'Staying cool, calm and positive'

A dialogical narrative analysis of emotional reactions in narratives about operable lung cancer

Schoenau, Mai Nanna; Missel, Malene; Holen, Mari

Published in:
Scandinavian Journal of Caring Sciences

DOI:
10.1111/scs.13241

Publication date:
2024

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Schoenau, M. N., Missel, M., & Holen, M. (2024). 'Staying cool, calm and positive': A dialogical narrative analysis of emotional reactions in narratives about operable lung cancer. *Scandinavian Journal of Caring Sciences*, *38*(2), 368-377. https://doi.org/10.1111/scs.13241

Received: 25 June 2023 | Accepted: 20 January 2024

DOI: 10.1111/scs.13241

Scandinavian Journal of Caring Sciences

ORIGINAL ARTICLE

'Staying cool, calm and positive': A dialogical narrative analysis of emotional reactions in narratives about operable lung cancer

Mai Nanna Schoenau PhD, MScN, RN, Clinical Nurse Specialist, Post Doctoral[1] | **Malene Missel PhD, MScN, RN, Clinical Nurse Specialist, Senior Researcher**[1,2] | **Mari Holen PhD, MScN, RN, Associate Professor**[2]

[1]Department of Cardiothoracic Surgery, Copenhagen University Hospital, Copenhagen, Denmark

[2]Department of People and Technology, Roskilde University, Roskilde, Denmark

Correspondence
Mai Nanna Schoenau, Department of Cardiothoracic surgery, Copenhagen University Hospital, Copenhagen, Denmark.
Email: mai.nanna.schoenau@regionh.dk

Funding information
Jens and Maren Thestrup's foundation for cancer research; Copenhagen University Hospital, Rigshospitalet; Roskilde University's doctoral school

Abstract

Background: Patients with lung cancer suffer from physical, psychosocial and particularly emotional challenges. Twenty-five percent of patients with lung cancer are offered surgery as a potential cure. Nevertheless, 40% of surgically treated patients will experience recurrence. Paradoxically, research shows a dominant narrative of operable lung cancer patients 'being lucky', which silences other narratives about suffering, worries and emotional challenges.

Aim: To explore narratives about operable lung cancer, particularly emotional reactions to illness and suffering in these narratives.

Methods: A qualitative design was applied. Six women and four men diagnosed with operable lung cancer were included from one university hospital in Denmark and interviewed 1 month after surgery using active interviews. The interviews were subject to dialogical narrative analysis. The theoretical foundation is social constructivism, with socio-narratological inspiration.

Findings: A typology of three emotional narratives emerged: 'staying cool', 'staying calm' and 'staying positive'. All three types of narrative are characterised by managing emotional reactions. Staying cool is characterised by not showing emotional reactions; staying calm narratives acknowledge emotional reactions, but that they need to be managed so that they do not burden relatives; and the last, staying positive, is characterised by managing emotional reactions in a positive direction. Together this typology of three emotional narratives revealed that operable lung cancer patients are under normative pressure from these socially preferred narratives of ideal emotional reactions to lung cancer.

Conclusion: A typology of three emotional narratives were identified and can be called 'feeling rules' that guide patients after lung cancer surgery to manage their emotions. Consequently, if patients do not live up to these three emotional narratives of staying cool, calm and positive, they may be socially isolated and restricted from access to support.

KEYWORDS
dialogical narrative analysis, emotions, interview, lung cancer, narrative

INTRODUCTION AND AIM

Illness narratives about emotional reactions to illness and suffering are constructed and composed from culturally available narratives [1, 2]. Through stories about illness, questions of how to react emotionally and how to express these reactions are situated within socially acceptable ways of being ill [3]. Culturally constructed illness narratives thus guide ill people's expressions of illness and suffering in certain directions, which makes the possible ways to express illness and suffering highly dependent on previous stories [2]. There is limited research on illness narratives in lung cancer, especially about suffering in operable lung cancer. The aim of this study is, therefore, to explore narratives about lung cancer in patients after surgery with curative potential. In particular, we were interested in exploring emotional reactions in these narratives.

BACKGROUND

Research shows that patients with lung cancer suffer; they have the highest level of emotional distress across all cancers [4, 5]. Furthermore, suffering and emotional distress are also present in patients with lung cancer who are offered potentially curative surgery [6]. Surgically treated patients suffer from physical symptoms, such as pain, cough and shortness of breath [7, 8], while also facing existential and emotional dimensions to which they respond with an altered and confusing mixture of feelings [9–12]. This means that even though patients with lung cancer are offered potentially curative treatment, they still suffer.

