



Research article

Evaluating a nurse-led narrative interview intervention with cancer patients with a first diagnosis: A feasibility study

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ABSTRACT

Narrative Medicine and Nursing are clinical-supporting intervention methodologies that aim to enhance professionals' communication skills and place patients at the heart of their therapeutic path. A narrative interview (NI) is a communication tool between practitioner and patient. The role of NI is debated extensively in the literature, but no studies focus on its use by nurses responsible for first-diagnosed cancer patients.

This study aimed to evaluate the feasibility and utility of NI, carried out by Nurses, in managing people recently diagnosed with cancer.

A pilot mixed-methods study with before-and-after-intervention evaluation, qualitative longitudinal data analysis, and concurrent data triangulation was conducted. The Mini-Mental Adjustment to Cancer assessed disease adaptation, while the Psychological Distress Inventory investigated psychological distress. The qualitative analysis of the narrative interviews assessed the usefulness of this intervention.

13 out of 14 eligible patients took voluntary part in the study. Of those, 9 (69 %) completed T1 and T2 questionnaires and NI. The following five themes emerged from thematic analysis: reaction to the disease, feelings related to the new condition of life, changes, importance of relationships and perception of care. Patients reported being highly stressed and recognized the importance of a supporting social network for better coping with the condition.

The adoption of an NI approach at the time of cancer diagnosis is feasible. Due to the limited sample size, it is unclear if NI may positively impact psychological distress in this patient population. Further studies would benefit from the integration of an additional investigation tool aiming to clarify whether NI promotes disease awareness in cancer patients. Furthermore, the recruitment of a larger sample is equally recommended.

1. Research question

Embedded within the broader frameworks of Narrative Medicine (NM) and Narrative Nursing (NN), this study explores the feasibility and utility of employing narrative interviews with cancer patients at their initial diagnosis, conducted by seasoned nurses.

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2. Study objective

The foremost goal of this investigation is to pilot the efficacy of narrative interview interventions executed by expert nurses on patients freshly diagnosed with cancer, assessing the potential advantages and practicability of this innovative approach.

3. Introduction

Situated within the expansive terrains of Narrative Medicine (NM) [1] and Narrative Nursing (NN) [2–4], this study investigates clinical-care methodologies rooted in precise communicative competencies aimed at enriching the health professional-patient relationship. Following a consensus reached at the Consensus Conference in Rome [1], both scholars and practitioners have drawn from various studies to characterize NM not just as a methodology centred around communicative competency but as a pivotal tool for acquiring, understanding, and integrating the different perspectives of individuals involved in the healthcare experience [5–7]. The primary objective of the NM approach is to co-construct a bespoke and collaborative care pathway, where the patients' perceptions, experiences, and emotions are integral for healthcare professionals to comprehend the patient's perspective [8] fully.

Additional goals of NM encompass aiding healthcare professionals in empathetically listening and responding to patient needs [9], enhancing the communication and reflective competencies of healthcare workers towards their patients [10], facilitating a mutual understanding of illness experiences between patients and clinicians [11], and advocating a shift from the traditional medical model towards a more person-centred approach, emphasizing the unique bio-psycho-social-ecological and cultural context of each individual [12].

NM has been the subject of scholarly attention for decades now [13], with its proponents advocating for the training of physicians and other healthcare professionals in these novel competencies [7,14].

The concept of Narrative Nursing [15], derived from NM, specifically addresses the nursing discipline. It emerged in the early 2000s [2] as a response to the limitations of biomedical care models that often overlook the holistic view of the patient [16]. This approach, termed "Integrated Narrative Nursing," aims not to oppose but to complement the traditional disease-centred medical model [3].

From a narrative standpoint, a cancer diagnosis represents a significant disruption in an individual's life story, necessitating adaptation and a reconstruction of the narrative to incorporate the illness [17]. Given the complex nature of chronic cancer conditions, quantitative methods alone fall short of addressing the comprehensive needs of affected individuals [18].

The role of nurses in fostering patient engagement, empowerment, and self-management has been underscored in numerous studies which propose insights based on chronic disease management and effective patient care protocols [19–22]. Communication skills are particularly crucial at the onset of a cancer diagnosis, a moment fraught with emotional significance for the patient [23,24]. Research has acknowledged that a skilled, communicative approach by healthcare professionals, especially nurses, can provide meaningful support to patients navigating the challenging journey of severe oncological conditions [25,26]. Additionally, studies focusing on patient stress and adjustment to illness have highlighted the importance of psychological support in aiding patients' coping mechanisms [27].

In this study, Narrative Interviewing (NI) serves as a relational tool between nurses and patients (both healthy and ill) and their families. It aims to elicit life and illness narratives to understand the participants' perspectives [4,28]. By sharing their health and illness stories, individuals convey unique viewpoints on their experiences [29].

In NI, nurses pose open-ended questions and listen intently to the narratives shared by patients, thereby reducing the loneliness and suffering associated with illness and promoting a sense of shared experience [30]. The application of NI seeks to explore patients' and their families' experiences, needs, resources, and capabilities, aiding in interpreting illness, re-enacting the experience, and enhancing patient engagement [31]. Effective narrative interviewing necessitates the development of narrative competence through specialized training [14,32].

To the best of our knowledge, there have been no studies to date employing narrative interviewing conducted by nurses at the initial diagnosis of cancer patients as a care intervention tool. This study raises the question: Can cancer patients positively receive a narrative interview conducted by an experienced nurse at their first diagnosis, and can this intervention facilitate self-reflection, strengthen the patient-Nurse relationship, and empower patients to mobilize their resources?

The primary objectives are to assess the feasibility and conduct a pilot evaluation of the utility of a narrative interview intervention by nurses for cancer-diagnosed patients.

The secondary objectives include.

- (i) highlighting the main findings of the Narrative Interview intervention (comprising two interviews conducted 15 days apart) on the psychological distress and adjustment to illness of the participants;
- (ii) delving into the perceptions and experiences shared by the interviewees during the first and second interviews, especially noting any changes in the meaning attributed to the illness and its surrounding contexts as expressed between the two sessions.

