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Comparison of Focus Groups on Cancer and Employment Conducted Face to Face or by Telephone

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Abstract

Findings from telephone focus groups have not been compared previously to findings from face-to-face focus groups. We conducted four telephone focus groups and five face-to-face focus groups in which a single moderator used the same open-ended questions and discussion facilitation techniques. This comparison was part of a larger study to gain a better understanding of employment experiences after diagnosis of gynecologic cancer. Offering the telephone option made it easier to recruit women from rural areas and geographically distant cities. Interaction between participants occurred in both types of focus group. Content analysis revealed that similar elements of the employment experience after cancer diagnosis were described by telephone and face-to-face participants. Participants disclosed certain emotionally sensitive experiences only in the telephone focus groups. Telephone focus groups provide useful data and can reduce logistical barriers to research participation. Visual anonymity might help some participants feel more comfortable discussing certain personal issues.

Keywords

cancer, psychosocial aspects; focus groups; group interaction; technology, use in research; workplace

Interviews provide an opportunity to gather detailed information on what it is like to experience a particular health problem from individuals who have lived through the experience. Two methods of conducting interview research are to speak with one person at a time and to hold focus group discussions with several study participants. Focus groups enable participants to react to and build on the comments made by other members of the group, yielding opinions and experiences that might not surface during individual interviews (Creswell & Plano Clark, 2007). The conversational atmosphere of a focus group comprised of peers can seem less intimidating than a one-on-one interview with a researcher, removing a potential barrier to recruitment. When conducting focus groups, enrollment barriers can be reduced by offering participation by telephone, especially for geographically dispersed individuals, such as those living in rural areas or those with relatively uncommon health problems (Cooper, Jorgensen, & Merritt, 2003). Eliminating the need for meeting facilities can reduce expenses and logistical issues, especially for focus groups held during the

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evening or on weekends to accommodate participants who have schedule conflicts during traditional business hours.

Telephone focus groups have been criticized because they lack nonverbal communication, which might reduce the richness of the qualitative data gathered (Krueger & Casey, 2000). Another criticism is that group interaction is difficult to manage because the moderator cannot see the participants. Those criticisms notwithstanding, telephone focus group participants appear more willing to discuss certain experiences or sensitive topics (Cooper et al., 2003). Visual cues such as jewelry or hairstyle do not accentuate differences between participants when research is conducted by telephone; this can help to establish a sense of shared social identity in the group (Lea, Spears, & Watt, 2007). Sharing identity with the group might lower the social stigma associated with disclosing potentially embarrassing experiences (Joinson, 2001).

Despite the potential advantages, the qualitative data gathered in telephone focus groups have not been evaluated to determine if they can meet research objectives as well as data gathered in face-to-face focus groups. In the present study, face-to-face and telephone focus groups were conducted by a single moderator using a standardized set of interview questions. This provided an opportunity to evaluate similarities and differences in the data according to focus group type.

Study Context

Employment and Cancer

We compared the findings from focus groups conducted face-to-face to those conducted by telephone in the context of a larger study that we carried out on employment and cancer (Frazier, Miller, Horbelt, et al., 2009; Frazier, Miller, Miller, et al., 2009). The goal of the primary study was to generate ideas about ways in which health professionals such as oncology nurses and oncologists might assist cancer patients with stressful job problems that occur in the months following diagnosis. Previous research has shown that most employed cancer survivors return to work (Taskila & Lindbohm, 2007). Jobs provide income and health insurance, and cancer patients often receive social support from their coworkers. Many patients, however, lose their jobs, decide to quit working, or become disabled. Pooled results from 36 studies that were conducted in the United States, Europe, and other countries revealed that 33% of the 20,366 cancer patients who were employed at diagnosis were no longer employed when followed up between 9 months and several years later (de Boer, Taskila, Ojajarvi, van Dijk & Verbeek, 2009). The cancer patients were more than twice as likely to have become unemployed during follow up as the 157,603 healthy controls.