Lung cancer is the second most common cancer in the world and the leading cause of cancer-related death worldwide [13]. In Denmark, about 4500 people annually are diagnosed with lung cancer. About 25% of these are offered potentially curative surgery [14], where 5-year survival is 62% [14]. Although surgery is performed with the intention of curing the patient, 40% will experience recurrence [14]. The standard of care for patients with operable lung cancer is structured according to enhanced recovery after surgery (ERAS) programmes [15, 16]. ERAS has standardised and optimised peri- and postoperative management, reduced complications and shortened hospital stay. Despite these benefits, research also points out unmet needs for patients regarding existential and emotional challenges [17, 18].

The main issue that concerns these patients is their suffering, even though they are potentially cured of their disease. In contrast to this suffering, several researchers have found a dominant narrative where cancer patients undergoing curative treatment are viewed as 'lucky' [19–21]. Sidenius et al. [19] found that 'feeling lucky' was fundamental but ambivalent in their study on patients' narratives about endometrial cancer, while Thisted et al. [20] illuminated how women with early-stage gynaecological cancer were 'labelled as lucky' by healthcare professionals, which contrasted with the women's own experiences. Schoenau [21], in a context of operable lung cancer, also found a dominant narrative of 'being lucky' due to a better survival rate than for patients not offered surgery. Taken together, this research points to a consistently dominant and culturally preferred illness narrative of 'being lucky' if the cancer is diagnosed at an early stage and is potentially curable. The three studies also highlighted, however, how 'being lucky' silenced narratives of suffering, leaving the patient alone with concerns and worries. Thus, dominant illness narratives seem to have an effect on how emotional reactions can be expressed and thereby the possibility for ill people to be heard and recognised in their suffering. Furthermore, research indicates an under-recognition of lung cancer patients' worries and concerns in the clinical encounter with healthcare professionals [9, 22–24]. In addition, lung cancer is seen as an individual responsibility because of the association between the disease and smoking, implying emotions of stigma, shame and blame [25]. Against this background, it is particularly important to explore how emotional reactions can be expressed in the context of lung cancer and it has been pointed out that exploring emotional dimensions in illness and suffering, illness narratives are a key resource [1].

METHOD

Theoretical underpinnings

In this study, we draw on social constructivism as an underlying approach. In social constructivism, narratives are viewed as constructed and influenced by the context of sociocultural resources [26]. We draw on theory of socio-narratology as described by Arthur Frank, emphasising that narratives are multi-voiced and always resonate with other stories and cultural narratives [2]. In a socio-narratological perspective, Frank argues that multiple voices are expressed in one single voice and points out that 'stories are composed from fragments of previous stories, artfully rearranged but never original' [27, p. 3]. These

fragments of previous stories are considered narrative resources that are necessary for us when creating narratives. Narrative resources are, therefore, an important element in our exploration of how emotional reactions to illness and suffering in patients with lung cancer are expressed by the patients following lung cancer surgery. An important aspect of socio-narratology is that it attends to stories as actors [2, p. 13]. Hence, when exploring how emotional reactions to illness and suffering in lung cancer patients are expressed and constructed, we will also take into account how they act, that is, the effect of the narratives [2].

Study design, recruitment and data collection

The design of the study was based on narrative ethnography, focusing on both narratives and the social context that condition narrative production [26]. In nursing research, ethnographic design has been used in the study of human actions and cultures [28]. The argument for using narrative ethnography is that it allows us to move attention beyond the stories to the narrative practice of storytelling and thereby explore what conditions stories, how they are used and with what consequences.

Participants were recruited from one university hospital in Denmark performing lung cancer surgery. Participants were purposively sampled and included in the study the day before their surgery. They had to be over 18 years of age, diagnosed with non-small cell lung cancer, referred to surgical treatment, able to speak and understand Danish and able to consent. One participant was approached at a time and followed through treatment at hospital using participant observation and participants were interviewed by the first author about 1 month after treatment. The interviews were recorded and transcribed verbatim. The interview approach was inspired by the concept of 'active interviewing', where the interviewer's role is to activate narrative production [29, 30]. The opening question of each interview was 'Could you please start by telling me about your experience of having lung cancer and your treatment? You can start where you find it most suitable for your situation'. Each interview also included questions originating from observations during the ethnographic study. These topics varied across participant interviews but were for instance related to a participant's previous experience of cancer in relatives, surgery as the only treatment and how they felt after being cured. Based on the active interview approach, the interview guide only provided suggestions and was used as a dialogical agenda [30]. There were no direct questions on emotional reactions to the diagnosis of lung cancer, but this emerged as a topic during the interviews and directed the researchers towards understanding how emotional reactions are expressed.

