifying patients who met the study's eligibility criteria through chart review, research staff approached potential patient-participants during an outpatient oncology treatment visit. Patients nominated support persons and provided contact information if the support person was not present for in person recruitment. Patients could participate separately from support persons, and interviews were completed individually. Researchers scheduled phone interviews with interested patients who reported regularly attending oncology appointments with a support person. Support persons attending routine medical appointments were either approached in the clinic or identified by patients and contacted via telephone by the research team to explore

**Table 1.** Patient, Support Person, and Health Care Provider Characteristics (N = 44).

Characteristic	Patient (n = 18)	Support Person (n = 16)	Health Care Provider (n = 10)
	n (%)	n (%)	n (%)
<b>Gender</b>			
Female	18 (100%)	7 (44%)	9 (90%)
Male	0 (0%)	9 (56%)	1 (10%)
<b>Race/ethnicity</b>			
Caucasian	10 (56%)	11 (69%)	4 (40%)
Hispanic/Latinx	4 (22%)	2 (13%)	2 (20%)
African American	3 (17%)	2 (13%)	1 (10%)
Mixed race	1 (6%)	1 (6%)	1 (10%)
Asian	0 (0%)	0 (0%)	2 (20%)
<b>Educational background</b>			
High school	6 (34%)	3 (19%)	—
Some college/trade school	6 (34%)	4 (25%)	—
College degree	3 (17%)	6 (38%)	—
Postgraduate/professional	3 (17%)	3 (19%)	—
<b>Years in practice</b>			
< 2 Years	—	—	3 (30%)
3–5 Years	—	—	1 (10%)
6–10 Years	—	—	2 (20%)
11–19 Years	—	—	2 (20%)
> 20 Years	—	—	2 (20%)
<b>Professional role</b>			
Oncologist (MD)	—	—	4 (40%)
Medical assistant/technician	—	—	3 (30%)
Nurse practitioner/registered nurse	—	—	3 (30%)
<b>Support person role</b>			
Partner	—	7 (44%)	—
Adult child	—	4 (25%)	—
Sister	—	2 (13%)	—
Parent	—	1 (6%)	—
Other (nephew/friend)	—	2 (12%)	—
<b>Cancer-related Information</b>			
<b>Cancer type<sup>a</sup></b>			
Ovarian	9 (50%)	—	—
Uterine	2 (11%)	—	—
Endometrial	9 (50%)	—	—
<b>Time since diagnosis (months)</b> <b>(Range 1–16 months)</b>	M = 4.22, SD = 3.37	—	—
<b>Age (years)<sup>b</sup></b>	M = 61.33, SD = 10.75	M = 57.50, SD = 12.76	M = 40.10, SD = 10.05

<sup>a</sup>Two patients diagnosed with more than one type of cancer.

<sup>b</sup>Patient ages ranged from 45 to 88 years; support person 30–72 years; health care provider 27–62 years.

interest. Health care providers were professionals involved in these patients' routine care and were identified by a gynecologic physician.

Patients and support persons were mailed or emailed their respective copy of the consent form to review prior to the interview. Verbal consent was obtained prior to any interviews, after interviewers confirmed participants' understanding of the project. After providing verbal consent, no participants expressed discomfort with or asked to stop the interview, all agreed to be recorded, and

none withdrew from the study. All aspects of study procedures and analyses were approved by both a Cancer Center Scientific Review Board and a university Institutional Review Board.

Four female members of the research team were trained to conduct semi-structured phone interviews, and each interviewer piloted the interview guide and received feedback. The use of telephone interviewing is an accepted approach to qualitative data collection (Novick, 2008) that allowed the research team to access geographically diverse

participants. Although visual cues that comprise contextual and nonverbal data used to interpret responses are lean as compared to face-to-face formats, telephone interviewing may increase participants' sense of comfort as well as efficacy to disclose sensitive information (Novick, 2008).

During interviews, patients were asked to discuss their interactions with support persons and health care providers during treatment visits, support persons were asked to focus on the patient and interactions with health care providers, and health care providers reflected on interactions with both patients and support persons. Main questions for the overall study focused on what is easy to share and what is held back at oncology visits when the support person and patient are both present (Checton et al., 2019). Respective patient, support person, and health care provider interview guides contained questions that solicited descriptions about support person involvement in gynecologic cancer treatment interactions, perceptions of support quality received by patients from support persons, and potential gaps in this support context. Specific questions that informed this study's results included asking patients about support persons' roles during treatment appointments, why and how these behaviors were both helpful and unhelpful (with probes for examples of each), and how patients could best be supported. Conversely, support persons described how they participated in the medical interactions and these subtopics. Health care providers were asked to discuss how support persons facilitated or interfered during patients' treatment appointments and the role patients typically want support persons to enact within these triadic health care interactions. A series of potential follow-up questions and prompts for each area followed, based on the participant's response.