Individuals who remain employed after cancer diagnosis often lose income by reducing their working hours. Among cancer survivors in Colorado who remained employed 2 years after diagnosis, 46% had decreased their work week by an average of 16 hours because of their cancer (Steiner et al., 2008). Almost half of the group said they avoided changing jobs because they feared they would lose their health insurance. In a study of breast cancer survivors in Canada, more than half said that the cancer had affected their work or career (Stewart et al., 2001). They were much less likely to disclose their diagnosis to work colleagues or to their supervisor than to their friends. Reasons for nondisclosure ranged from wanting to avoid being the subject of gossip to fear that it might negatively affect their job or career prospects.

Counseling about employment is a recommended component of cancer care (Hewitt, Greenfield, & Stovall, 2006). Oncology nurses, oncologists, and social workers provide psychosocial support for newly diagnosed cancer patients who are undergoing primary

treatment such as chemotherapy, radiation, and surgery. Much research has helped provide these professionals with improved methods of treating physical symptoms that affect role function, such as nausea and vomiting during chemotherapy, and psychological symptoms such as anxiety and depression (Jacobsen, 2009). In contrast, little research is available to provide frontline clinical interventions to prevent or lessen psychosocial distress from employment problems during cancer treatment (Feuerstein, 2005; Steiner, Cavender, Main & Bradley, 2004).

Employment-related counseling can be provided by specialists such as vocational counselors, occupational therapists, physiatrists (rehabilitation physicians), and others. In some communities, however, there is limited access to such service providers. Unmet psychosocial needs having to do with employment remain prevalent among cancer survivors. One in seven cancer survivors in a large Pennsylvania study said that, during cancer diagnosis and treatment, they had at least one unmet psychosocial need related to doing their work or keeping their job (Barg et al., 2007). To begin developing educational materials and interventions to address these psychosocial needs, we sought information characterizing these experiences by conducting a focus group study. We studied women with gynecologic cancer because they are underrepresented in previous qualitative studies of the employment experiences of cancer survivors (Taskila & Lindbohm, 2007).

Our study was guided by the philosophical traditions of phenomenology, in which the aim is to understand unique individuals and their subjective experiences and interactions with others (Lopez & Willis, 2004; Starks & Trinidad, 2007). We used the two main phenomenologic research approaches—descriptive and interpretive (hermeneutic)—to choose the focus group interview questions and to guide the data analysis. Descriptive phenomenology is used to characterize the key elements of an experience, especially aspects that have not previously been described thoroughly (Lopez & Willis, 2004). In the hermeneutic tradition, the researchers' expert knowledge and published research are used to help design the study, collect the data, and interpret the findings to suggest ways in which patient care could be improved.

Descriptive Component of Our Primary Study

Our primary study included a descriptive phenomenology aspect because existing research on role function during cancer treatment has incompletely conceptualized the positive and negative contributions of employment to quality of life (Steiner et al., 2004). The most common employment endpoint in cancer studies—and often the only employment endpoint—is whether or not the individual returned to paid work. When researchers want to assess role function using a scale endpoint, typically a quality-of-life instrument is used which asks about employment-related role function as well as ability to fulfill roles outside of work in each role function question. An example is the Functional Assessment of Cancer Therapy instrument family, which directs individuals to rank the extent to which they are “able to work (include work at home)” (Cella et al., 1993).

To collect these descriptive data, our moderator asked participants to talk about what quality of life means to them, and how it had been affected by their jobs or work relationships. During data analysis, we primarily used inductive reasoning. Our main finding was that blending role function at home with that at work did not capture adequately the influence of employment on quality of life. Return to postoperative role function, for example, often proceeded more quickly at home because the cancer survivor could take frequent breaks when doing household tasks, but could not do so at a paid job. Based on these findings, we recommend that cancer researchers consider supplementing standard quality-of-life instruments with additional employment-related items (Frazier, Miller, Horbelt, et al., 2009).