Ten participants were included between September 2019 and March 2020 and interviewed in a non-hospital setting (see Table 1: participant characteristics). Six interviews were held at the participant's home, and a relative participated in two of these interviews. One interview was held in the researcher's office, one interview at the participant's workplace and two interviews were conducted by telephone due to the COVID-19 situation. The interviews lasted from 39 to 87 min (mean: 61 min). The study adhered to the Standards for Reporting Qualitative Research agenda [31].

Data analysis

In the analytical process we focused our attention on narratives about emotional reactions, guided by dialogical narrative analysis (DNA) as described by Frank [2]. The identified narratives about emotional reactions were described in terms of a typology based on the expressions of different emotional reactions and analysed using DNA regarding content and effect. We, therefore, analysed 'what is told in the story—the story's content—and what happens as a result of telling that story—its effect' [2, pp. 71–72]. Furthermore, we analysed the narrative resources the participants drew on when expressing their emotional reactions.

According to Frank, DNA is performed by posing dialogical questions and through these entering a dialogical interactive analysis with the text. Thus, we created dialogical questions inspired by Frank's advice on how to

TABLE 1 Participant characteristics.

Characteristics	Patients ($n = 10$)
Age: mean (range)	69 (52–85)
Gender	
Female	6
Male	4
Living arrangement	
Cohabiting	6
Living alone	4
Cancer stage	
IA	2
IIA	1
IIIA	2
IB	1
IIB	3
Metastatic disease	1

approach the analysis, exemplified by this excerpt from Frank: 'Who uses a story to hold their own, and how the story does that, are crucial questions. But it must always be complemented by the question of whom the story renders vulnerable: Who now has an increased problem of holding their own, once the story has been told?' [2, p. 78]. These dialogical questions of who is holding their own, meaning who manage to maintain their position and stay in control despite difficulties, have inspired the following analytical questions used in the analysis as presented in Table 2.

Inspired by Frank [2], the analysis included several readings of the interviews. Each interview was read and analysed according to the dialogical questions and all interviews were then read and compared to bring voices from each interview into the dialogue. A narrative emotional typology was revealed through the analytical process. These will be presented in the Findings section and illustrated with short excerpts from the interviews as a part of ensuring the study's rigour.

FINDINGS

The analysis identified a typology of three different, but interrelated, narratives about emotional reactions to the diagnosis and treatment of operable lung cancer, respectively, 'Staying cool', 'Staying calm' and 'Staying positive'. 'Staying' is used consistently in the typology to highlight how a continuous narrative *act* is performed by the participants. The three types of narratives are interrelated by being all concerned with managing emotional reactions in a certain socially and culturally preferred way. In the following sections we will describe the content and effect of each of these three narratives.

Staying cool

The staying cool narrative reflects how the participants' emotional reactions were performed in a certain deliberate and decisive way characterised by a narrative act of staying cool. This was a narrative act of showing the world around oneself that one is in control in the unfamiliar situation of having lung cancer and undergoing treatment. This type of staying cool emotional narrative was used in different contradictory ways in which, on the one hand, it was viewed as preferable to narrate about oneself as being a patient who was able to stay cool, but on the other hand, it was also a necessary act performed to protect oneself in an unfamiliar situation with lung cancer.

'Staying cool' as a preferred and deliberate narrative is exemplified in the following excerpt:

> And then a doctor told me he was sorry to have to tell me I had lung cancer. And that was an unpleasant experience, but there was nothing to be done about it. I expect it's because I've been smoking cigarettes for many years. There's no doubt about that [...] But I just stay quite cool, you know. Or, well, I don't, but I... nobody can see what I'm thinking. I said to myself, well, that's that then.

'Staying cool' is here the preferred narrative about emotional reactions to a lung cancer diagnosis, but this narrative also reveals that this act is a construction of how the participant's emotional reactions present themselves to him. In the staying cool type of emotional narrative, the participants are thus holding their own by not showing emotional reactions. This is not to be mistaken as not having any emotional reaction, but only that this should be kept to oneself. This narrative is also connected to the stigma of lung cancer as a disease caused by smoking and in this case the cause is explained by the participant as many years of smoking. The narrative draws on a rationality where it is a natural explanation to get lung cancer if you have smoked, making it meaningful to construct a narrative without an emotion like surprise or shock and where it seems important to react emotionally by staying cool.

Furthermore, the staying cool narratives are filled with small subtle hints that suggest that emotional reactions are undesirable and useless in the given situation. They also reflect a desire to demonstrate control of the situation and distance oneself from a vulnerable sick role. This internalised effort to stay cool is also a narrative of social emotional control. Acting and narrating about oneself as almost a stoic figure is a powerful narrative of what is expected of the ill person in a social and cultural context. At the core of this emotional reaction is a confirmation of belonging to the community of healthy independent individuals pushing away any intimation of mortality.

One effect of this type of staying cool emotional narrative is that it might be difficult for others to hold their own if they experience strong emotional reactions and a desire

TABLE 2 Dialogical questions guiding the analysis.

