

Using Narrative Research to Understand the Quality of Life of Older Women With Breast Cancer

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Purpose/Objectives: To elucidate some of the issues that affect the quality of life of older women (70 years of age and older) diagnosed with breast cancer.

Design: Descriptive design

Setting: A National Cancer Institute-designated site in the southeastern United States.

Sample: 12 women who were at least 70 years of age undergoing treatment (radiation, hormonal, or chemotherapy) for breast cancer.

Methods: Two to three interview encounters per participant, each lasting approximately one hour.

Findings: Eight major themes emerged: Importance of God, Positive Attitude, No Alteration in Lifestyle, Physician Trust, Caregiver to Others, Importance of Health, Importance of Family, and Alteration in Lifestyle.

Conclusions: The eight major themes are similar in terminology but varied in individual meanings.

Implications for Nursing: Nurses must determine whether older women with a diagnosis of breast cancer are also primary caregivers to other individuals. As the story-gatherers for the healthcare team, nurses can use the data derived from interviews to document patients' health histories and provide a therapeutic process of coping with illness.

Key Points . . .

- ▶ Many older women with breast cancer are active and independent despite the disease and its treatment.
- ▶ Nurses should assess caregiver responsibilities because of the possibility that the patient is a primary caregiver while undergoing cancer treatment.
- ▶ Nurses should conduct a complete health history and accurately assess support elements (e.g., family, role) that are vital in the treatment of cancer.

exists concerning breast cancer and premenopausal women, research specific to treatment and QOL issues of older women with breast cancer is not nearly as prevalent. Additionally, narrative methodology is not abundant with respect to older people and cancer. This review will consider current literature with respect to QOL of older women with breast cancer as well as issues concerning the lack of research in this cohort.

Ferrell, Grant, Funk, Otis-Green, and Garcia (1997, 1998) performed a narrative study of the QOL of patients with breast cancer that included women up to age 79. The mean age of the study participants, however, was only 50 years. The research was published as a two-part study on the multi-dimensional aspect of QOL based on a conceptual model of physical, psychological, social, and spiritual well-being. The first part of the study looked at the constructs of physical and social well-being. QOL issues, such as lack of adequate pain assessment and poor control of pain, as well as fears that pain may indicate recurrent disease, which often contributed to an ambivalence communicating pain to the healthcare team, were reflected in the data. The study concluded that breast cancer had a lasting effect on the women's lives with respect to coping and continued residual symptom management. The second part of study dealt exclusively with psychological and spiritual well-being using the same sample population (Ferrell et al., 1998). Issues of survivorship, fear of recurrence, death, hope, and reality were identified. This study expanded the aspect of a spiritual domain as an element of QOL.

Not all older women perceive cancer in a similar manner. One study focused on the perceptions of the breast cancer experience of African American women aged 39–83 in North

Cancer is predominately a disease of the aged (National Center for Health Statistics, 2003). The National Cancer Institute's Surveillance, Epidemiology and End Results data suggest that 50% of all cancers are diagnosed in patients 65 years and older and that 60% of all deaths occur in this population (Havlik, Yancik, Long, Ries, & Edwards, 1994; National Comprehensive Cancer Network, 2004; Yancik & Ries, 1991). Breast cancer is the most common malignancy-related death in older women (Balducci, Silliman, & Baeky, 1998), and researchers have called for an increase in studies related to breast cancer specifically in older women (Balducci, 1994; Balducci et al; Trimble et al., 1994). Understanding some of the issues that affect older women who are undergoing cancer treatment may help direct care to reduce some treatment-associated difficulties that may arise. The purpose of this narrative research was to identify themes in the interview data that are reflective of the quality of life (QOL) of older women with breast cancer. The study findings may contribute to nurses' awareness of the possible perceptions and elements of QOL that many older women may possess and the importance of sensitivity toward these potential concerns. This study was intended to contribute to the growing body of knowledge concerning the needs of older patients with cancer.