Each patient and support person received a \$50 VISA gift card on interview completion, with health care providers receiving \$100 gift cards. Patient interviews ranged from 22:57 to 67:59 minutes ( $M = 40.14$ ,  $SD = 13.17$ ), support person interviews ranged from 21:14 to 71:02 minutes ( $M = 41.61$ ,  $SD = 14.59$ ), and health care provider interviews ranged from 29:32 to 76:35 minutes ( $M = 54.12$ ,  $SD = 15.27$ ).

### Qualitative Content Analyses

All audio files were transcribed, verified, and de-identified by at least three members of the research team. A priori themes related to social support typologies and the role of informal support persons in facilitating or interfering with the patient's cancer experience informed open coding, inductive coding, and thematic analyses of data. Thematic content analyses were utilized to explore emergent themes (Braun & Clark, 2006) that capture patient,

support person, and health care provider perceptions of the role of the support person accompanying the patient to the triadic treatment visit (RQ1) and perceptions of specific support person behaviors that would best support patients in this context (RQ2). This approach is appropriate for examining participants' perspectives because it organizes and describes data in rich detail while searching for patterns (Braun & Clark, 2006). This study acknowledges that participants' dialogue is representative of their individual experiences and meanings (Braun & Clark, 2006). The analytic process began with reading and rereading the transcriptions. Two authors individually reviewed the transcripts, selected salient excerpts illustrating relevant emergent themes, and maintained memos regarding message content related to identified themes to improve data triangulation.

The thematic analyses were conducted separately for each of the triadic groups. Then, emergent themes were compared across the triadic groups. To identify manifest themes (e.g., informational, instrumental, and emotional support), the two researchers reviewed, named, and delineated examples that arose across the emergent categories within each triadic perspective. Next, the researchers contrasted notes on specific excerpts and themes to resolve any discrepancies in interpretation, continuing this process in an iterative fashion until agreement emerged. Major themes emerged across the three roles, and particular attention was given to the prominence/frequency of specific themes across roles as well as variation in subthemes to note the alignment and divergence of findings for patient, support person, and health care provider.

## Results

Four main themes emerged from the analyses. Data suggest that across all three perspectives, participants discussed support persons' facilitation and interference (RQ1) in terms of (1) instrumental support, (2) informational support, and (3) emotional management behaviors. The fourth theme (RQ2) captured triadic perceptions of specific support person behaviors that best facilitate patients' gynecologic cancer treatment visits. The next sections present patient, support person, and health care provider perspectives with representative quotes and how the perspectives are and are not aligned.

### Instrumental Support

The first theme that emerged across the triadic perspectives included the importance of instrumental support that support persons provided to patients. Instrumental support behaviors emerged as supportive actions that facilitated patients' task management and daily life routines.

**Patient instrumental perspectives.** Patients described support persons' instrumental support behaviors as the mundane tasks performed, including becoming patients' "uber driver(s)" and managing life happening outside of patients' cancer-related appointments. Instrumental support included scheduling and managing events in the life domain to accommodate patients' increased support needs compared to life before cancer diagnosis. One patient noted that her husband "even changed his hours at work to...go around me, so he could be there for me." Patients also identified support persons monitoring their dietary needs, exercise levels, and complex medication regimens as essential acts of instrumental support. Beyond everyday task facilitation, patients identified support persons' physical presence during clinical appointments as a primary form of instrumental support. Another patient said that her husband "comes with me for everything and he listens to everything I hear and doesn't hesitate...That has made me so much more secure...Made this whole situation better."

**Support person instrumental perspectives.** Support persons routinely discussed instrumental support provided to patients as a task that was often attended to over other responsibilities in the support person's daily life. One support person stated that their workplace was "OK with it, but they didn't want me out for a long period of time. And so I decided to resign so I could be with her through this and help get her through this." Although patients' treatment-related needs disrupted the normal functions of many support persons' routines, support persons viewed instrumental assistance as inherently associated with their support role. Support persons identified their physical presence during appointments, transportation, monitoring activity levels and medicine routines, scheduling appointments, and housekeeping tasks as primary ways they provided instrumental support to patients with much of this support occurring outside the treatment visit. A different support person shared that providing instrumental support to his aunt "[is] a joy. I come do her dishes, I clean...whatever she wants me to—I do things without her asking." Support persons indicated that they attend most or all cancer-related appointments, and their instrumental support descriptions matched patient reflections.

**Health care provider instrumental perspective.** Health care provider perspectives of how support persons provided patients with instrumental support emphasized the importance of support persons' physical presence during clinical appointments. One health care provider stated, "I think just being there for them. Just their physical presence helps...The fact that they have someone with them to worry about that stuff... Makes it a little less stressful." Health care providers viewed support persons' instrumental behaviors as providing transportation and physical

assistance to patients who are "so weak." Health care providers recognized the importance of support persons' patient-advocacy role in becoming "a voice for that patient." Another health care provider stated,

It's very important because when you're in the bed, you call for a nurse...you don't know how long you have to wait. And it gets very frustrating when you're there by yourself...and there's no one to help you, and you're relying on someone to answer your call. Whereas if you have a family member, they could be proactive, go out to the hallway, say, "you know, this patient needs help right now."