- Which emotional reactions appear in narratives about operable lung cancer?
- Which are the preferred types of emotional reactions emphasised in the narratives?
- Which types of emotional reactions are disapproved of in the narratives?
- Which narrative resources are drawn on?
- What effect does the construction of narratives about operable lung cancer have on the expression of emotional reactions?

to express such reactions. A prominent effect triggered by the staying cool narrative is found in the participants' stories of how they manage not to react emotionally and thus position themselves as particularly calm and in control, as exemplified in the following quote:

> When I left there and they told me all that, a lot of people would be in shock because of that. But I just see it as a fact, well, if that's the way it is, then that's it. If they said to me, you've only got two weeks to live, I would adjust to that.

This is thus an example of a narrative act of holding one's own by distancing oneself from possible, imagined, contrasting and undesirable emotional reactions. The narrative is concerned with how others might react and how to separate this from one's own emotional reaction.

The staying cool type of emotional narrative also has elements of functioning as a way of protecting oneself and controlling the uncontrollable of being diagnosed with lung cancer. In this context, staying cool becomes a kind of management or survival strategy.

> The doctor made a bit too much noise, so I think he could have quietened down a bit. So he could sense how shaken and upset I really was. He never realized that. He just thought I was kind of strong and smart like he was. And I wasn't like that under the surface, and I was sitting there short of breath, and then I kind of became cool towards myself, to protect myself in that conversation. Like that. I realised the conversation was making me lose myself. So I wouldn't go to pieces.

This narrative highlights how staying cool is an *act* for the participant, but in a different way than the first description. Here, it is out of necessity and not the preferred emotional reaction. In this excerpt there is no room for the patient's emotional reactions to the illness, and thus we see how the narrative of staying cool is important for patients' ability to protect themselves and maintain the expected social and cultural norms. This reveals how the staying cool type of emotional narrative makes it difficult for others to hold their own, hence this type makes people who do not stay cool vulnerable.

Staying calm

Staying calm is another type of narrative response to emotional reactions. In this narrative, emotions are expressed as a natural reaction to illness and suffering and as emotions that must be managed. This type of narrative about emotional reactions to lung cancer is concerned with how the participants were hanging on to stay calm even though they were emotionally affected by their illness. Such explicit management of emotional reactions is exemplified in the following narrative excerpt which reveals a movement between narratives of feeling sad and needing to cry and an attempt to stay calm:

> So you have to deal with this, there's no use sitting there crying, of course you've had your moments, that's normal [...] It brings on your tears, and when we sit and talk about it, that can't be avoided, can it? So then you have to say to yourself, ok, this doesn't help, it only makes it worse. Of course I've been bawling my eyes out, of course that's what you do. It's perfectly natural.

This staying calm type of emotional narrative recognises that illness causes emotional reactions but illness is also seen as something uncontrollable that should be controlled, and the act of controlling such uncontrollable emotional reactions is what people strive for to live up to the socially accepted and expected way of reacting emotionally to a diagnosis of operable lung cancer. One is socially expected to stay calm, which in this narrative is a way to hold one's own.

The effect of the staying calm type of narrative on the management of emotional reactions is that even when the participants explicitly express their emotional reactions, they manage not to let these emotional reactions disturb or interfere with their work or people around them, as exemplified in the following excerpt:

> I've been in a bad mood, and I've also been sad and frightened, and I've also told him up there on the top floor that now I think he could let me off a bit. But apart from that, I don't think it's been... so I've been able to keep up my good mood, at least so it didn't disturb my work or other people if I've been depressed.

The *act* of staying calm thus needs to be performed by ill people in order not to spoil the well-being of other people with emotional reactions to the illness, as that might not be socially acceptable. The function of this narrative type is basically to present oneself as a person who is in control in an uncontrollable situation and who can manage emotions, to prevent the illness from affecting social relations.

The staying calm narrative also pointed to self-pity as an emotional reaction that was uncomfortable and to be

avoided, as exemplified in this quote: 'When I think about it, I can get kind of really, oh my God, it was so tough, but I make sure I don't go around feeling sorry for myself, because it was a really tough time for me'. This reveals that self-pity is an emotional reaction to be managed. To the participants, self-pity means that one takes on a powerless role and considers oneself a victim. Constructing the staying calm narrative can thus function as a remedy for the burdensome, intrusive, unpleasant and socially unacceptable emotions of self-pity. This narrative demonstrates that society values people who do not show negative emotions such as worry, sadness and anger and who can manage these emotions themselves, by staying calm.