4. MATERIALS and METHODS

4.1. Study design

A pilot mixed methods study was designed, featuring a before-and-after intervention evaluation, qualitative longitudinal analysis of

Table 1

Study design: quantitative evaluation, qualitative evaluation and narrative interview intervention.

	Pre- Intervention T0	INTER-VENTION Narrative Interview 1	Post- Intervention T1	INTER-VENTION Narrative Interview 2	Post- Intervention T2
PDI (Psychological Distress Inventory) Quantitative Evaluation	X		X		X
Mini-MAC (Mini-Mental Adjustment to Cancer) Quantitative Evaluation	X		X		X
Narrative Interview Qualitative Evaluation		X		X	

Table 2

Narrative nursing framework.

Concepts	NARRATIVE NURSING Applied to health sciences
Person	The person is considered in his or her wholeness and integrity, paying attention also to inner realities (experiences, emotions, feelings)
Disease	Illness and Sickness
Analysis of the person	They consist of the experiences, emotions, meanings attributed to illness, personal illness narrative
Role of patient	Patient is an illness expert based on his/her experience
Method	Narrative and interpretative
Tools	Interview, narrative, patient agenda, autobiography

data [33,34], and concurrent data triangulation [35], following the protocol published by Artioli et al. [36]. The intervention consists of two Narrative Interviews (NI 1 and NI 2), conducted 30 days after the cancer diagnosis and 15 days following the first interview, respectively. Table 1 outlines the evaluation of the intervention.

4.2. Theoretical framework

"Narrative Nursing" is designed to underscore the importance of the narrative aspect within the nursing field. This approach prioritizes the individual's recounting of their illness experience, thereby acknowledging and valuing the inner human elements, such as emotions, feelings, personal experiences, and life stories, beyond the observable signs and symptoms. This model distinctively incorporates methodologies from the humanistic disciplines, notably storytelling [28] and the patient's agenda [37], adapting these elements to enhance patient care [32]. The conceptual model derived from this approach is systematically outlined in Table 2.

4.3. Intervention

In this study, nurses who received specialized training utilized the Narrative Inquiry (NI) method. The objective was to comprehensively understand the perceptions and experiences shared by participants during the initial and follow-up interviews. Given the constraints posed by the COVID-19 pandemic, researchers conducted interviews using a hybrid approach: face-to-face where feasible, otherwise via telephone. All interviews were audio-recorded to support accurate transcription and subsequent analysis. To foster an environment of non-judgmental listening and mutual trust, crucial for the NI process, interviewers underwent comprehensive training through interactive courses, emphasizing these principles [29,38].

4.4. Setting and study population

The study focused on patients from the Oncology Service at a hospital in Northern Italy. A convenience sampling strategy was employed, including patients newly diagnosed with cancer. To respect the participants' emotional state, the research team contacted patients approximately one month after communicating the diagnosis.

Eligibility criteria were as follows: fluency in Italian, an initial cancer diagnosis, age over 18 years, willingness to participate in the study, and provision of informed consent. A research team member (a physician not associated with the oncology department) facilitated recruitment and liaised with the clinical staff to identify eligible participants. After determining eligibility with the attending physician, researchers provided study details to patients. Upon agreeing to participate, the project manager contacted patients to complete consent forms and schedule interviews and questionnaire sessions. The interviews were organised directly by two interviewing researchers, while two additional team members were responsible for administering and collecting the questionnaires.

4.5. The research team

The multidisciplinary research team, affiliated with a University Facility and external to the Ward Team, comprised authors of this study, including five nurses (all with postgraduate qualifications), a physician, an educator, a psychologist, and a project manager. Two nurse researchers (GA and GC) with expertise in qualitative research, medicine, and narrative nursing conducted interviews. The

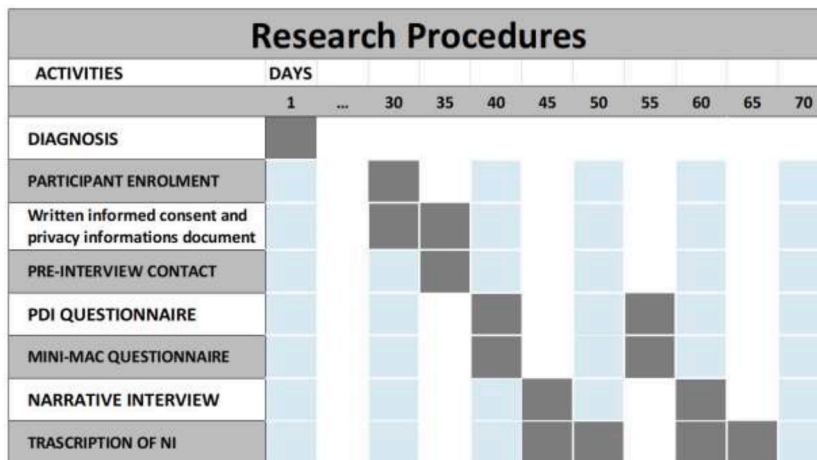


Fig. 1. Gantt chart.

team engaged with the clinical staff to introduce the study's aims and secure access for patient recruitment. The clinical team was informed that the study's early phase aimed to assess the intervention's reception by patients and its impact on their illness perceptions.

4.6. Assessment and intervention procedures

Evaluations were both quantitative and qualitative.

4.6.1. *Quantitative evaluation* is administered immediately after enrollment (T0), 30 days after diagnosis (T1), and following each interview (T2)

Assessments utilized Italian-validated tools, including the Psychological Distress Inventory (PDI) [39] for psychological distress and the Mini-Mental Adjustment to Cancer (Mini-MAC) [40,41] scale for adaptation to illness. These scales were administered at T0, T1, and T2, and the evaluation process was detailed in a Gantt chart (Fig. 1).