Health care providers suggested that support persons instrumentally supported patients by engaging in advocacy efforts that helped raise health care providers' awareness of patient needs, preferences, and life choices.

**Summary of instrumental support perspective (mis)alignment.** In sum, all three perspectives aligned in highlighting the importance of support persons' physical presence during treatment visits. Patient and support person perspectives further aligned in recognizing many patient needs that prompt support persons' instrumental support provision. Health care provider perspectives diverged by accentuating how support persons advocate for patients, compensate for patients' physical weakness, and display nonverbal cues during treatment interactions.

### *Informational Support*

The second central theme that arose across triadic perspectives involved support persons providing informational support to patients. Informational support encompassed support persons' behaviors aimed at managing, clarifying, and providing information on behalf of patients.

**Patient informational perspectives.** Patients identified numerous ways that support persons help them navigate the burden of information management associated with their care. Namely, patients described how support persons functioned as a "second set of ears." Patients identified support persons' contributions of active listening, information seeking, information clarification, information tracking (e.g., note-taking), and information coordination (e.g., communication about symptoms and treatment with health care providers), and language translation as critical behaviors that facilitated their care. Patients reported feeling overwhelmed when attempting to process the vast information associated with diagnosis and treatment. In this context, one patient described how "once I heard I had cancer, I shut down...When she told me after everything, my examination, that I was going to need chemo, I shut down." A patient also shared that her support person takes notes, "because sometimes it's so



overwhelming, I can't really remember what they said. So, she does take notes . . . She asks questions." A different patient stated that her support person:

Gives me major support when I have questions about stuff. Coming out of the hospital with arms full of paperwork and information. We sat together for two weeks. . . Just to separate all the information, and he figured out what I should eat, what I should not eat, how much to eat, what time to eat.

**Support person informational perspectives.** Support persons' perspectives of their information management roles aligned with the patient perspectives. Support persons described their information efforts in terms of seeking, clarifying, tracking, coordinating (e.g., communication with health care providers about patient symptoms), note-taking, and engaging in active listening processes. One support person reported taking "copious notes," and another support person reported contacting nurses regarding questions that "pertain to [her] sister that she may have forgotten to ask." Several support persons self-identified as "the librarian" and "scribe" who "maintain[s] the binder to keep all the papers squared away." Another support person elaborated how they assisted by:

Knowing where to find the papers. . . I got the pending appointments in the front. I got the ones in the back in sequence and lab work in sequence so she can see her progress. . . When you go lookin' for stuff, you want to be able to find it.

Support persons discussed the various ways that they seek to manage communication between patients and health care providers, including attempts to direct the conversation, ensuring the patient is accurately absorbing information communicated by health care providers, and verifying the accuracy of information communicated to health care providers regarding the patient's health status. One support person said that she was present during interactions with her mother's health care provider to "make sure that she is understanding verbal instructions." Another support person shared:

If in the meeting with the oncologist. . . if I think she's just not comprehending, I will then talk to the oncologist and say, you know, "I'm not sure she got that. . . Can you run that by her again?" . . . But I can tell, my mom sometimes gets glazed over. . . So, I just got to make sure [the oncologist] picks up on that.

**Health care provider informational perspectives.** Similar to patients and support persons, health care providers described the role of support persons as an "extra set of ears" and a "second brain." Health care

providers additionally discussed engaging with support persons about patients' symptoms by phone between treatment visits. Health care providers also commonly highlighted the importance of support persons taking notes and providing assistance in posing questions on the patient's behalf within clinical interactions. One health care provider stated that patients often are left wondering "Oh, wait, what'd she say about this, or that?" Another health care provider noted that patients look toward support persons and question, "What did I want to ask?" Health care providers discussed how support persons manage patients' confusion by clarifying patients' understanding of clinical information and treatment procedures. A different health care provider stated that support persons are "like my lawyers and you know, they say "No, mom, she said this this and that, I wrote it here." This health care provider also noted that support persons' nonverbal behaviors were rich sources of information that they observed during treatment interactions:

When I'm having these conversations and I'm trying to figure out where the problems are. . . I look at the caregiver. . . and by their reaction I know if they're in tune with me or with her. . . Even if the patient is not in tune, but the caregiver is in tune, then sometimes I direct a little bit of the conversation. . . to the caregiver and I pause because it's like a translator, sometimes. . . They have a communication level for years that I don't have. And they're able to communicate what I'm saying, a little better. Sometimes worse.