The underlying resources of this type of narrative on emotional reactions to illness draw on not only an understanding of emotions as possible to change cognitively but also the notion that individuals have a responsibility to perform this type of management of emotions. The person has a responsibility to avoid being a burden and showing self-pity, thus creating an effect where the narrative makes it difficult for others to hold their own if they feel self-pity, or are unable to manage uncomfortable emotions and stay calm.

Staying positive

While the staying cool and staying calm types of narrative on emotional reactions to lung cancer dealt with controlling and managing emotions to keep them hidden from view and to avoid burdening relatives, a third type of emotional narrative, staying positive, emerged in the interviews. The content of the staying positive narratives comprised the participants' descriptions of how they maintain a good mood and manage to be optimistic and positive despite a diagnosis of lung cancer. Such narratives were constructed in contrast to sadness, despair, resignation and other intrusive and uncontrollable emotional reactions to illness. The staying positive narrative was thus constructed as opposed to how the participants imagined other people's more distressing emotional reactions to a lung cancer diagnosis and surgery, as exemplified in the following excerpt of staying positive and keeping up a good mood.

> But I don't think I got a depression afterwards or anything at all. I don't think I was sad or having a terrible time [...] So actually, you never know how you're going to react until you're in the situation. So, I might just as well have got depressed, but the opposite happened, which was that I actually kept up my good mood, and thought it was okay.

Staying positive appears here as the preferred way to react emotionally, while the opposite should be avoided. In relation to the first two narrative types of staying cool and staying calm, this narrative is concerned with not only managing emotions, but managing them in a certain positive way. This means that a continuum is created, clarifying who is holding their own in the narrative and who is deemed vulnerable, as an effect of this persistently staying positive type of narrative. Thus, at one end of this continuum, people who manage to embrace the staying positive narrative as an emotional reaction to illness are the socially accepted ones, while at the other end those who are relegated to being overwhelmed by difficult and distressing emotions are seen to be vulnerable. However, staying positive is also an *act*, as described in the following:

> You just hope it's not going to happen to you, but when it does, you have to deal with it as best you can, I think [...] It's about accepting it yourself. I think that's the most difficult part. Like saying to yourself, well, you've got it, and then you have to make the best of it, instead of just completely falling apart. But really get into it and be glad they told you it's not actually worse than it is, I think. Try to be a bit positive about it. I think that helps you instead of just thinking, oh my God, I won't survive this. I don't think I feel really down like that. Lots of people might break down completely [...] But you sort of have mixed feelings.

This quote shows that staying positive is viewed as helpful and is thus a narrative that creates the participants as people who manage to be positive and to control their emotions in a difficult situation with lung cancer. It is a narrative where the participants look back at the difficult times of diagnosis and surgery and put themselves in a position of a person who persevered through those difficult times and thus succeeded in a difficult situation. The construction of this narrative draws on narrative resources with the assumption that staying positive is beneficial for the well-being of ill people and something that people should actively be working on. One effect is that patients with operable lung cancer are obliged to stay positive, since this is the culturally preferable narrative about emotional reactions.

DISCUSSION

Our analysis identified a typology of three different yet interrelated narratives about emotional reactions to

operable lung cancer. Their relatedness was seen in the way all three narrative types dealt with managing emotional reactions in certain ways. As a basis for this discussion, we draw on earlier research on cancer narratives in further examining the effect of this narrative typology of emotional reactions on illness and suffering in patients surgically treated for lung cancer and to show how our findings resonate with other stories, as described in the study's theoretical underpinning.

The emotional narrative type of 'staying cool' revealed the importance for the participants of not being overwhelmed or surprised by emotional reactions. Missel et al. [12] found that patients with operable lung cancer distanced themselves from acknowledging that they had cancer, despite simultaneously expressing a sense of shock. Plage and Olson [32] demonstrated how surprise and shock is a sociocultural issue appearing in the face of an unanticipated cancer diagnoses. However, staying cool might be a certain narrative type of emotional reaction to cancers that are situated as individual risk and deservedness and where cultural frames of deservedness and responsibility are narrative resources influencing possible emotional reactions to a lung cancer diagnosis. The effect is thus that emotional reactions such as staying cool are socially and culturally imposed on people affected by those cancers viewed as related to lifestyle factors, for example, lung cancer.

Staying calm was another type of narrative emotional reaction derived from the empirical data based on the notion of not wanting to burden others with uncontrolled emotional reactions. These findings complement those from other studies of cancer illness narratives. Wright et al. [33] found that patients with breast cancer did not want others to feel burdened and felt that they had to reassure their relatives that they were okay, which was difficult and led to their withdrawal from social interactions. Not wanting to evoke feelings of sadness or discomfort in others, they withheld information about their illness [33]. Specifically regarding patients surgically treated for lung cancer, Missel et al. [11] found how this diagnosis disturbed their social relationships by making the patients withdraw from their relatives, because they wanted to protect them and not affect them emotionally. The opposite situation, in which relatives withdrew from patients due to difficulty in talking about the cancer, was also described [11]. This suggests an important effect of the emotional narrative of staying calm on patients' social contact, because the underlying understanding of talking about negative emotions such as sadness is that it would burden others. Consequently, if patients with lung cancer are unable to adopt the staying calm narrative, they might be left isolated and alone with their uncontrollable and distressing emotions.