4.6.2. *In qualitative evaluation* employing the NI method, the first session occurred right after the T0 questionnaire administration and the second 15 days after the post-initial interview. Interviews explored three main themes

- * Patient's perception of cancer diagnosis communication
- * Patient's adaptation to the newly diagnosed condition
- * The impact of cancer on personal life history and interpersonal relationships (see suppl. material n° 1)

The design of the NI sessions at T1 and T2 facilitated thematic analysis by maintaining a similar structure, allowing for comparative evaluation of changes in participants' perspectives between interviews.

Fig. 1 depicts the conduction of the study over time.

4.7. Data analysis

4.7.1. *Quantitative data analysis*

The investigation utilized responses from questionnaires collected at three pivotal moments: the initial baseline (T0), an interim point (T1), and the study's conclusion (T2). In assessing the Psychological Distress Inventory (PDI), individual item scores were aggregated, with a necessary adjustment through the reversal of scores for questions 2 and 6. The analysis of the Mental Adjustment to Cancer (Mini-MAC) scale involved summing scores across specific items to delineate distinct psychological coping profiles related to cancer. Scores from items 2, 10, 18, 23, and 24 were compiled to articulate the "Fighting Spirit" (FS) profile, with items 4, 6, 7, 12, 14, 15, 16, 20, and 21 addressing the "Despair/Depression" (DD) profile, items 1, 3, 8, and 19 for "Fatalism" (FA), items 5, 9, 13, 22, 25, 28, and 29 for "Anxious Preoccupation" (AP), and items 11, 17, 26, and 27 for "Avoidance/Minimization" (AM). The study employed descriptive statistical methods, calculating mean, median, significant percentiles, and standard deviation to analyse the data distribution. No statistical analysis using parametric testing was performed. The Shapiro-Wilk test was applied to evaluate the normality of data distribution, and the non-parametric Wilcoxon paired test was used to identify differences pre- and post-intervention, avoiding parametric testing.

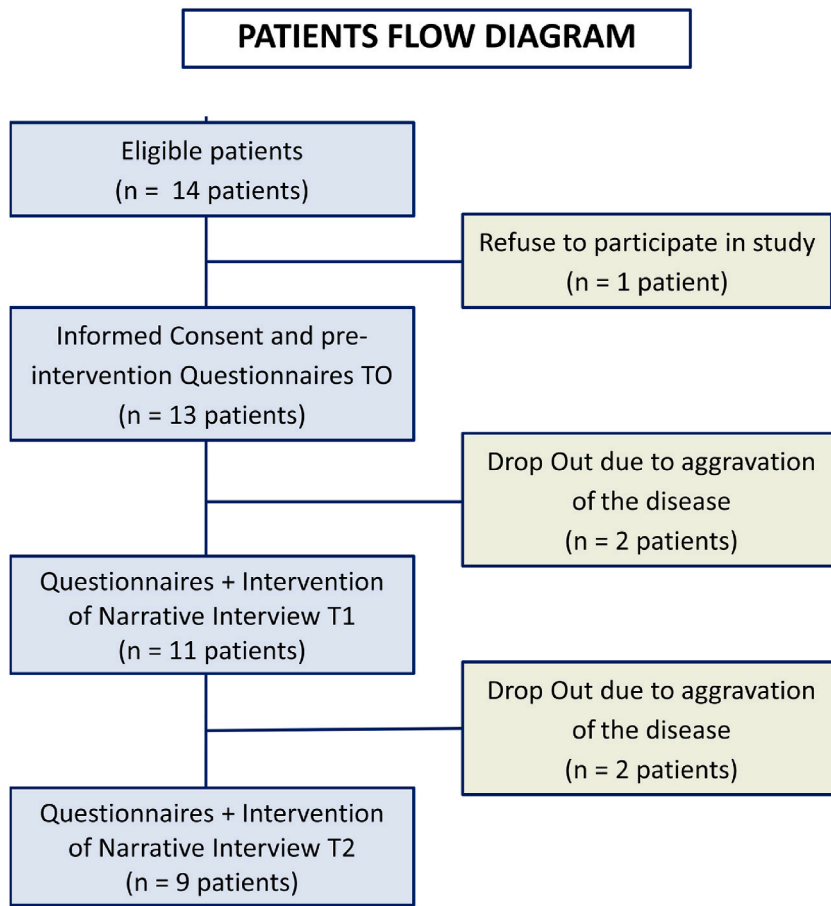


Fig. 2. Patients flow diagram.

4.7.2. Qualitative data analysis

The qualitative segment entailed a detailed examination of narrative interviews conducted at T1 and T2. All interviews collected at times T1 and T2 were aggregated and separated between T1 and T2. The interviews were coded, transcribed verbatim and analysed according to Braun & Clarke's thematic analysis methodology. [42–44]. Two independent researchers carried out the analysis, with discrepancies resolved through discussion or the involvement of a third researcher. This process began with identifying meaningful units within the narratives, which were then grouped into sub-themes and central themes. Researchers conducted a comparative analysis between T1 and T2 to identify shifts in themes and sub-themes over time, facilitated by a comprehensive discussion among the research team [33,34]. Data triangulation complemented this analysis, merging qualitative and quantitative insights to enrich the analysis [45,46].

4.8. Ensuring qualitative data integrity

The research team structured interviews with open-ended questions to capture the depth of participants' experiences and to foster uninhibited expression. The multidisciplinary research team engaged in reflective discussions on the data, its analysis, and the resulting conclusions to ensure the credibility of the findings [47]. The use of participant quotes was extensive in defining the identified themes and sub-themes, adhering to the COREQ guidelines [48] for qualitative research reporting (see suppl. material n° 2)

4.9. Evaluation of research aims

4.9.1. Primary aims evaluation

The feasibility of the study was assessed based on.

- (a) The enrollment rate of eligible patients
- (b) The completion rate of the intervention
- (c) The average length of interviews

Table 3
Sample description (N = 13).