Interpretive Component of Our Primary Study

We used an interpretive phenomenology approach to identify ways in which oncology professionals might be able to help employed patients prevent or improve common job problems (Lopez & Willis, 2004; Starks & Trinidad, 2007). We used social cognitive theory when selecting focus group interview questions and analyzing our data because it provides a promising conceptual framework for designing interventions to help patients adopt health-related behaviors (Bandura, 2001; Kinzie, 2005; Rogers et al., 2004). Social cognitive theory states that there is an ongoing interaction between behavior, environmental factors, and personal factors. Environmental factors range from socioeconomic conditions to characteristics of the physical environment, such as an employee's work station or commute. An important personal factor is self-efficacy—the belief in one's ability to meet a goal or solve a problem. Other personal factors that work together to influence behavior are valuing a certain outcome, and believing that a behavior will produce the desired outcome (positive expectation) or that refraining from the behavior will produce an undesired result (negative expectation). Also important are knowledge and skills (behavioral capability), and forethought manifested, for example, as setting personal goals. Behavior is reinforced by direct learning (personal experiences or training), vicarious learning (observing the outcomes when role models and other people choose to engage in or refrain from the behavior), and by reflecting on these experiences in the context of personal values and aspirations (Bandura, 2001).

Applying social cognitive theory to our study, we chose, for example, the interview question, "After cancer diagnosis, to whom did you turn for advice about your job?" Patients with low self-efficacy might not feel confident enough to ask others for advice or assistance when symptoms interfere with being productive at work. We hoped that participants would provide examples of self-efficacy by describing how they sought and received such help. Thus, a deductive element in our interpretive analysis was to look for quotations illustrating constructs that could be used in education materials to help increase patient behaviors that would help them prevent or manage job problems. We also used inductive reasoning in the interpretive analysis because of the paucity of preexisting interventional research on improving employment outcomes (Steiner et al., 2004). We summarized our interpretive analysis as a set of clinical recommendations for frontline cancer care providers (Frazier, Miller, Miller, et al., 2009). During analysis of the data in our primary study, we noticed that participants discussed certain topics only in the telephone focus groups. We therefore returned to our data to compare the similarities and differences in the data obtained according to focus group type.

Methods

The methods we used in the primary study for recruiting participants, conducting the focus groups, and analyzing the data are summarized below. The data analysis methods used for the comparison of data by focus group type are then presented.

Recruitment

The research protocol was approved by the Institutional Review Boards of the University of Kansas School of Medicine (Wichita, Kansas) and the Wake Forest University School of Medicine (Winston-Salem, North Carolina). Each participant provided written informed consent. We designed the recruitment to assemble a group of women who had experienced the phenomenon of interest, i.e., those who had had been diagnosed at least 3 months previously with ovarian, endometrial, or invasive cervical cancer and who were employed when their cancer presented. Nearly all of the cancer survivors were recruited by the health professionals at the gynecologic oncology clinic at each medical school campus using a flyer

about the study. The remaining participants heard about the study from notices in local newspapers, on an Internet message board, or by word of mouth. We obtained some information from medical records and by questionnaire to help describe the participant group (e.g., cancer type and occupation), but collected our main data in focus groups. We offered the option of participating by telephone to help make the study more convenient for employed women and individuals who lived far from the research center.

Focus Groups

Audio recordings were made of the focus groups and the sessions lasted 60 to 75 minutes. A woman moderator led all focus groups by following a single interview guide. She asked participants not to state their last names, assured them that there were no wrong answers, and said they could each choose how much they wanted to talk or not talk. The guide began with open-ended questions on quality of life. The four remaining questions were on employment after cancer diagnosis; specifically, feelings about having a job or career, advice sought about employment matters after diagnosis, help received with job issues during treatment; and tips about employment for newly diagnosed women. After posing these questions, our moderator listened for employment-related experiences and followed up with nondirective prompts such as, “Tell me more about that,” or “Does anyone else want to comment on this issue?”