The staying positive emotional narrative type can be seen as a particular emotional reaction to a curable cancer, and thus a narrative act of survivorship. Frank describes survivorship as a form of craft activity where patients perform survivorship from an archive of culturally available narratives [1]. In this narrative type of emotional reactions to lung cancer, participants thus performed survivorship by adopting a narrative about staying positive. We found that the participants managed their emotions by constructing an optimistic reaction to their situation. Broom et al. [34], in their study on the emotional practice of cancer survivorship, point out that emotions such as positivity may paradoxically lead to normative pressure on the individual to triumph over disease. A desire to remain positive, however, might leave other emotions undesired and devalued, which complements our findings. Broom et al. [34] also found that distressing emotions were considered taboo and something to be locked away, related to our findings showing how negative emotions were seen as a burden.

In this typology of narratives of emotional reactions to illness and suffering in patients after lung cancer surgery, we identified overall strategies to manage emotional reactions. Hochschild [35] describes how managing emotions takes place in accordance with so-called 'feeling rules'. Through the lens of Hochschild, these narratives about staying cool, calm and positive can be seen as feeling rules guiding patients in their expression of emotional reactions. Furthermore, this *act* of emotional management could reflect 'expressive deep acting', understood as a way of adapting to socioculturally required emotions [36]. Thus, people suffering from surgically treated lung cancer are narratively acting according to culturally and socially preferred emotional reactions to managing emotions by adapting to sociocultural feeling rules of staying cool, calm and positive.

Implications for practice, education, and research

The study findings have practical implications for both education and clinical practice, as the findings underscore the importance of healthcare professionals addressing patients suffering following surgery for lung cancer in a nuanced way, to make sure the patients are not left alone to deal with their suffering. In research, there has been a rising awareness of using narrative methods as an intervention [37]. Our study can be used in planning of narrative interventions, as we highlight that not all narratives are culturally preferred and may need special attention if we wish to establish

interventions where patients can create nuanced narratives about their illness and suffering.

Study strength and limitations

We believe that this study provides crucial knowledge on the difficulties of patients suffering from illness, whether curable or not, in expressing emotional reactions, since, as we have demonstrated, socially and culturally constructed narratives determine acceptable ways to express emotions. Hence, the narrative approach of this study is seen as highly insightful and therefore a strength. Furthermore, the use of DNA was a rewarding approach since it allowed us to explore narratives in dialogue with existing narrative resources and how the identified narratives were interrelated. The study's strength is also how the rigour was ensured, by explicit description of each element of the research process.

This study was carried out in a Danish context and findings might, therefore, differ in other cultural settings since narratives are dependent on the sociocultural context. Furthermore, findings are from interviews conducted at one point in time, 1 month after lung cancer surgery. It would be interesting in future research to follow patients for a longer period after curative treatment for a life-threatening illness and explore whether emotional reactions are expressed differently with a longer time span since surgery and a diminished threat to the patient's life.

CONCLUSION

Through DNA of interviews with 10 participants we identified a narrative typology of three emotional reactions to illness and suffering in patients after lung cancer surgery, namely 'staying cool', 'staying calm' and 'staying positive'. The staying cool emotional narrative was based on a desire to hide emotional reactions and keep them to oneself, since emotional reactions were seen as undesirable and useless. Furthermore, by staying cool, participants could narratively distance themselves from the vulnerable sick role. The narrative of staying cool was also found to be an emotional reaction to protect oneself. The staying calm emotional narrative acknowledged that lung cancer caused emotional reactions such as sadness, fear and anger, but that these emotions should be controlled and managed to a point where they do not burden social relationships. This narrative revealed an individual responsibility for controlling uncontrollable emotions and showed that especially self-pity was to be avoided and controlled, since it made the participants appear as victims and powerless. The staying positive emotional narrative showed that emotions should be managed in a positive way since this positivity was perceived as helpful and beneficial as an emotional reaction to illness and suffering.

The management of emotional reactions in the three narrative types can be called 'feeling rules' that guide patients after lung cancer surgery to manage their emotions to enable them to stay cool, calm and positive. One effect, however, is that these vulnerable patients might then be restricted from access to the compassion and support they need and thus left isolated if they cannot adapt to this typology of emotional narratives.