Literature Review

Although cancer is a disease largely of the aged, minimal research exists specifically in women with breast cancer who are older than age 70. Although a reasonable amount of literature

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Digital Object Identifier: 10.1188/04.ONF.1153-1159

Carolina (Mathews, Lannin, & Mitchell, 1994). Although the construct of QOL was not specifically mentioned in the study, the narrative research represented the domains commonly associated with QOL as defined by Cella et al. (1993): physical well-being, emotional well-being, functional well-being, and social/family well-being. The study called for understanding of rural health beliefs by healthcare providers.

Older women generally tend to perceive cancer differently than younger women. Issues such as a greater hesitation toward initiating cancer care, a strong desire to maintain independence, and a greater number of comorbidities have been found in narrative studies (Cameron & Horsburgh, 1998; Tannenbaum, Nasmith, & Mayo, 2003). Additionally, many older women find that current health care does not meet their needs and voiced opinions that coordinated attention should be given to physical, psychological, and emotional health assessment (Tannenbaum et al.). As people age, the number of comorbidities increases. Approximately five comorbid conditions exist in people older than 70 years of age (Fried, Storer, King, & Lodder, 1991), thus a need exists for more comprehensive health care (Balducci, 2003). Breast cancer is not usually the only diagnosis that older patients face. Conditions such as hypertension, chronic obstructive pulmonary disease, and osteoporosis are examples of coexisting ailments that they may experience. Older women must receive care from healthcare providers who are aware of the additional concerns of older patients.

Treatment options in the care of older patients with cancer should be based on health and degree of frailty instead of chronologic age (Balducci, 2003). In terms of breast-conserving interventions (i.e., lumpectomy) versus mastectomy, women choosing lumpectomy have reported greater QOL (de Haes, Curran, Aaronson, & Fentiman, 2003; Kiebert, de Haes, & van de Velde, 1991) without compromising survival (Van Tienhoven et al., 1999). Moreover, the long-term QOL of patients with breast cancer was not found to differ among treatment groups (surgery, chemotherapy, and radiation) of women 67 years of age and older (Mandelblatt et al., 2003). Studies such as de Haes et al. and Mandelblatt et al. help to define treatment options for older women and reinforce the benefits of breast-conserving treatment, when possible, regardless of age.

Regarding the use of adjuvant chemotherapy in women aged 70 and older, researchers found that age was an independent factor in many physicians' decisions concerning adjuvant treatment of older women, without considering comorbidity (DeMichele, Putt, Zhang, Glick, & Norman, 2002). More research is needed to develop treatment guidelines for older adults with breast cancer and gain insight into how treatment affects QOL.

Methods

This descriptive study used selected, in-depth interviews and detailed observations of the clinical setting. The methodology used in this project was pilot tested, and the research was conducted at a large cancer center in the southeastern United States.

Sample

The sample comprised 12 older women with breast cancer. The participants were considered an opportunistic sample

and were dependent on availability and consent. They were involved in active treatment (chemotherapy, radiation therapy, or hormonal), at least 70 years old, female, and diagnosed with breast cancer. Approval for this study was obtained from the Cancer Center and Research Institute Scientific Review Committee and the institutional review board at the University of South Florida. All of the participants were asked to sign an informed consent form prior to the interviews.

Procedure

The interviews consisted of open-ended questions intended to motivate the participants to reflect on their life experiences before the cancer diagnosis as well as after (and during) the diagnosis and treatment. The interviews were conducted in the medical center waiting room (n=3), participant's home (n=6), infusion center (n=3), or examination room (n=5). Two of the participants were interviewed both at home and in the examination room.

The tapes were transcribed, in most cases, several days after the interviews took place. Raw data field notes also were transcribed at the top of each of the transcribed notes. Analysis using Owen's (1984) three criteria for thematic identification was used as a framework to address the basic research question "What are the elements affecting the QOL of women 70 and older who are currently undergoing treatment for breast cancer?" Owen's criteria are recurrence of ideas within the narrative data (ideas that have same meaning but different wording), repetition (the existence of the same ideas using the same wording), and forcefulness (verbal or nonverbal cues that reinforce a concept).