**Summary.** Overall, the three perspectives aligned in viewing support persons as a "second set of ears" within the treatment visit and valued support persons' efforts in seeking and managing information. Support person and health care provider perspectives further aligned by highlighting support persons' attempts to manage patients' level of confusion and facilitate patient understanding during treatment visits.

### *Emotional Support*

The third theme identified across the triadic perspectives involved support persons' facilitation and interference with patients' communication about emotional and relational topics. Emotional support involved varying degrees of openness and willingness to participate in communication about cancer-related emotions.

**Patient emotional perspectives.** Patients reported managing cancer-related anxieties and emotions with support persons using sharing and withholding strategies. Patients who communicated openly with support persons reported increased perceptions of relational closeness, patience from their support persons, and appreciation for

the opportunity to share their experiences. One patient stated that she had direct conversations with her support person “early in the process” that established how they would “just face [cancer] together, no matter how good or bad it was.” Patients reported that support persons’ humor helped them cope with stressors including hair loss, prognosis related fears, and uncertainty. A different patient suggested that engaging in communication about her cancer experiences allowed her support person to “be more expressive of her feelings about me.” Another patient described the value of her father’s emotional support:

He said, “You know, you might be very sensitive and like an emotional person, but you’re not weak. There’s nothing weak about you after what you’ve been through.” He took me to everything...He’s just like, “You’ve been a pin-cushion, and you’re...amazing.” You know, that made me feel good...Because I’m really trying to be strong.

Some patients preferred not to engage in any communication about difficult emotions in this context. Instead, these patients and their support persons favored processing emotions and life events “one day at a time...not to think ahead...not to upset myself unnecessarily.”

**Support person emotional perspectives.** Support persons discussed the “emotional, physical, [and] spiritual” support that they exchange with patients. Support persons’ views aligned with patients’ perspectives; however, notable differences arose between the views. Namely, support persons identified “trying to cheer up” patients who were “down in the dumps” to help maintain mutually created positive outlooks. Support persons reported attempts to construct a sense of togetherness to reassure patients that emotional support resources were available. For example, one support person spouse stated:

I’ve always made sure that I was as positive as I could be with her and reassuring her that if it was cancer, there would be a plan and I’d stick with her...And, unfortunately, when we found out it was, I just kept always saying to her, “we’re gonna follow the plan,” you know...The experts, we’ll see what they say. We’ll read up.” Just trying to reassure her that we were gonna figure it out.

Support persons discussed a willingness to emotionally support patients by becoming communicative outlets for patients’ “venting.” Support persons were aware of the need to tailor their communication to fit patients’ situational and emotional needs. One support person shared that they “typically have to figure out how to deliver what needs to be said to [the patient] because of how she may receive it.” Further, support persons were cognizant of taboo topics that could provoke “tensions” with patients. When navigating difficult talk (e.g., prognosis and

survival rate), support persons tended to avoid initiating these conversations to prevent upsetting patients.

Support persons reported managing or withholding their emotions to avoid becoming an additional “burden” on patients. One support person shared how she perceived herself as “more of the stronger one” compared to her daughter despite her [support person] sensitive and emotional nature:

I decided it was my job to be the strong one and hold it together because I feel like...She needs me to be strong for her and...to be positive and not allow her to feel like she’s not going to get better and all. I’m just holding positive vibes for her.

Support persons also assisted patients’ emotional management by identifying opportunities to initiate communication about emotion with health care providers. Another support person described how they would “take advantage” of certain moments to “bring up things that I think may be affecting [the patient] at the moment or that she would like to ask but will not dare to ask.” Support persons reported strategically engaging in or circumventing emotionally supportive communication based on perceptions of patients’ needs in a particular moment.

**Health care provider emotional perspectives.** Health care providers discussed cancer treatment as a “delicate situation” that often leaves patients “devastated.” Health care providers reported support persons’ presence buffered patients’ “anxieties” or “distress” that may prevent patients from coherently participating in the interaction. Health care providers recognized that support persons play vital roles in “sympathizing and empathizing” with patients’ individual experiences. Although health care providers expressed numerous emotional benefits of support persons’ participation, they also discussed how support persons’ negative emotions at times pose a potential contagion risk for patients. For example, one health care provider stated that it is important for support persons to try “not to impose their own issues...frustrations or anxieties.” Health care providers recognized the general importance of support persons’ emotional support, suggesting that “even if you’re not doing anything, just [the support person] being there...physically helps.” Health care providers discussed the value of support persons’ enactment of emotional support behavior as predominantly—although not exclusively—positive for patients’ mental and emotional well-being.

**Summary.** Taken together, the three perspectives aligned in viewing support persons’ emotional support as mostly facilitative of patients’ emotional expression and well-being. Support persons’ perspectives demonstrated an awareness of patients’ unique emotional needs. Health care provider perspectives diverged by adding



how support persons' misunderstanding of patients' preferences for managing emotions could contribute to negative emotional contagion from support persons to patients.