AUTHOR CONTRIBUTIONS

The first author planned the study, recruited participants, conducted the interview, data-analysis and wrote the original draft. The second and last author contributed to supervising the data-analysis, reviewing and editing the manuscript.

ACKNOWLEDGEMENTS

We thank the patients participating in the study for their time and engagement.

FUNDING INFORMATION

This study received grants from Roskilde University's doctoral school, Copenhagen University Hospital, Rigshospitalet—The Heart Centre and Jens and Maren Thestrup's foundation for cancer research.

CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

The research ethics committee of Roskilde University granted ethics approval (j.nr. 2019–1141) and the study was carried out in accordance with the Helsinki II Declaration. During recruitment, participants received written and oral information about the study, including information that all data would be anonymized and that they at any time, without giving a reason, could withdraw from the study. Written informed consent was gained from all participants.

ORCID

Mai Nanna Schoenau https://orcid.org/0000-0002-4814-5888
Malene Missel https://orcid.org/0000-0003-3267-8038

REFERENCES

1. Frank AW. Survivorship as craft and conviction: reflections on research in progress: reflections on research in progress. Qual Health Res. 2003;13(2):247–55. https://doi.org/10.1177/1049732302239601
2. Frank AW. Letting stories breathe. University of Chicago Press; 2013. https://doi.org/10.7208/chicago/9780226260143.001.0001
3. Segal J. Cancer experience and its narration: an accidental study. Lit Med. 2012;30(2):292–318. https://doi.org/10.1353/lm.2012.0017
4. Bergerot CD, Razavi M, Clark KL, Philip EJ, Pal SK, Loscalzo M, et al. Emotional problem-related distress screening and its prevalence by cancer type: assessment by patients' characteristics and level of assistance requested. Psychooncology. 2021;30:1332–8. https://doi.org/10.1002/pon.5685
5. Carlson LE, Zelinski EL, Toivonen KI, Sundstrom L, Jobin CT, Damaskos P, et al. Prevalence of psychosocial distress in cancer patients across 55 north American cancer centers. J Psychosoc Oncol. 2019;37(1):5–21. https://doi.org/10.1080/07347332.2018.1521490
6. Rajapakse P. An update on survivorship issues in lung cancer patients. World J Oncol. 2021;12(2–3):45–9. https://doi.org/10.14740/wjon1368
7. Oksholm T, Rustoen T, Cooper B, Paul SM, Solberg S, Henriksen K, et al. Trajectories of symptom occurrence and severity from before through five months after lung cancer surgery. J Pain Symptom Manag. 2015;49(6):995–1015. https://doi.org/10.1016/j.jpainsymman.2014.11.297
8. Poghosyan H, Sheldon LK, Leveille SG, Cooley ME. Health-related quality of life after surgical treatment in patients with non-small cell lung cancer: a systematic review. Lung Cancer. 2013;81(1):11–26. https://doi.org/10.1016/j.lungcan.2013.03.013
9. Kyte K, Ekstedt M, Rustoen T, Oksholm T. Longing to get back on track: patients' experiences and supportive care needs after lung cancer surgery. J Clin Nurs. 2019;28(9–10):1546–54. https://doi.org/10.1111/jocn.14751
10. Maliski SL, Sarna L, Evangelista L, Padilla G. The aftermath of lung cancer: balancing the good and bad. Cancer Nurs. 2003;26(3):237–44. https://doi.org/10.1097/00002820-200306000-00011
11. Missel M, Pedersen J, Hendriksen C, Tewes M, Adamsen L. Regaining familiarity with own body after treatment for operable lung cancer—a qualitative longitudinal exploration. Eur J Cancer Care. 2016;25(6):1076–90. https://doi.org/10.1111/ecc.12383
12. Missel M, Pedersen JH, Hendriksen C, Tewes M, Adamsen L. Diagnosis as the first critical point in the treatment trajectory: an exploration of operable lung cancer patients' lived experiences. Cancer Nurs. 2015;38(6):E12–E21. https://doi.org/10.1097/NCC.0000000000000209
13. Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, et al. Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2021;71(3):209–49.
14. Dansk Lunge Cancer Gruppe [Danish lung cancer group]. *Årsrapport 2021* [Annual report 2021]. 2021.
15. Kehlet H. ERAS implementation—time to move forward. Ann Surg. 2018;267(6):998–9. https://doi.org/10.1097/SLA.0000000000002720
16. Kehlet H, Wilmore DW. Evidence-based surgical care and the evolution of fast-track surgery. Ann Surg. 2008;248(2):189–98. https://doi.org/10.1097/SLA.0b013e31817f2c1a
17. Donsel PO, Missel M. What's going on in the hospital?: A qualitative study investigating patient experiences of prolonged hospitalization after video-assisted thoracoscopic surgery. Cancer Care Res. 2023;3(4). https://doi.org/10.1097/cr9.0000000000000046
18. Missel M, Beck M, Donsel PO, Petersen RH, Benner P. Do enhanced recovery after lung cancer surgery programs risk putting primacy of caring at stake? A qualitative focus group study on nurses' perspectives. J Clin Nurs. 2023;32(13–14):4037–48. https://doi.org/10.1111/jocn.16555
19. Sidenius A, Mogensen O, Rudnicki M, Møller LMA, Hansen HP. Feeling lucky: hierarchies of suffering and stories of endometrial cancer in a Danish context. Sociol Health Illn. 2019;41:950–64. https://doi.org/10.1111/1467-9566.12875
20. Thisted LB, Zoffmann V, Olesen ML. Labeled as lucky: contradictions between what women and healthcare professionals experience regarding the need for help after the early stages of gynecological cancer. Support Care Cancer. 2020;28(2):907–16. https://doi.org/10.1007/s00520-019-04882-2
21. Schoenau MN. Dominant restitution narratives of "being lucky": an ethnographic exploration of narratives about operable lung cancer. Eur J Cancer Care. 2022;31:e13633. https://doi.org/10.1111/ecc.13633
22. Hill KM, Amir Z, Muers MF, Connolly CK, Round CE. Do newly diagnosed lung cancer patients feel their concerns are being met? Eur J Cancer Care. 2003;12(1):35–45. https://doi.org/10.1046/j.1365-2354.2003.00324.x
23. Johnson M, Tod AM, Brummell S, Collins K. Discussing potential recurrence after lung cancer surgery: uncertainties and challenges. Eur J Cancer Care. 2018;27(5):e12870. https://doi.org/10.1111/ecc.12870
24. Timmermann C, Uhrenfeldt L, Birkelund R. Ethics in the communicative encounter: seriously ill patients' experiences of health professionals' nonverbal communication. Scand J Caring Sci. 2017;31(1):63–71. https://doi.org/10.1111/scs.12316
25. Chapple A, Ziebland S, McPherson A. Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. BMJ. 2004;328(7454):1470–3. https://doi.org/10.1136/bmj.38111.639734.7C
26. Gubrium JF, Holstein JA. Narrative ethnography. In: Hesse-Biber SN, Leavy P, editors. Handbook of emergent methods. Guilford Publications; 2008. p. 241–64.
27. Frank A. Practicing dialogical narrative analysis. In: Holstein JA, Gubrium JF, editors. Varieties of narrative analysis. Los Angeles: SAGE Publications; 2015. https://doi.org/10.4135/9781506335117.n3
28. Uhrenfeldt L, Martinsen B, Jørgensen LB, Sørensen EE. The state of Danish nursing ethnographic research: flowering, nurtured or malnurtured—a critical review. Scand J Caring Sci. 2018;32:56–75. https://doi.org/10.1111/scs.12466
29. Frank AW. Just listening: narrative and deep illness. Fam Syst Health. 1998;16(3):197–212. https://doi.org/10.1037/h0089849
30. Holstein J, Gubrium J. The active interview. Thousand Oaks, CA: SAGE Publications; 1995.
31. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of