VARIABLE		FREQUENCY
GENDER	Man	8
	Woman	5
AGE	Range: 60-65	13
CIVIL STATUS	Unmarried	1
	Married	7
	Divorced	2
	Widower/Widow	3
EMPLOYMENT	Housewife	2
	Employed	6
	Retired	5
EDUCATION	Primary School	2
	Middle School	5
	Secondary School Diploma	5
	University Degree	1
PATHOLOGY	Breast	3
	Intestine	2
	Leukemia	4
	Lung	2
	Lymphoma	1
	Pancreas	1

The feasibility criteria included a minimum of 50 % compliance in recruitment and intervention completion, with the average interview duration falling between 15 and 30 min.

4.9.2. Secondary aims evaluation

A pilot mixed-methods approach was utilized to assess the intervention's impact on psychological distress (PDI) and adaptation to illness (Mini-MAC). Changes in patients' illness perceptions and experiences were examined between T1 and T2 interviews. This comprehensive evaluation aimed to elucidate the psychological and experiential dynamics of patient coping mechanisms and their evolution throughout the study.

5. Results

Patient recruitment was conducted from September 2020 to March 2021, following the protocol's approval before the onset of the COVID-19 pandemic in Italy on January 30, 2020. The pandemic-related restrictions largely influenced the extended recruitment phase and smaller sample size.

5.1. Primary outcomes

The primary outcomes of the study were as follows.

- Out of 14 patients identified as eligible, 13 consented to participate in the study, resulting in a 93 % adherence rate to the research.
- All 13 patients completed the initial (T0) questionnaires, 11 completed the first follow-up (T1) questionnaires, and 9 completed the second follow-up (T2) questionnaires. Thus, 69 % of the enrolled participants completed the study. The attrition was primarily due to deteriorating clinical conditions.
- The duration of the interviews ranged between 15 and 30 min. The average length of the initial interviews was approximately 20 min and 39 s, whereas the follow-up interviews averaged 21 min and 19 s.

Fig. 2 illustrates the study's flowchart of patient enrollment and completion rates.

5.2. Secondary outcomes

Secondary outcomes were categorized into two types, focusing on quantitative findings.

5.2.1. The first type of the secondary objective was to evaluate the effect of the intervention on the psychological distress and the adaptation to illness in cancer patients

The detailed characteristics of the participants are presented in Table 3.

The outcomes of the questionnaires, as illustrated in Table 4, are expressed in terms of the median (25th percentile - 75th percentile) and mean (\pm standard deviation). These results demonstrate relatively low levels of psychological distress (PDI) at all measured points during the survey period. In terms of the Mini-Mental Adjustment to Cancer (Mini-MAC) scores, the findings reveal.

Table 4
PDI results and Mini-MAC (N = 13).

	Median (p25-p75)			Mean (\pm SD)		
	T0 (N = 13)	T1 (N = 11)	T2 (N = 9)	T0 (N = 13)	T1 (N = 11)	T2 (N = 9)
PDI	23 (21–25)	29 (21–31)	25 (24–33)	24.00 (\pm 3.54)	27.55 (\pm 5.90)	28.00 (\pm 5.36)
FS	17 (13–18)	16 (13–20)	16 (13–19)	16.31 (\pm 2.95)	15.73 (\pm 3.20)	15.56 (\pm 3.68)
DD	11 (11–15)	14 (9–15)	12 (11–16)	12.69 (\pm 3.22)	12.55 (\pm 2.98)	14.56 (\pm 4.16)
FA	11 (10–12)	12 (10–13)	12 (10–13)	11.38 (\pm 2.50)	11.82 (\pm 2.40)	12.22 (\pm 2.39)
AP	14 (13–16)	15 (13–17)	16 (16–25)	14.46 (\pm 3.91)	15.55 (\pm 3.30)	19.22 (\pm 4.60)
AM	11 (10–15)	13 (11–15)	13 (10–15)	12.08 (\pm 2.60)	12.45 (\pm 3.05)	12.00 (\pm 3.35)

Table 5
Results of Wilcoxon test. NS $p > 0.05$ (N = 13).

	T0 vs T1	T0 vs T2	T1 vs T2
PDI	NS	NS	NS
FS	NS	NS	NS
DD	NS	NS	NS
FA	NS	NS	NS
AP	NS	0.009	0.009
AM	NS	NS	NS

- Notably high levels of Fighting Spirit (FS),
- Generally low levels of Denial (DD),
- Substantially high levels in the Fatalism (FA) profile,
- Low levels of Anxious Preoccupation (AP),
- Significantly high levels of the Avoidance (AM) profile.

The Shapiro-Wilk test was utilized to assess the distribution of the collected data. Except for the Psychological Distress Index (PDI) values at the initial time point (T0) with a p-value of 0.044 and at the final time point (T2) with a p-value of 0.036, the data predominantly exhibited a normal distribution. However, due to the limited number of measurements, a decision was made to employ non-parametric tests for analysis, favouring a more cautious statistical approach.

The Wilcoxon test was applied to all PDI and Mini-Mental Adjustment to Cancer (Mini-MAC) variables to investigate the differences across the three-time points (T0, T1, and T2), as detailed in Table 5. Prior to conducting this test, the assumption of variable symmetry was verified to ensure an accurate comparison between the different times for each variable under consideration.

Notably, as outlined in Table 4, significant differences were observed primarily in the Anxious Preoccupation (AP) component of the Mini-MAC, specifically when comparing the initial and final time points (T0 vs T2) and the mid-point to the final time point (T1 vs T2). These findings suggest notable changes in the levels of anxiety-focused coping among participants throughout the study.

5.3. *The secondary type of outcome aimed to explore the evolution in patients' experiences and perceptions of their illness through two interviews conducted at T1 and T2. A thematic analysis of these interviews revealed significant shifts across five key themes*

(A) Reaction to the Disease. Initially, the diagnosis was perceived as a traumatic and difficult-to-accept event. By T2, there was a noticeable shift towards acceptance and a daily struggle with the reality of the disease.