### *Patient Ideal Support Behaviors Support*

The final theme (RQ2) involved perceptions across all three participant roles regarding which specific support person behaviors would best facilitate patients' treatment visits. Patients were asked what things they would like for their support person to do when accompanying them to treatment appointments. Similarly, health care providers were asked what kinds of behavior patients would like to receive from support persons, whereas support persons responded with their views of the things that patients would like for them to do when attending the oncology treatment visits.

**Patient ideal support perspectives.** Patients overall expressed appreciation for support persons' efforts; however, patients also discussed discrepancies in the support that they believed would best facilitate their treatment visits compared to the support actually received. The main thread throughout patients' accounts involved the need to maintain a sense of independence. One form of maintaining control for patients included seeking cancer-related information from various preferred sources including health care providers, the internet, or learning from others' personal experiences with managing cancer. Patients preferred instrumental support that aligned with their self-presentation goals and perceptions of their bodily capabilities. For example, patients frequently discussed exercise and nutrition regimens as sources of conflict. One patient stated that her support person would "tell the doctor, she's not doing...He'll make me look bad in front of the doctor...like my appetite isn't great and, you know, he'll harp on me with the doctor about me not eating." Patients repeatedly emphasized the importance of support persons remaining "relaxed" by not "imposing" their opinions and beliefs to ensure that they maintain control over their own health and care. Patients also noted that support persons might lack the skills or resources necessary to enact effective support behaviors despite well-intentioned attempts. For example, another patient's husband changed bandages to protect her leaking drain shunt, but "he didn't put the dressing on right...He tried his best, though."

A subset of patients indicated that they favored solitude rather than the companionship provided by support persons at certain moments during their treatment visits. One patient discussed the desire to avoid support persons' information-seeking and question-posing because she does not "feel like talking when I'm there. I would prefer to just be alone and doing it...Just drop me

off, or just pick me up. That's all I need." This viewpoint was reported by a minority of patients and did not align with either support person or health care provider perspectives.

Patients described tension when their voice was not prioritized as support persons attempted to provide or seek information. Patients reported feeling like they had "lost [their] voice" when support persons "proceeded to speak on [their] behalf." Trying to address this concern, a patient "had a discussion with [her support person] and I said to her 'listen, I can speak on my own and please...allow me to do that and if I need your help, I'll include you in the conversation.'" After addressing this tension with her support person, the patient noted that "now...if they want to address something, they do it, but not talking over me, or instead of me. So, the conversation, the dialogue, has changed, for the better."

In terms of emotional support, patients recounted different experiences in terms of desiring companionship from support persons. Patients generally wanted to maintain a sense of normalcy in which support persons remain socially engaged by not avoiding the patient. Further, patients preferred that support persons remain upbeat and positive, as if the patient was not managing cancer. One patient explained that "sometimes people will say, 'Is there anything you need?' and I'll be like, 'I need some company,...that's been the biggest thing.'" Patients discussed how they wished to avoid "everyone around me being doomy and gloomy." Patients reported feeling "blessed" and thankful for support persons' "comfort words" during times of health-related uncertainty, which reassured them that "everything was going to be OK."

Moreover, patients reported that support persons' inability to relate to their lived cancer experiences could prompt emotional challenges. Discussing her support person's misunderstanding of her experience navigating identity and physical appearance, one patient said:

Basically, I can talk to her about everything, but...She feels like, "Oh, well, if you're not comfortable, just walk around without [the wig]."...You know, there are some people that would do that. I'm just not one of them...She's trying to do a good thing, though, but I don't think she just always understands, because if you're not in it, you don't get it.

Another patient described how her emotions were influenced by her support person's tendency to be "nervous":

When they're putting the [port] needle in, he gets a little squirm-ish. I really like to send him out: 'OK, I'm fine, you can go out.' Because that'll get *me* nervous...So I'd rather him go out of the room...Until she finishes that.

Patients preferred receiving support that affirmed rather than contradicted their emotional experiences. Patients' narratives suggested that support persons could be sources of both comfort and discomfort depending on support persons' awareness of patients' efforts to manage emotions that may fluctuate at individual moments across treatment scenarios.

**Support person perspectives of patients' ideal support.** Support persons also reflected on the types of support that they perceived patients wanted. Support persons were aware of patients' desires to maintain control over their health and decision-making. This perception led support persons to verbalize concerns with patients that support persons were "over doing it" in terms of their level of participation. One support person established an agreement with the patient stating, "if you don't want me to do something, please tell me. Or if I'm too much, tell me." Support persons were aware that their information provision to health care providers could conflict with patients' sense of independence. For example, another support person stated:

I feel like I had to go over her head, which is why I describe our relationship as a reversed relationship. I have to do that with many things...Often she will delay making a decision...A severe reaction to something or a situation worsening can be mediated if it's...attacked head on.

