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**Background/rationale or Objectives/purpose:** Individuals diagnosed and treated for various cancers are not equally comfortable with the label “survivor”. In general women treated for breast cancer (BC) like the term, whereas men with prostate cancer do not like the label. We explore how males with BC feel about the label “cancer survivor”.

**Methodology or Methods:** Males with any stage BC were eligible to participate in an online survey about their comfort with various labels used to describe cancer patient populations. Descriptive statistics were used to characterize the sample and thematic analyses were undertaken on open-ended responses.

**Impact on practice or Results:** Sixty-eight participants have completed the survey so far. The majority were from the USA (47%) or Australia (21%), within age ranges of 60-69 (37%) and 70-79 (27%) and diagnosed as stage 2 (45%). Preliminary results indicate that 58% moderately-to-strongly like the term “survivor” but 14% moderately-to-strongly dislike the term.

Forty-three percent of participants believe the term “cancer survivor” best describes their identity compared to: “a person who has had cancer” (37%), a cancer “patient” (14%), “victim” (2%), and other (5%). Factors associated with endorsing the survivor label include: being cancer-free without recurrence, and the notion that they are “still living” and/or “back to normal”.

**Discussion or Conclusions:** Men vary in how comfortable they are with the label “cancer survivor” depending on the disease and disease status. In general male BC patients more closely align with female BC than with prostate cancer patients. Comfort with the label “survivor” appears to be more influenced by the disease status, progress, and control than with sex/gender.

## 89 | How important is culture when helping families cope with loss?

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**Background/rationale or Objectives/purpose:** Several factors can influence how families adjust to the loss of a loved one. Culture is often considered one of these. Cultural norms, values, beliefs can shape the experience of loss. However, how one copes with loss often transcends culture. The challenge is to what extent do we need to pay attention to culture in delivering interventions. Does culture account for 100% of the total variance in defining how one experiences loss?

**Methodology or Methods:** Goals of this workshop are three-fold:

1. Identify common cultural factors that can impact families' adjustment to loss through self-reflection practice
2. Use clinical vignettes to identify culturally sensitive interventions
3. Invite participants to join in small groups to identify key elements in guiding their practice

**Impact on practice or Results:** When delivering culturally sensitive interventions, health care professionals have to be aware of their own biases that could interfere in delivering care. Proper assessment of the family's needs must also take into account the potential impact of the family's cultural values, norms and beliefs when facing the loss of a loved one.

**Discussion or Conclusions:** Culture can be an important factor in how families experience loss. However, overemphasis on culture at the expense of the individual might misdirect one's interventions. As Dr. Gomez-Carrillo states: we need to [refocus on the individual rather than treating “the culture”].

## 105 | Fear of Cancer Recurrence in Men Diagnosed with

## Breast Cancer

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**Background/rationale or Objectives/purpose:** Fear of cancer recurrence (FCR) has been associated with anxiety and depression and is one of the most commonly reported problems for cancer survivors. Little is known about how men with breast cancer experience FCR. The purpose of this study was to document the prevalence and examine factors associated with FCR in men diagnosed with and treated for breast cancer.

**Methodology or Methods:** Males with any stage of breast cancer were eligible to participate in an online survey that examined levels of FCR using the Fear of Cancer Recurrence Inventory- Short Form scale (FCRI-SF). FCRI-SF scores < 16 indicate minimal levels of FCR. Scores of 16-21 indicate problematic levels of FCR, and scores 22 ≥ indicate clinically significant FCR. A frequency analysis was used to determine the percentage of participants that fell above or below the clinical cutoff.

**Impact on practice or Results:** To date, 68 participants completed the survey and 65 completed the FCRI-SF. The mean FCR score was 24. The majority of participants (64.6%) had clinically significant levels of FCR. 20% of participants had problematic levels of FCR and 15.4% of participants had minimal levels of FCR. A linear regression analysis showed that age was the only significant factor ( $p < .05$ ) associated with FCR. FCR levels increased with age until participants reached the age of 70, where FCR levels then began to decrease.

**Discussion or Conclusions:** Males treated for breast cancer report clinically significant fear of cancer recurrence. Compared to published data for women with breast cancer, our study suggests that men have greater FCR than women with the same disease.

## FINAL CATEGORY: I. EHEALTH RESEARCH & INTERVENTIONS

## 35 | Increasing access to cancer supportive modalities: The roles of e-health, volunteers, and patients-as-partners

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**Background/rationale or Objectives/purpose:** Individuals with cancer often experience barriers to accessing psychosocial support in busy cancer care settings. Timely, accessible, and cost-contained support is imperative. This study began pilot testing a blended modalities supportive approach comprising informational e-handouts and volunteers/patient-as-partners' phone calls.

**Methodology or Methods:** Individuals diagnosed with cancer within the last six months at a University-affiliated cancer center in Montreal, Quebec completed the 25-item Cancer Support Community distress measure and were presented with various formats of cancer supportive services.

**Impact on practice or Results:** Of the 88 participants who took part in this study, 76% requested one or more modality (i.e., informational e-handouts,  $n = 42$ ; phone calls,  $n = 4$ ; or both,  $n = 21$ ). Eighty-four percent requesting these modalities reported not having used any psychosocial support services in the past year (e.g., support groups, professional support, counselling or a psychiatrist). A significant negative correlation was found between participants' age and requested modalities ( $r = -.351, p < .05$ ) with younger making more requests than older participants. Those who requested both modalities reported significantly lower distress compared to those who did not [ $F(3,64) = 3.52, p = 0.02$ ]. Ninety-two percent thought that newly diagnosed individuals would want to receive similar resources, with all agreeing or strongly agreeing that volunteers/ patients-as-partners were knowledgeable in discussing distress-related issues. Overall, supportive modalities usability scores