Data Analysis

Primary study—A content analysis was performed (Elo & Kyngas, 2008; Starks & Trinidad, 2007). The focus group moderator made notes concurrently about the topics under discussion in each focus group and transcribed the audio recordings afterwards. We began analyzing the transcripts soon after the first focus groups were conducted and we proceeded continuously as additional focus groups were completed. A data immersion approach was used (Crabtree & Miller, 1999). Our moderator and another investigator read and reread the transcripts independently to conduct open coding, conferring frequently to establish the definition of each topic in the evolving coding scheme. We extracted participant quotations and copied them onto a spreadsheet, grouping them by topic.

We combined or split topic groups to create overarching categories after discussing options and coming to consensus (Creswell & Plano Clark, 2007; Krueger & Casey, 2000). Employment-related topics, for example, fell into categories that represented tasks faced by cancer survivors in three time periods: immediately after diagnosis, during primary treatment, and during extended survivorship. Learning about expected job restrictions was one of the tasks that occurs first, when the treatment plan unfolds just after diagnosis. We conducted text searches using synonyms for keywords in the quotations for a given topic to ensure that all such quotations were identified. We again reread the transcripts to ensure that we represented the context accurately for quotations that we selected to represent the data in reports or patient education materials. We asked the study participants and other stakeholders (participants’ family members, physicians, nurses, human resources professionals, and others) to critique these materials. This feedback revealed, for example, that the three time periods derived from topic categorization were a good way of organizing health-related employment tasks that occur after cancer diagnosis.

Present study—After noticing the possible differences in topics by focus group type, reimmersion in the data was accomplished by rereading the transcripts with special attention to focus group type. We defined a focus group in this analysis as a mediated discussion meeting among 4 to 8 study participants (Creswell & Plano Clark, 2007; Krueger & Casey, 2000). We therefore excluded data from the primary study that was obtained during a

session attended by less than four women (28 cancer survivors) or by questionnaire only (one cancer survivor).

Because participant interaction is one of the advantages of focus groups compared to individual interviews (Creswell & Plano Clark, 2007), we looked for encouraging statements that women made to each other, and instances in which several women engaged in an extended dialog with each other in the absence of interspersed prompting by our moderator. A major characteristic of telephone communication is lack of visual information, so we looked for statements in the face-to-face focus group transcripts that reflected participant opinions about the appearance of other participants.

Using the content analysis results from our primary study, we sorted the quotations that we had coded by topic and overarching categories so that we could make side-by-side comparisons by focus group type. We also compared each topic by whether it represented sensitive personal information. Whether personal information is considered sensitive varies according to sociocultural context. We considered sensitive topics to include sexuality, bodily functions such as bowel or bladder control, poor hygiene, actions considered by some to be immoral or cowardly, and illnesses that the participants described as having been caused by personal failing; topics such as these are generally regarded as potentially stigmatizing (Breitkopf, 2004; Brondani, MacEntee, Bryant, & O'Neill, 2008; Culley & Hudson, 2007; Griffiths et al., 2006).

Results

Participants

A total of 44 women attended a focus group: 25 women participated in one of five face-to-face focus groups (four to eight women per group) and 19 women participated in one of four telephone focus groups (four to seven women per group). The women's jobs at the time of cancer presentation represented a broad spectrum of occupations in sales or service, health care, manufacturing, education, and other white-collar fields. The age distribution, types of gynecologic cancer, and other participant characteristics were similar in the face-to-face and telephone focus groups except that rural residence was more common among women who participated by telephone (61.1% were from rural areas in the telephone groups compared to 20.0% in the face-to-face groups). Offering the telephone option enabled women to participate in the study from the comfort of their homes, as illustrated by the following quotation from a woman receiving chemotherapy for a recurrence of ovarian cancer: "Actually, I am not feeling good today. I have been in bed all day. When you called, I was asleep. I have been in bed most of the day. I am on my third day of Doxil."