Thematic identification was performed on both intrathematic and interthematic levels. The themes isolated on an individual basis (intrathematic) then were compared on a projectwide basis (interthematic), allowing for the development of the major content themes encountered in the interviews. The major themes isolated were suggestive of the elements that many participants experienced while undergoing treatment for breast cancer.

Findings

Standard demographic data were collected on all subjects, including age, ethnicity, marital status, date of cancer diagnosis, other major health diagnoses, and type of treatments since breast cancer diagnosis (see Table 1). All of the participants were Caucasian, middle-class women, with a median age of 75.8 years. Five of the women were married, and five were widowed. Most of the women had metastatic breast cancer (11 of 12) and were undergoing treatment for advanced disease. For 50% of the participants, a daughter was the primary caregiver. Seven of the 12 participants lived without a spouse. Four of the seven lived with an adult daughter who acted as the primary caregiver. Three lived alone and had friends who provided assistance with transportation and basic emotional needs. All of the women had undergone surgery (mastectomy or lumpectomy). At the time of data collection, five of the participants were being treated with hormonal therapy, three with hormonal and radiation therapy, three with chemotherapy, and one with radiation therapy only. The person undergoing radiation therapy was being treated for bone metastasis. The participants treated with chemotherapy included one woman being treated with gemcitabine and two with doxorubicin/

Table 1. Demographic Data

Variable	n	%
Age (years)	–	–
Range = 70–83	–	–
\bar{X} = 75.8		
Ethnicity		
Caucasian	12	100
Marital status		
Married	5	42
Widowed	5	42
Divorced	2	16
Advanced disease		
Recurrence	11	92
Local	1	8
Caregiver		
Son	1	8
Husband	3	25
Daughter	6	50
Friends	2	17
Current treatment		
Hormonal	5	42
Chemotherapy	3	25
Radiation	1	8
Radiation/hormonal	3	25

N = 12

cyclophosphamide combination therapy; one was receiving paclitaxel.

Transcripts were read many times to identify Owen's (1984) criteria (repetition, recurrence, and forcefulness). Most themes were identified because of recurrence. Repetition was recognized in a smaller portion in the participant interviews but considerably more so than forcefulness. Of the 12 participants, 5 expressed no forcefulness, 4 expressed forcefulness regarding anger about medical care, 1 in respect to feeling overwhelmed with medical procedures, 1 about her disease progression, and 1 used forcefulness three times to express the importance of her faith, medical care, and dependence relating to her symptomology.

Thirty themes were isolated using intrathematic analysis. Table 2 shows the total number of themes isolated and the number of participants identifying the theme. The themes were separated into major and minor categories. Major themes were those identified by five or more of the participants.

Discussion

Of the 30 themes, 8 were considered to be major themes. Each individual participant had a personal variation of a single identified theme.

Importance of God

For some of the participants, the importance of God was the result of many years of spiritual connection, church attendance, and a general lifestyle. One participant suggested that her faith in God had been present all her life. Devotion to foreign missions, national ministries, and integration of her children into a religious, God-oriented lifestyle had been her life's dedication. The participation suggested that her current spiritual inspiration was strengthened during her ordeal with breast cancer.

Others mentioned that they used prayer during stressful periods throughout their illness and did not necessarily have a lengthy life's history of church affiliation and God-related pursuits. One participant who had no church affiliation and a denied belief in God stated that when she was in the hospital and in an extreme amount of pain, she said, "I would take hold of the bed rails and say, 'Oh, God, give me strength. Give me strength 'til morning.'"

Several participants reported that they felt comforted during times when they prayed about their illness or treatment. Another participant found that prayer and faith had provided strength during her disease progression. Her prayers focused on a painless death and that her family would cope well with her loss.