recommendations. Acad Med. 2014;89(9):1245–51. https://doi.org/10.1097/ACM.0000000000000388
32. Plage S, Olson RE. Surprise reveals the affective-moral economies in cancer illness narratives. Qual Health Res. 2021;31(14):2730–42. https://doi.org/10.1177/10497323211044468
33. Wright JD, Kroenke CH, Kwan ML, Kushi LH. "I had to make them feel at ease": narrative accounts of how women with breast cancer navigate social support [article]. Qual Health Res. 2021;31(6):1056–68. https://doi.org/10.1177/1049732321989999
34. Broom A, Kenny K, Kirby E, Lwin Z. The collective/affective practice of cancer survivorship. Br J Sociol. 2019;70(4):1582–601. https://doi.org/10.1111/1468-4446.12616
35. Hochschild AR. Emotion work, feeling rules, and social structure. Am J Sociol. 1979;85(3):551–75. http://www.jstor.org/stable/2778583
36. Hochschild AR. The managed heart. University of California Press; 2012. https://doi.org/10.1525/j.ctt1pn9bk
37. Roikjær SG, Gärtner HS, Timm H. Use of narrative methods in rehabilitation and palliative care in Scandinavian countries: a scoping review. Scand J Caring Sci. 2022;36(2):346–81. https://doi.org/10.1111/scs.13050

How to cite this article: Schoenau MN, Missel M, Holen M. 'Staying cool, calm and positive': A dialogical narrative analysis of emotional reactions in narratives about operable lung cancer. Scand J Caring Sci. 2024;00:1–10. https://doi.org/10.1111/scs.13241