Similarities in Group Dynamics

Interpersonal exchanges were common in both types of focus groups. In the same way that participants in the face-to-face focus groups often talked animatedly to each other while waiting for the session to start, in the telephone groups, when our moderator came back on the line after calling in all participants, conversations between the women were already in full swing. Telephone group participants made supportive statements to each other as they elaborated on a topic, and extended exchanges occurred:

Moderator: What does quality of life mean to you?

Participant (P) 1: I think to me it means being able to keep my routine. Being able to continue to pretty much do my normal life. I guess that is what it would mean in a nut shell. You know, just being able to see friends and go out and do things that I enjoy.

P2: I agree with that summary, P1. I like to live as normal a life as I can. I don't think I have changed anything. I do the everyday things that I have always done.

P3: I agree with that too, P1, to be as normal as you can.

P4: I think that to have good quality of life, also you let go and not worry about all the little fine details anymore.

P3: Very true. This is P3 agreeing with you.

P4: Not to be so worried about if the house is perfectly clean anymore or anything.

Women in both types of focus group appreciated the opportunity to participate in the research. For example, a woman in a telephone group said, "Thank you for including me in the group. I have enjoyed being here and taking part in this effort. I got a lot out of our conversation this evening."

Similarities in Employment Topics Discussed

The telephone focus groups generated employment experience topics that were very similar to those generated in the face-to-face focus groups. In both types of focus groups, women talked about positive experiences such as developing a greater appreciation for the important things in life after cancer diagnosis. A comment in a face-to-face group was, "I feel more appreciation toward everything. Even the grass and seeing the trees." In a telephone focus group a woman said, "I have more patience. I didn't have a lot of patience before." Examples of similarities in employment topics categorized by the four work-related questions on the focus group interview guide are provided below.

What are your feelings about having a job or career?—Women in both types of focus groups said that work was one of the priorities in their lives. Being able to work was described as beneficial, illustrating the social cognitive theory construct of positive expectation from the behavior of returning to work after diagnosis. For example, a woman in a face-to-face group said, "It is real important. I do not think I would have a sense of identity without it." A telephone focus group participant made a similar statement: "[Work] gets you out of the house and you don't dwell on the fact that you have cancer. You interact with people."

After cancer diagnosis, to whom did you turn for advice about your job?—

Both types of focus groups generated a list that included the same types of people who provided support and advice: family members, health professionals, friends, people at work, and other cancer survivors. Below is an example from a face-to-face group participant that illustrates vicarious learning to increase one's repertoire of behaviors for managing symptoms during cancer treatment (the social cognitive theory construct of improving behavioral capability):

There was a lady who had had breast cancer that I talked to a lot. She worked too. I knew she had worked while she went through it. She gave me advice. That kind of helped me a lot as I went through it.... She had told me there were times when she would have to go home and maybe take a longer lunch, rest and come back.

A similar social environment was described in a telephone focus group: "A lot of the people I work with—not a lot I guess—there have been about 8 who had breast cancer. They are survivors of breast cancer. So we have got kind of our own little cancer group."

The types of work recommendations that women reported receiving from physicians were similar in the face-to-face and telephone focus groups. Oncology nurses also played a substantial role in helping cancer patients manage work issues. This quotation from a woman in a face-to-face group was typical of both types of focus groups, and illustrates self-efficacy as well as the value she placed on receiving advice from an experienced nurse:

I call my doctor, actually his nurse.... I can bounce an idea off her.... She is very understanding. She is very calming. It is nice to have someone who is experienced—who is just very matter of fact about things.... She helps with work issues.

Which people at work helped you with a cancer-related problem?—Comments about help received from occupational health nurses were remarkably similar in the two types of focus groups. In a face-to-face group, a woman said,

I worked at the factory.... They have what they call a First Aid Office with a nurse in there all the time.... And they told me when I checked in and went through the process of coming back into the shop.... “Any time you feel tired or whatever, you come down here and you lay down.”

In a telephone group, an occupational health nurse was described as very helpful, even though the cancer survivor worked at a remote location:

My company did have a nurse that came out from our headquarters monthly to our station, and so she always spent extra time with me, and kind of went over everything, and was always available.... She was wonderful.