(B) Feelings Related to the New Condition of Life. There was a change from projecting and deferring life to the future to living and managing the illness in the present moment.

(C) Change. Participants moved from the realization that life had radically changed to the understanding that there was no return to the pre-illness state.

(D) Importance of Relationships. Initially, support was viewed as coming exclusively from the family. Over time, this view expanded to include a more comprehensive social system, acknowledging broader support networks.

(E) Perception of Care. The perception of the care team evolved from seeing them merely as professionals to recognizing them as trusted and supportive figures in the healthcare journey.

Table 6 presents a detailed compilation of these themes, the associated sub-themes, and the shifts in meaning observed between T1 and T2. This table underscores the dynamic nature of patients' coping mechanisms and adaptation processes over time, reflecting a journey of transformation in their perceptions and experiences of illness.

Table 6 collects and describes the topics, the related sub-themes and meaning-shift between T1 and T2.

Table 6
Meaning shift among T1 vs T2 interviews.

SUB-THEME	FROM T1	MAIN THEME	TO T2	SUB-THEME
Trauma of the disease Between awareness and unawareness Willingness to the face the disease as a battle	<i>Traumatic even difficult to accept</i>	1. REACTION TO THE DISEASE	<i>Awareness of the disease and the difficulty in dealing with it</i>	Trauma of the change Awareness of disease It becomes necessary to face the disease in a good mood
Between fears and letting oneself go Preoccupation for the unknown and for others (beloved persons) Conviction of getting healed and going back to life as before	<i>The disease is poorly understood, but there is a long-term view</i>	2. FEELINGS RELATED TO THE NEW CONDITION OF LIFE	<i>The disease is known and the situations of the moment are faced</i>	Preoccupation that the strength to fight decreases Rage and nervousness against oneself Face with willingness the treatments
Life before is not as life now Changes of relationships Between isolation and help of need Unconditioned help of the family	<i>One discovers life changes radically</i>	3. CHANGES	<i>One understands you cannot go back</i>	Awareness of not being able to do what was done before Change of perspective The solidarity of family and friends
Clear and timely relationships	<i>Family support</i>	4. THE IMPORTANCE OF RELATIONSHIPS	<i>Support of the family enlarged to the social world</i>	
	<i>Trust in team</i>	5. PERCEPTION OF CARE	<i>Support of team</i>	Availability and humanity

5.4. Qualitative findings

5.4.1. Theme 1: reaction to the disease

The change of meaning identified in the first theme highlights a passage from a traumatic event that is difficult to accept to an awareness of the disease and the difficulty in dealing with it.

5.4.1.1. *Traumatic event challenging to accept.* In this first theme, in the T1 interviews, three sub-themes are identified.

(i) *The trauma of disease*

The disease presents itself immediately in all its drama, in particular when the diagnosis is discovered, which for some "was a shock" (Cod. 9.2) and, immediately afterwards, the participants report the sensation of feeling as if "the world collapsed on me" (Cod. 8.3) and of feeling lost. Patients, especially in the initial stages of the disease, let themselves be overwhelmed by fear and discouragement because they live in a state of total disorientation concerning everything that will happen from the moment of diagnosis onwards (Cod. 4.10). Recognizing the trauma of the disease, patients also know that "it takes time to process" (Cod. 10.1), to process this new situation. The patients say: "It was not that I was fine; otherwise, I would not have gone to the emergency room. But I certainly would not have expected everything that happened afterwards" (Cod. 5.2).

(ii) *Between awareness and unawareness*

At first, the patients mainly place themselves in a condition of unawareness of their disease, both because they do not have "the perception of being sick" (Cod. 11.5) and because they tend to underestimate the situation: the fact emerges "not feeling like patients at risk" (Cod. 3.14). Gradually, even in the first interviews, however, awareness begins to develop first of the disease and "of what is happening to him/her" (Cod. 2.1), then of the fact "that I will not recover" (Cod. 4.5). Below are some of the voices of the participants: "I thought it was less serious than it was, in short, I knew that there was something (...), but in short, I thought that ..." (Cod. 9.7). "Everything was rapid and the diagnosis was also somewhat expected here ..." (Cod. 3.4).

(iii) *Willingness to face the disease as a battle*

However, the diagnosis of the disease, which causes intense trauma, stimulates patients to find the strength to face it, thinking "now let us start this battle" (Cod. 9.9). The interviewees are willing to deploy all their resources to forcefully face what awaits them, with a constant commitment that leads them to "leave nothing to chance" (Cod. 4.2). In fact, the following can be deduced from the interviews: "I have to win it, so no more gossip, chatter, and start this thing here, start this thing with extreme fierce" (Cod. 9.8).

5.4.1.2. *Awareness of the disease and the difficulty in dealing with it.* Also, in the first theme, even in the T2 interviews, three sub-themes are identified.

(i) *Trauma of change*

The outbreak of the disease causes changes that affect every sphere of the patient's life, strongly impacting their daily life, which has "clearly changed" (Cod. 4.9). In particular, physical appearance, lifestyle changes, and social life are affected by the disease's effect. The patients in the interviews report: "[my life] has changed in everything, in everything and for everything ... perhaps not only because of my illness" (Cod. 3.6).

(ii) *Illness Awareness*

All patients show that, at this point, awareness of the disease is vital: "I know what I am getting into" (Cod. 5.5). Knowing what they have to face allows them to take a step towards acceptance and awareness of the traumatic event: "I accepted it" (Cod. 6.11). Awareness and acceptance allow the interviewees to find a new normality: "You have to accept your illness, you have to go on, you have to find your new rhythm of doing things" (Cod. 4.15).