Overall, support persons noted that controlling patients' health was a source of "disagreement:"

I want to try and get her to do more exercise, and it's easier said than done. She's the one that had the surgery. She's the one that...went through all of the chemo and all that, but I think if she gets out there and does a little bit more exercise, I think she'll feel better.

Support persons also perceived that their informational support behaviors could be a source of tension for patients. One support person said that "I think she feels...I talk when I shouldn't be talking. I should more or less be listening because this is pertaining to her and not pertaining to me." Support persons suggested they manage their need to seek information with trying to prioritize the patient's voice by "chiming in" with a reminder after waiting for the patient to finish discussing main topics and concerns with the health care provider. Other support persons recognized that their direct approach to question asking could leave patients feeling "overwhelmed" which caused some support persons to "limit my interaction because... I'm there to communicate if needed only." Additionally, support persons felt that patients might perceive their behavior as "a little overly stressed" which may conflict with patients' preferences to "stay on the

positive side of it." In sum, some support persons described that they are at times conscious of discrepancies between the support they provide versus what behaviors may be ideal for supporting patients in this context.

**Health care provider perspectives of patients' ideal support.** Health care providers perceived that patients prefer support persons' physical presence during most, if not all, clinical interactions. Health care providers described how patients "just black their mind" in face of the wealth of information they receive. Further, one health care provider stated that patients "don't want to hear that they have the cancer, even though they are dealing with it" and reiterated the importance of support persons' presence in helping to "get information and digest information." A different health care provider said that generally, "most women want [support persons] to be sort of in the shadows" to provide support that is "not too aggressive."

Health care providers identified ways that support persons complicated interactions and interfered with patients' preferences for receiving support during appointments. Health care providers reported that support persons providing "personal opinions of a medication or treatment or oftentimes a story of a bad experience they had...might be causing more fear than support." For example, support persons' optimism, rooted "out of love", at times complicated health care providers' ability to communicate accurate information to patients. One health care provider discussed how support persons may attempt to:

Reinterpret and change what [the provider is] saying to make it softer and sometimes different than what [the provider] just said...and when that happens, I actually clarify and look at them and tell them, 'Well, that's not exactly what I'm saying.'...I do want the patients to have a realistic expectation...if they don't grieve with reality and truth then they can't move on.

Health care providers acknowledged that support persons' desire to communicate in ways that maintain mutual pretense (i.e., positive cancer-related communication focused on cure) could interfere with health care providers' ability to clearly deliver information to patients.

Health care provider perspectives on emotional support aligned with patient views by expressing that support persons at times "imposing their own anxieties, their own agenda" could put "unnecessary pressure on the patient." One health care provider recognized that patients may feel that support persons indirectly "[give] them guilt for being sick or not being around or not feeling well." Health care providers suggested that one feature of emotional support for patients involved "knowing that there's going to be another person there in case there's an emergency to support them." Health care providers believed that patients:

Want their support just to be there... Besides holding hands or giving a hug or tap on the shoulder, they would like them to know that they're not alone... When the family says, "Listen, we're going to be there together. We fight this together."

**Summary.** Health care providers aligned with patients and support persons in viewing that although support persons address important patient needs during visits, the directness and frequency of support persons' involvement within interactions may interfere with patients' preferences for receiving support. Health care provider and patient perceptions also contradict regarding the quantity of support person presence during visits, compared to at times being alone.

## Discussion

This research contributes to qualitative health communication literature by considering triadic patient, support person, and health care provider perspectives regarding support persons' facilitation and interference of patients' experiences when attending gynecologic cancer treatment visits (RQ1). This project also contributes to understanding the specific behaviors enacted by support persons that facilitate and/or interfere with communication occurring during treatment visits involving patients and health care providers. Further, this research explored alignment and divergence in patient, support person, and health care provider perspectives regarding which support person behaviors best facilitate patients' gynecologic treatment visits (RQ2). The following discussion provides an overview of the (mis)alignment of triadic perspectives, implications, limitations, and future research and conclusions.

### Alignment of Triadic Perspectives

All three perspectives aligned in recognizing the key *instrumental support* benefits received from support persons that facilitate patients' treatment experiences, including support persons' physical presence, transportation assistance, and management of scheduling and medication regimens. Further, patients' and support persons' perspectives identified primary support person behaviors such as managing the patient's household and life responsibilities, physical activity level, and nutrition, topics that occur outside of the treatment interaction but often are raised within the context of the treatment visit. Ultimately, support persons perceived that their instrumental support behaviors were a central way to support patients. Patient perspectives echoed the view that instrumental support was a critical component that facilitated their care. The triadic perspectives also aligned in agreeing that support persons' instrumental support, at

times, interfered with patients' goals when gaps occurred between patients' support needs and the types of assistance support persons provided.