Women in both types of focus groups gave mixed reviews of supervisors and coworkers. A supervisor helped a woman who asked for help with lifting when her coworker refused, as described by a face-to-face focus group participant:

I tried to do all the work I could. There was a little lifting and I could not do that. I had to ask one girl.... And so I said, “Can you help me lift these out of the box?” “I’m busy.” She turns her head. But then I told the boss, “You know, I need some help here.” And then he ended up doing the lifting for me.

The above comment illustrates self-efficacy in finding needed assistance in the workplace. In the telephone groups, participants also described positive coworker reactions to their postoperative lifting restrictions, illustrating the physical as well as the social environment constructs of social cognitive theory:

I do a lot of lifting in my job.... My doctors advised me not to because, they said, “You don’t want to come here and have a hernia.”.... And my people, my team would not let me lift.... Even now, I have a lot of them that say, “Get out of the way. I will do this.”

Negative experiences with coworkers were also described, such as this social environment description by a woman who participated by telephone:

I worked in car sales.... We were one where you didn’t take a turn selling cars—it was the first one who got to the customer. Fight your way out the door.... I mean they didn’t think anything of stealing your deal from you.... So it was pretty cut-throat.

What tips about work would you suggest for women newly diagnosed with cancer?—Advice provided by the cancer survivors was similar in both types of focus groups. Women said that keeping one’s supervisor informed improves work experiences during cancer treatment. Another recommendation was to keep in touch with coworkers to

receive social support. These comments from a woman in a telephone group who lived in a rural area were typical of this experience for both types of focus groups, and illustrate a positive expectation of a desired outcome resulting from a behavior:

I was out here by myself.... And finally when I got to be in touch with the real world, these ladies would send me e-mails and it was just the highlight of my day to be able to converse with somebody.... So [my coworker] starts sending me cards. It was a hoot! He would send me Valentine's Day cards and St. Patrick's Dday cards. It was really nice.

Women in both types of focus groups said to find out early about the employer's benefit program. Experiences that described the advantages of doing so included getting all the benefits to which one is entitled and preventing stress from having to complete confusing Family and Medical Leave Act paperwork shortly after major surgery (Family and Medical Leave Act, 1993). Women in both types of focus groups described how cancer caused them to put their jobs into perspective, illustrating the construct of self-reflection to modify personal aspirations. In a face-to-face group a woman said,

I used to get very stressed about [my job].... I was making it much more than it was. My husband said to stop obsessing about it. So I did stop getting stressed about it.... I learned to pull back to what was important.

In a telephone group, a similar revelation was,

I think sometimes, especially as women, you think, even if you're not feeling really good, you should keep plugging along. And I think a lot of women do that even when they have been told to stop, enough is enough, take care of yourself. If someone on the outside had told me that, that would have been nice.

Women in both types of focus groups said that sharing a lot of personal information about one's cancer is not necessary. In a face-to-face group, a woman took the stance of a role model when she gave this advice: "I do not mean that you have to tell them everything, but, you know, I think we need to be honest with ourselves as well as with the people that we work with." Similarly, in a telephone group, a woman recommended not burdening coworkers with too much information: "I get tired of hearing about the same thing every day, over and over and over—I don't want to plague them with hearing it every day just over and over and over."

Differences in Sensitive Topics Discussed

Fears were described more vividly in the telephone focus groups. The telephone group participant who made the following remark did not end her statement on an upbeat note, or return to the topic later to say that she courageously overcame her fear or that she had gained anything from having been so afraid:

There's nights that I can't sleep. And that is certainly on my mind at times like that—at quiet times, in the middle of the night, and things like that. There is certainly that fear of, of death, and recurrence again and what it's going to mean.

In contrast, the fear experienced by a participant in a face-to-face group was portrayed as being under control and improving:

I don't think I will ever get over the fear of getting it or having it recur. Now, they say as time goes by it gets better. I think about it every day, several times a day. There were times earlier that it was every minute.