(iii) *It becomes necessary to face the disease with a good mood*

Patients reserve particular importance to "Do not let yourself down" (Cod. 5.7), and find the strength to face the disease with serenity, being "always positive" (Cod. 7.8) and finding every day a reason to look at life with pro-activeness. Positivity is recognized as a fundamental element in dealing with a condition of great difficulty: "I experience positive things every day. I try to live them every day" (Cod. 7.2).

5.4.2. *Theme 2: feelings related to the new condition of life*

The search for the change of meaning from T1 to T2 highlights a shift from the idea that "the disease is little known, but there is a long-term vision" to the idea that "the disease is known and the situations of the moment are faced".

5.4.2.1. *The disease is poorly understood, but there is a long-term view.* In the second theme in the T1 interviews, there are three sub-themes.

(i) *Between fears and letting go*

A mix of overwhelming emotions characterizes the stories of the interviewees. Fear represents a prevailing state of mind in the experiences collected: it is linked to "not making it" (Cod. 1.5), and sometimes one feels the need to let emotions flow out in tears for what is defined as a real "leap in the dark" (Cod. 10.13). It is reported that: "It scares me that there are not treatments, that there is not something to make you feel good" (Cod. 1.8).

(ii) *Concern for the unknown and others (loved ones)*

Not knowing the evolution of the disease generates fears and concerns in patients due to the lack of certainty about "what will come from there on" (Cod. 4.13). However, people try to maintain long-term forecasts by keeping an optimistic view: "I am convinced that I will get out of this" (Cod. 2.8). The most significant concern in this first phase of the disease is directed to the loved ones and to what "is happening all around" (Cod. 5.8), the desire to preserve the beloved from the suffering experienced by the patients: "one should never see his/her child being sick" (Code 1.10).

(iii) *Conviction to heal and return to life before*

In this first phase, despite the difficulty of the health situation, the hope of defeating the disease and being able to return to life represents an anchor for moving forward. The "conviction of healing" (Cod. 3.12) is present in various interviews. In addition, the hope is to recover the characteristic happiness of the pre-diagnostic period: "I have always been happy up to this moment. And I still want to be" (Cod. 6.7).

5.4.2.2. *The disease is known, and the situations of the moment are faced.* Also, in the second theme, in the T2 interviews, three sub-themes are highlighted.

(i) *Concern that the strength to fight is reduced*

If the disease is faced as a battle to be fought at the beginning of the path, going forward, the patients report that the situation "begins to be frustrating" (Cod. 1.3). Concerns focus on whether or not they are able to deal with the disease decisively. Patients reporting that the disease "takes away your strength a little" (Cod. 6.18) to face the obstacles deriving from treatments are also responsible for reducing the ability to resist what happens.

(ii) *Anger and nervousness towards oneself*

In this phase of the disease, patients are very attentive to the feelings they experience: anger, nervousness, and discouragement dominate this delicate phase of the patient's life. The thought for the other is set aside, and we focus on ourselves. We feel like victims of "bad luck or good luck" (Cod. 1.4), of the effects of the disease and the therapy, of thinking about what we will have to face (Cod. 7.3). Patients state: "I have some pressure on me" (Cod. 7.1).

(iii) *Willingly face the treatments*

Maintaining a proactive and positive approach helps to face the path, thinking about the future: "Thinking about the next day" (Cod. 7.7), without dwelling on therapeutic failures is helpful for not getting discouraged and "overcoming everything" (Cod. 7.9) maintaining a rational position, functional to "consider everything" (Cod. 8.15), even the worst evolution. "But the thing is there, it is in progress, I have to fight it, I also have to consider the fact that I could also fail ..." (Cod. 8.16).

5.4.3. *Theme 3: changes*

In the third theme, a change occurs regarding awareness of one's present and future life. In particular, two crucial sub-themes can be identified.

5.4.3.1. *It turns out that life changes dramatically.*(i) *life is not what it used to be*

Illness requires a radical change of life: "let us say it changed as from day to night" (Cod. 5.7). The changes mainly affect the physical condition: "I no longer have the strength to do the things I used to like" (Cod. 8.11), "and then the aesthetic aspect also changes" (Cod. 4.24). The disease limits the life of the patients so much that they define it as "a little halved ..." (Cod. 6.8), imposing a new balance on them: "I had to change my mindset completely" (Cod. 9.16).

(ii) *Relationship change*

Relationships and social relationships change due to the effects of the disease, and patients feel "locked in home" (Cod. 10.19); as a result, even sociality is drastically reduced: "the moment of leisure, that is missing a lot" (Cod 3.21). In a condition of reduced social contact, the value of relationships with the people closest to them is recognized by the interviewees: "I realize that I am lucky to have so many people who love me and want to do their part and give me their share" (Cod 4.28).

5.4.3.2. *One understands that there is no turning back.* Also, in the third theme in the T2 interviews, two sub-themes emerge.(i) *One discovers that he/she can no longer do what he/she used to do*

The disease breaks into the lives of patients who now live with a new reality: "I find it more difficult to stay outside" (Cod. 2.7); "Unfortunately I can never go out" (Cod. 3.2). Over time, patients acquire the awareness that their life will never go back to what it was before, in fact they report: "Hoping to be able to live my life ... I will no longer be able to do what I used to do before" (Cod. 4.11).

(ii) *Perspective change*

The interviewees assert that the new condition has led them to a change of perspective by endowing small things with meaning: "things, stupid things, that is, about what you say of things, like how beautiful they were" (Cod. 8.15); it denotes how the evolution of the disease is an aspect that opens reflections and concerns on prospects. The interviewee's quote: "Prospects or in any case what could be the short or long evolution of the disease change here ... this is the only concern" (Cod. 9.10).

5.4.4. *Theme 4: the importance of relationships*

The change in meaning identified is from "family support" to "family support extended to the social sphere".

5.4.4.1. *Family support.* In the fourth theme in the T1 interviews, two sub-themes stand out.(i) *Between isolation and the need for help*

The results show, on the one hand, the willingness to personally manage the disease without the help of anyone by moving away from the affected people and, on the other, the need to have family support and the help of loved ones as a lever to deal with the disease. In fact, "the family is a support" (Cod. 9.25). The interviewee's report: "I have my daughter and my wife, and they have me, I know I can count on them" (Cod. 10.18).