All three perspectives aligned in viewing support persons' role in *information support* or as a "second set of ears" as a key feature of support persons' participation that facilitated clinical interactions. Specifically, the three perspectives viewed support persons' active listening and information tracking (e.g., note-taking) behaviors as helpful within clinical scenarios. Support persons understood this function of their support role as librarians tasked with managing information. Although patients acknowledge that support persons make intentional efforts to help them manage information, exploring the support persons' perspectives illuminates the multifaceted and strategic nature of these processes. Support persons recognized that information seeking (e.g., asking questions) and information coordination (e.g., reporting patient symptoms to health care providers) with health care providers could conflict with patient self-presentation and interaction goals. Thus, support persons attempted to tailor their actions to meet patients' information-management needs by asking indirect questions and interacting with health care providers outside of the clinical space. Further, some support persons reported directing conversations with health care providers to bolster and reinforce patients' information comprehension. However, some patients reported that support persons sharing information with health care providers created tension. These findings support [Petronio et al.'s \(2004\)](#) conclusions that as health care providers solicit information from support persons about the accuracy of patient reports, support persons feel obligated to respond to health care providers despite their awareness of patients' preference for how the information should be handled and potentially not divulged. Although a support person sharing details with health care providers serves an important care function, health care providers may inadvertently place support persons in uncomfortable situations by challenging patients' reports of their symptoms and diminishing a patient's power by soliciting support person input in this way ([Petronio et al., 2004](#)). Our current results expanded [Petronio et al. \(2004\)](#) findings that only included support person perspectives. In the present study, following instrumental support behaviors, patients and support persons consistently discussed support persons' informational support behaviors throughout interviews.

The three perspectives also aligned in generally valuing the *emotional benefits* of support persons' presence. All perspectives suggested that the perceived availability of emotional support resources (vs. the frequency of engaging in emotional communication) facilitated patients' emotional well-being. Patients and support persons both reported only selectively engaging in open emotional

communication while desiring to avoid upsetting each other (Checton et al., 2012) or prompting negative emotions (Bontempo et al., 2020). Support persons highlighted the strategic nature of their emotional communication with patients through examples that include involving health care providers who acted as buffers in conversations about emotion. Health care provider and patient perspectives aligned in recognizing how support persons' negative emotions or doubt regarding prognosis and treatment could negatively affect patients' emotional well-being. For some patients and support persons, maintaining positivity was a coping strategy in this context (Bontempo et al., 2020). However, in line with previous research (Goldsmith & Ragan, 2017) health care providers noted that patient and support person choices to maintain "mutual pretense" could complicate clinical communication such as the delivery of unfavorable news related to treatment/prognosis or sharing symptoms or side effects. Overall, these results suggest that patients and support persons predominantly shared communal coping orientations rather than coping individually with cancer experiences, consistent with Koenig-Kellas et al.'s (2021) findings.

Finally, the three perspectives aligned in perceiving that patients' treatment visits are best facilitated by support person behaviors that preserve patients' sense of independence, support patients' interaction goals, and prioritize patients' voices (RQ2). All triadic perspectives described how support persons should enact their role non-aggressively and "in the shadows" to forefront patient questions and concerns during treatment visits. However, consistent with Laidsaar-Powell et al. (2013), the current results suggest that health care providers should be aware of how support persons' involvement in decision-making communication outside of the visit affects the triadic communication interactions occurring during clinical appointments. Both patients and support persons highlighted patients' varying styles for receiving health information (e.g., health care providers, internet, and sharing personal experiences), and all three roles discussed the importance of support persons refraining from imposing their own beliefs during the visit. Further, all three perspectives reported that support person control attempts created tensions or disagreements with patients and, at times, with health care providers. This finding is consistent with prior research that suggests support persons experience dialectal dilemmas when attempting to balance their individual needs and support behaviors (e.g., openness vs. closedness; Petronio et al., 2004). In the present study, some patients reported frustration that support persons could not fully understand their cancer-related needs, preferences, goals, and experiences.

### *Predominance for Misalignment of Triadic Perspectives*

An important point of divergence amongst the triadic perspectives involved the emphasis on which support behaviors were viewed as most facilitative for patients within the health care interaction. Patients reported that support persons' information management behaviors, followed by instrumental and emotional support behaviors, were critical in their experiences. Support persons' perspectives aligned with those of patients in often discussing how their provision of information management was central to supporting patients, followed by instrumental support and emotional support behaviors. Health care provider perceptions also emphasized support persons' facilitation of information management as critical. However, health care providers highlighted support person roles in emotional support within the treatment visit, whereas patients and support persons raised more examples of support outside of clinical interactions. In part because health care providers' observations of support person behaviors are limited to the medical interaction, health care providers emphasized instrumental behaviors that facilitated and interfered with patients' communication within clinical settings. However, patients and support persons were more likely to discuss the facilitation and interference of instrumental support within the patient's life domain outside of the oncology treatment visit.