Certain topics were only mentioned in the telephone focus groups. One of these was guilt about taking a new job after receiving support from coworkers and managers in the workplace:

When I was diagnosed, I had been at my job for two years. It was really good, I mean everybody was very supportive.... I think I stayed home for probably eight weeks.... but they still kept me on their payroll, at regular pay. I wasn't getting my commission, but still I was getting something. And then I was offered a job probably three months after I returned to work. And I felt guilty leaving because they had been so good to me over my treatment and stuff.

Sexuality was only mentioned in the telephone focus groups. One woman described being afraid that sex could cause her cancer to metastasize: "That was one of the questions I asked the doctor—if my husband and I get intimate, can he stir up things to have those floaters to go someplace?" A sexually stigmatizing experience was related by a woman who was labeled by a coworker as promiscuous after being diagnosed with ovarian cancer (even though sexual activity is not actually a risk factor for ovarian cancer):

He [my coworker] said that one of the women had said that ovarian cancer only comes if you've had multiple sexual partners.... I was like, "Oh my gosh, let me tell you what a boring sexual life I have had." But yeah! And it really hurt my feelings.

Being able to see each other in the face-to-face focus groups resulted in negative behavior between participants on one occasion. The following face-to-face discussion occurred in a focus group during which most of the conversation was mutually supportive and cordial. One woman (P5) said that pain would have a worse effect on her quality of life than a handicap or disfigurement. A young, attractive participant (P6) replied that a handicap or disfigurement would matter to her. An older woman (P7) then made an envious statement about the younger woman's appearance, and belittled her by referring to her in the third person. Our moderator attempted to diffuse the tension, but the older woman took the floor immediately and admonished the younger woman to live her life differently, again using the third person:

P5: Pain would be an issue [for my quality of life]. It depends on the level of course. A handicap is not an issue. A perfect body would not be an issue.

P6: It is for me.

P7 [referring to P6]: She is not over 50, and if she is, I want to look like her. I think we all want to look like her.

Moderator: Any other issues on survivorship or the quality of life or the difference between before the diagnosis and after the diagnosis?

P7: I realize how short life is.... My life is almost over. There are so many things I wish I had done different. I really do.... Not realizing that at her age [motioning to P6], to do all these things and be all these things in spite of yourself.

Discussion

To our knowledge, no previous study has compared qualitative data gathered in telephone focus groups with that from face-to-face focus groups. We found that participants interacted with each other spontaneously in the telephone focus groups, which allowed memories to be stimulated under a group process that was similar to the interactivity the face-to-face focus groups. Our content analysis revealed that, in both types of focus groups, similar elements of

the employment experience after cancer diagnosis were described and a mixture of positive and negative employment experiences were shared. Statements in both types of focus groups represented social cognitive theory constructs such as environmental influences, behavioral expectations, the value placed on expected effects of behaviors, and vicarious learning (Bandura, 2001; Rogers et al., 2004). Examples of the important construct of self-efficacy were shared by participants in both types of focus groups, such as asking an oncology nurse for advice about managing work, and asking a supervisor for help with lifting. A rich collection of quotations was obtained from both types of focus groups to use in developing patient and health provider education materials.

Using telephone focus groups helped us recruit participants from rural areas and from two states. In a similar fashion, telephone and face-to-face focus groups were used by researchers in Maryland to identify how communities could help promote early diagnosis of oral cancers (Horowitz, Siriphan, Canto, & Child, 2002). Urban participants attended the face-to-face focus groups, whereas the telephone focus groups were more convenient for the participants from the rural areas of Maryland's eastern shore. In a study of the psychosocial aspects of living with the risk of breast cancer (Appleton, Fry, Rees, Rush, & Cull, 2000), telephone-based methods were used to enhance access to the study by geographically dispersed women. Those focus groups were reportedly easy to organize and conduct by telephone. Using this design also eliminated travel and meeting-related expenses.