(ii) *The unconditional help of the family*

The family, however, represents a solid point for most of the interviewees, a source of unconditional help and psychological support. *"They are wonderful as support"* (Cod. 9.23). The closeness of loved ones is one of the aspects most felt by the interviewees. They quote: *"The people you feel closest to are even closer to you in some way, even if at a distance"* (Cod. 3.22).

5.4.4.2. *The support of the family extended to the social.* In the fourth theme in the T2 interviews, a single sub-theme emerges.

(i) *The solidarity of family and friends*

Also, in the second interview, all the participants forcefully pointed out that the closeness of family and friends represents a fundamental resource for tackling the treatment process: *"they are always there"* (Cod. 5.12). Social life, although limited by the disease, represents a fragment of normality which the interviewees do not want to give up. This aspect is how they report: *"Even my friends are still all ... how do you say?!.. yes, they are all ... they are very close to me here"* (Cod. 2.6).

5.4.5. Theme 5: perception of care

The change in meaning highlights a shift from *"the support of the team"* to *"confidence in the team"*.

5.4.5.1. *The support of the team.* A sub-theme emerges in the fifth and final theme in the T1 interviews.

(i) *Clear and timely report*

The initial relational approach between patient and professional, characterized by clear and effective communication: *"He wanted to explain to me thoroughly"* (Cod. 4.4), represents the starting point for the person who must undertake a complex and full treatment path of uncertainties: *"In that department, there are people inside who are extraordinary, and in a department like that it means a lot"* (Cod. 10.8).

5.4.5.2. *Trust in the team.* In the fifth theme, in the T2 interviews, a single sub-theme is highlighted.

(i) *Availability and Humanity*

The team's ability to welcome and support the sick person is fundamental for trusting and continuing in the treatment process: *"Patients acknowledge that they feel comforted"* (Cod. 5.2) by the availability of healthcare personnel. The humanity of the professionals and their ability to instil trust are central characteristics and appreciated by the patients who report: *"In my opinion, it should come out ... because they have a humanity that one does not always find ... I have found a great amount"* (Cod. 3.10).

5.5. Triangulation of results

In summary, the quantitative and qualitative data show that the patients do not show exceptionally high levels of stress (quantitative data), while the qualitative data highlight the importance of the relationships that are created with family members, friends, and the treatment team, which together provide important support [49].

High levels of fighting spirit (quantitative data) are found in qualitative data, such as the 'willingness to face the disease as a battle' and the willingness to face it in a good mood [50].

The low levels of depression and hopelessness (quantitative data) are also expressed in the qualitative data in the initial feelings of conviction to recover and to return to one's former life, which gives way to anger and worry and not to depression [51].

The high levels of fatalism (quantitative data) are combined with qualitative data relating to changes when, in the second interview, the participants recognize that there is no turning back.

The levels of anxious concern, which increase significantly (quantitative data) [52], seem to deviate from the qualitative data, which do not show elevated anxiety aspects in the participants' expressions. The qualitative data show that the interviewees associate positive feelings with negative ones related to the trauma of the disease.

However, the qualitative data does not mention high levels of the "avoidance/minimization" profile, where the participants immediately try to know and familiarize themselves with their disease.

An essential element that appears only in the qualitative data is awareness of the disease [53], which manifests itself very early, i.e., at the second interview only 15 days after the first.

6. DISCUSSION and CONCLUSIONS

The present study aimed to evaluate the feasibility and utility of an NI intervention in patients with the first diagnosis of oncological disease. Expert nurses interviewed patients about one month after the diagnosis was communicated and 15 days after the first interview.

The feasibility of the study protocol was demonstrated by the primary outcomes and secondary outcome of qualitative assessment,

with some more reservations than the secondary outcome measured with quantitative tools. Based on the parameters we indicated, the percentage of subjects who joined the study and that of patients who completed it suggest that introducing the NI is a feasible intervention.

However, the dropout rate seems to be high. This phenomenon is undoubtedly due to the study period during which the COVID-19 pandemic developed. However, this finding may lead us to consider improving sample recruitment and increasing the involvement of departmental staff. The fact that the dropouts were all determined by a worsening of the clinical picture could make us reflect on the importance of taking the clinical dimension into account in the trajectory of oncological disease.

The patients agreed to collaborate positively in the study, considering it essential for themselves and other patients in their condition.

The interviewers collected these statements informally at the beginning or conclusion of the interviews.

The study's quantitative data highlight what is already present and known in the literature; that is, the study shows how a cancer diagnosis creates a succession of strong emotions in the person resulting from shock. Pervasive feelings of helplessness, disbelief, anger, high levels of stress and fighting spirit, high levels of fatalism or anxiety and minimization of the disease emerge [52,54]. Some qualitative data also agree with the literature, e.g., the emergence of hope concerning the possibility and willingness to face the disease [55,56].

Qualitative data emerge from our study that are not readily found in the literature, including qualitative data, and highlight elements of novelty in the research.

These are novel factors: the importance of the relationships created with family members, the 'willingness to face the disease as a battle', and the willingness to face it in a good mood, or the participants recognize that there is no turning back.

The qualitative data show that the interviewees associate positive feelings with negative ones related to the trauma of the disease, and the participants immediately try to know and familiarize themselves with their disease.

Triangulation of the data shows exciting differences between qualitative and quantitative data, showing that, in the trajectory of illness, patients also experience conflicting emotions [30].

The study also found that some people respond to the discovery of the diagnosis with unexpected coping skills, defining the disease as a battle to be fought [50]. This finding is important because although the quantitative data do not demonstrate an altered adaptation to the disease, the fighting spirit could be a predisposing factor for this condition.

In this change process, the proximity of a motivating family, social, and healthcare environment assumes excellent importance [49].