Health care providers' perspectives diverged from patients' perspectives regarding desired companionship and support persons' physical presence during appointments and treatment procedures. Whereas health care providers believed that patients preferred support persons to always be present in visits, several patients favored solitude rather than companionship during specific aspects of treatment or clinical interaction.

These collective results are significant because they hold implications for clinical communication practices and begin to fill the numerous gaps in our empirical understanding of support persons' involvement in ongoing medical interactions with patients and health care providers. In light of the findings, oncology health care providers should attend to the unique needs and preferences of both patients and support persons when reflecting on how to effectively manage triadic clinical interactions. Ultimately, findings suggest that health care providers should remain cognizant of the support person role in aiding patients with gynecologic cancer both within and beyond clinical interactions. Health care providers may consider facilitating patient-support person conversations related to the support person role if tensions are apparent or escalate. Findings indicate patients prefer to be supported in ways that align with their individual level of need for support; thus, support persons should be aware of

how their participation may either facilitate or interfere with patients' goals that both precede and proceed clinical interactions with health care providers.

### Limitations

One benefit of these data is that they allow for examination of a specific timepoint *during* treatment, rather than asking participants to retrospectively reflect on their experiences after receiving treatment. Nevertheless, this research includes some limitations. Although a strength of the current research design involves capturing patient, support person, and health care provider perspectives, these data reflect individual perspectives and are not explored as triadic units. Additionally, the sample size was smaller and included a majority of participants who were Caucasian, limiting our ability to generalize findings to specific support person and health care provider role types or the unique experiences of other racial/ethnic groups. Even though results indicate that support persons may overstep their roles at times in this triadic interaction, the present study results are primarily positive regarding the role. It is possible that only women and their support persons with predominantly satisfying or high-quality relationships agreed to participate in the study, thereby introducing some skew to the findings. Data analyzed within this study were also collected within a larger research project; thus, the facilitation and interference of support persons' behaviors, or alignment and divergence of triadic perspectives were not an explicit focus of interview or probing questions. However, participants were explicitly asked about their perceptions of what behaviors support persons performed that were helpful or unhelpful within gynecologic cancer treatment interactions, with probes to explore facilitation/interference.

### Future Research and Conclusions

Future research should explore differences in patient-support person-health care provider triad perceptions of support person participation in gynecologic cancer at multiple points in time to capture experiences during phases of the cancer trajectory. For example, it is critical to consider communication during the diagnostic phase and treatment decision-making when uncertainty may be especially heightened for patients (Thorne et al., 2009) and explore how support persons may contribute to buffering the negative effects of illness during later trajectory phases (MacGeorge et al., 2011). It is also important to consider how a multitude of influential actors beyond support persons and health care providers included in the present sample (e.g., other relatives, general practitioners, and information sources including the internet and media) contribute to patients' gynecologic cancer experiences.

Thus, future research should explore triadic communication, and the patient-support person-health care provider triad specifically, as fluid and dynamic rather than as a static interaction context. Further, research should examine how patient-support person-health care provider triadic communication relates to clinical protocols of treatment and follow up procedures, as well as additional aspects and actors involved in patients' cancer trajectories.

Future research should better capture the experiences of culturally diverse patients and support persons to investigate varied cancer and support experiences and patterns in this context (Neufeld et al., 2008; Ruttman, 1996). Another avenue for future research would be to explore in depth patient-support person gender groupings/pairings to investigate potential differences in same sex communication of daughters, sisters, and friends who are support persons in this context versus opposite sex interactions such as for heterosexual relationships where the spouse is a male support person. This manuscript focused on role in the interaction rather than on the gender configurations. Future work could consider also the specific characteristics of diverse patient-support person dyad relationship pairings (e.g., spouse vs. friend). Another important question for future analyses involves distinguishing features of triadic interactions between a variety of unique health care provider roles, with much current research focused on oncologists or nurses/NPs but not the differences in those interactions and often excluding technicians. Subsequent research should address the experiences of women with gynecologic cancer who do not share healthy or positive relationships with their support person, as well as health care providers' efforts to negotiate the provision of care with patients in unhealthy or abusive relationships.

Many gynecologic cancer patients navigate the cancer trajectory accompanied by highly involved support persons. Thus, it is critical to understand the implications of triadic communication occurring during treatment interactions in this context. More specifically, it is important to consider respective patient, support person, and health care provider needs within the triad. These results suggest that patient, support person, and health care provider interaction preferences align and diverge in numerous ways and that each member of the triad often works to manage emerging conflicts by employing strategic behaviors to facilitate individual goals for interaction during (and beyond) patients' cancer-related treatment appointments. This is an area ripe for future qualitative research to improve health communication in the cancer context.

### Declaration of Conflicting Interests



The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.



## Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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