Our findings suggest that telephone focus groups might yield some information that is different than that generated in face-to-face focus groups. Certain topics such as sexuality were only brought up by women who participated by telephone. Unconquered fear was described by telephone but fear disclosed in the face-to-face focus groups was portrayed as under control or improving. Visual anonymity during the telephone focus groups could have made women more comfortable disclosing sensitive information. This phenomenon has been observed in studies that were conducted to explore the Social Identity Model of Deindividuation Effects (Lea et al., 2007). According to this model, group membership (social identity) can prompt individuals to take on attributes of the group (deindividuation). If there are fewer perceived interpersonal differences among members of a group, group cohesiveness improves and individuals believe that other members of the group are trustworthy (Lea et al., 2007; Tanis & Postmes, 2005).

Gynecologic cancer survivors formed a type of social group to which all of our research participants belonged. Even though this was something that everyone in the study had in common, the women differed in many ways. Some were in their late 50s and others were in their 30s. Clothing styles sometimes suggested that women were from different social classes. Some women's cancers had been cured and they looked healthy, and others had suffered relapses and looked less healthy. In our face-to-face focus groups, these differences were plainly visible, and on one occasion, provoked antisocial behavior toward a participant whose youth and beauty perhaps defined her as an outsider in the eyes of the older participant.

In our telephone focus groups, removal of visual identification probably enhanced the sense of belonging and fostered trust and sharing of sensitive information. Telephone participants in our study knew that other participants could not see them. Visual anonymity can help people feel more comfortable talking about personal experiences and reduce the social stigma associated with disclosing potentially embarrassing opinions or experiences. These effects have been documented in studies of computer-mediated compared to face-to-face communication (Joinson, 2001). Results in that study suggested that visual anonymity encouraged disclosure of personal information. Because sharing one's personal story tends to increase a feeling of intimacy between individuals, visual anonymity encourages other

members of a discussion group to reciprocate. Trusting behavior during communication by computer is affected by perceived group membership. When subjects communicated with a partner perceived to be a member of their social group, trusting behavior was more likely (Tanis & Postmes, 2005). Lack of personal information about their partner did not inhibit trusting behavior as long as the partner belonged to the subject's social group in that study.

Another way that the sense of anonymity is probably greater in telephone compared to face-to-face communication is that participants might come from geographically distant locations, making it unlikely they would meet by chance. Anonymity of this type is less well assured in face-to-face focus groups because participants typically live in the same geographic area and might even receive health care at the same clinic. Telephone communication also removes visual distractions that would be present in face-to-face focus groups. When reflective thought is interrupted by loud noise, visual images, or performance of a competing task, introspection and self-awareness are reduced. Removal of distractions promotes more frequent and more accurate disclosures of personal information (Joinson, 2001).

A limitation of telephone focus groups is that discourse analysis could be more challenging because body language supplementing verbal communication cannot be evaluated (Starks & Trinidad, 2007). There are some limitations in the applicability to the present study of research that has used computer-mediated communication to investigate the Social Identity Model of Deindividuation Effects (Joinson, 2001; Lea et al., 2007; Tanis & Postmes, 2005). This is because social processes in groups of 4 to 8 individuals might differ in some ways from social processes in pairs of study subjects. In focus groups, a moderator is present to promote an atmosphere of trust and support and to help stimulate conversation about the research topics. Telephone communication is different than computer-mediated communication; anonymity is less complete in telephone communication because voices have identifying characteristics.

Conclusions

Telephone focus groups can foster interpersonal conversations among participants and generate content analysis results that are similar to those generated in face-to-face focus groups. Offering a telephone option is a promising method for increasing access to participation in focus group research among individuals who live in rural areas. Participants from geographically distant sites can join the same focus group, and groups of adequate size can be formed to study individuals with relatively uncommon disorders such as cervical or ovarian cancer. Telephone focus groups are more convenient for some participants, such as those who are well enough to hold a telephone conversation but feel too ill to travel to the research center. Telephone methods might be especially well suited for studying sensitive personal experiences.

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