The literature emphasises the team that takes charge and accompanies the patient through the care pathway [57,58].

The data from this study show that family and friends support the ill person; this finding suggests that more attention should be given to preventing family burnout. Articles with interventions to support the family already in burnout are primarily found in the literature [59,60].

Our sample found itself in agreement with the fact that the communication of the diagnosis should take place with honest, transparent and punctual words as it represents a starting point for the patient to begin to elaborate on the new life condition and entrust himself or herself to the care professionals. This aspect underlines the need for a team capable of adapting the communication style to the patient in front of them [61], capable of feeling empathy and listening [62–64]. The usefulness of exploiting practical communication tools can be seen. One of them is NI, a tool that primarily allows active listening and which, as introduced, participates in uprooting patients from that condition of loneliness and suffering that the disease implies, allowing them to share their experiences with professionals [20].

The qualitative literature concerning oncological disease [65] frequently mentions changing life. In our study, the disease and therapies impact different aspects of daily life and hope as a coping strategy. The search for a new normality becomes essential for dealing with the disease and its effects.

New elements stand out from the study's data in disagreement with the literature, such as the relatively limited temporal dimension of awareness development and the adaptation process to the new life. Narrative Medicine, used in other studies, highlighted an improvement in awareness [66,67], but the time frame needs to be described. In fact, in a short time, the interviewees go from unawareness of the disease at T1 to developing awareness at T2 after only 15 days. This element represents a starting point for reflection worthy of deepening through further studies. Other innovative elements of this study include the proposal to use an NI as a tool that experienced nurses can use to help patients talk about themselves in the face of an unfavourable diagnosis and not instead, as the literature mentions, used for research [68–71], or as a therapeutic intervention proposed by specialists [72,73].

The present study intends to be part of an innovative stream of literature in which NI is used to care for a person diagnosed with cancer. NI, using self-talk and the perception of being listened to, having the opportunity to share this with health professionals in a dimension of co-construction of the disease trajectory.

6.1. Strengths of the study

In contrast to several other studies, we analysed a heterogeneous sample that includes more males than females, is not limited to cancer type, has a low-to-medium primary scholarship, and has an average high age.

The choice is using narrative interviews conducted by nurses. Unlike other studies, we did not analyse stress and adjustment to illness through questionnaires. We analysed how illness people's perceptions can change through an individual path of reflection and how people activate resources that can be helpful without necessarily having to turn to specialists in the field. Active listening by the research nurses supports all this.

By developing awareness, patients know what is happening and the changes in their perception of the disease. Activating one's resources, especially the help and closeness of family and friends, developed self-management.

6.2. Limitations of the study

The study has some limitations, which are outlined below. First, a small sample size is needed for solid significance assessments, particularly quantitative assessments.

Another significant limitation is the lack of an instrument that evaluates the tool's effectiveness based on the patient's evaluation and the providers' perspectives.

The treatment team was informed about the study. However, the team could be more involved in carrying it out.

6.3. Conclusions

The NI intervention demonstrated feasibility and potential in enhancing patient awareness and coping mechanisms without significantly impacting measured psychological distress, likely due to sample size limitations. Future research should aim for larger samples and consider incorporating professional feedback to deepen understanding of NI's impact on patient well-being.

Ethics statement

The authors declare that this manuscript is a unique version of their data.

Authors ensure that they have written entirely original works and that they do not use the words of others.

The authors thank the patients who participated in the research.

The authors declare that they submitted only this article from the research data collected and analysed.

The authors affirm that they did not use generative AI and AI-assisted technologies in scientific writing.

Ethical approval and consent to participate

This study involves human subjects. All procedures were performed in compliance with institutional guidelines and the appropriate institutional committee.

This study obtained the favorable opinion of the Ethics Committee of the "Area Vasta Emilia Nord" on 09/24/2019 (code 779/2019/OSS/AUSLRE) and authorized by the Company General Management on 10/21/2019 (Protocol n° 2019/0121902).

The study was carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans (<http://www.wma.net/e/policy/b3.htm>).

Before starting the study, the authors state that a study information form, a study consent form, and a confidentiality authorisation form were submitted to the participants, signed by the participants, collected by the researcher, and stored in a private repository.

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Data availability statement

We provide public access to the research data supporting our paper, to comply with the open data requirements of the journal.

Research data are available at the link: https://zenodo.org/records/11032464?token=eyJhbGciOiJIUzUxMiJ9.eyJpZCI6ImMxNmUzNzgxLTRmNzQtNDMyMC04Y2RjLWw9Y2BzNjMDg5ZiIsImRhGEiOnt9LCJyYW5kb20iOiZMzVkNzFhMTMxMWM1Mjk5NjQ5ZjZhYjZkMDQyYTIwOCJ9.DAFeTeTWw9Yb2Bs6NLJGRrQKr9-fxsyqpiP55MBRg-gOmBtCtBg_4lQqKet0nW1u2muB6lXnSzsU_IIHz3xQ and referenced as Artioli, G. (2024). "Narrative Interview" intervention in Oncology: Qualitative and Quantitative Data [Data set]. Zenodo. <https://doi.org/10.5281/zenodo.11032464>.

This link will remain available for 3 years after the publication of the article.

CRedit authorship contribution statement

Giovanna Artioli: Writing – review & editing, Writing – original draft, Methodology, Investigation, Data curation, Conceptualization. **Laura Deiana:** Investigation, Formal analysis, Data curation. **Maria Bertuol:** Investigation, Formal analysis, Data curation. **Giovanna Casella:** Investigation, Formal analysis, Data curation. **Massimo Guasconi:** Software, Investigation, Formal analysis, Data curation. **Chiara Foà:** Methodology, Investigation, Formal analysis, Data curation. **Rosangela De Simone:** Project administration, Data curation. **Leopoldo Sarli:** Writing – review & editing, Supervision. **Antonio Bonacaro:** Writing – review & editing, Visualization, Validation, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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