For some participants, church friends and activities were closely associated with God. One participant commented that she never would have been able to get to all of her treatments if it were not for her church friends. Church played a significant role in socialization for many of the participants, espe-

Table 2. Intrathematic Analysis

Theme	n
Mammogram did not reveal cancer.	4
Appreciation of life	3
Scared or afraid at time of diagnosis	4
Felt shocked at the time of diagnosis or recurrence	3
Importance of God	8
Learning to live with it	4
Importance of a positive attitude	7
No alteration in lifestyle	6
Importance of physician compliance	2
Physician trust	6
Coping by working outside the home	2
Anger	4
Changes in body image	4
Importance in medical care	2
Caregiver to others	6
Need to protect family	5
Abruptness of the diagnosis and treatment	1
Cancer brought family closer	3
Cancer not the only stressor	4
Importance of health	6
Denial	3
Importance of cancer screening	4
Importance of family	9
Powerlessness	2
Importance of independence	1
No other family member with cancer	1
Would not go through treatment again	4
Reconstruction concerns	2
Importance of pets	2
Worried about cancer returning	1

N = 12

Note. Major themes are indicated in bold.

cially for those who did not live in a retirement community or had caregivers. One participant no longer had neighbors on whom she could depend, and her friends and support system were associated with her church.

Several participants said that they were thankful to God for the good health they were experiencing at the time of the interviews. One participant mentioned several times that she was thankful for the independence she was experiencing and that her disease had not progressed in approximately one year.

Importance of Family

Not unexpectedly, many participants suggested that family support was very important, especially when they received the diagnosis and while they were undergoing treatment. Family was defined in the interviews as spouse, children, grandchildren, great-grandchildren, and siblings.

Many families of the participants were spread out throughout the United States and other countries. Geographic mobility has led to smaller households, with an increased number of older people living alone with family networks more dispersed (Adams & Blieszner, 1995). Despite distances, many participants considered family support (often from adult children) as being vital to their survival.

Seven of the 12 participants looked to their children as their primary support. Three participants relocated to live with children and reported generally positive outcomes. One participant relocated to live with her daughter at the time of diagnosis. The daughter was helpful in finding physicians, completing insurance-related tasks, and helping with daily living activities during the initial treatment when fatigue and nausea affected her mother's general health. This participant reciprocated by helping to care for her six-year-old grandson and assisting in the family business during times when symptoms allowed. The participant and her daughter provided reciprocal support for each other. Another participant helped her daughter with cooking and monthly costs, and her daughter provided care during times of cancer treatment-related illness.

The importance ascribed to family increased with the diagnosis of cancer. One participant stated that the threat of death heightened not only her involvement with her family members but also her perceptions of the love that she felt for them. The experience of facing death enhanced participants to value family in a deeper, more appreciative manner. The notion of "valuing" seemed to refer to placing importance on human interaction versus material possessions or employment success. One participant said, "I don't know if it is age or the breast cancer, but things aren't as important that you thought were important." This type of statement tends to refer to placing emphasis on personal interactions, a commonly repeated theme.

Physician Trust

Many participants expressed trust in the physician as paramount. One participant stated that she "wouldn't know what to do" without her physician. Many of the women repeated similar phraseology concerning their oncologists. The fact that participants placed trust in their oncologists when receiving a diagnosis and undergoing treatment of a potential life-threatening illness is reasonable; however, the notion of trust may have several meanings.

For some women, trust may have meant following the doctor's orders or prescribed interventions without questioning or

when they felt unsure of the potential outcomes. One participant relayed an account of a surgeon who told her that she needed to have surgery to remove her breast and eventually her uterus.

The doctor made arrangements for me to go into the hospital, and I said, "No, I'm not." And he said, "Yes, you are." And I said, "Well, if you promise that you won't give me [the medicine] that causes a beard to grow on the face." And he said, "No, I'm not, honey, I wouldn't do that to you." So I had the mastectomy one Monday. They came in and sat on the edge of my bed and say, "We [are] going to take you back to surgery next Monday." And I said, "What for?" and he says, "A hysterectomy. . . . [You] were still menstruating, and the ovaries act just like . . . they can spread all over the body, so we are going to do a hysterectomy as a prevention." So they did a hysterectomy as a precaution, and I thought I'd never get over it.

Another participant viewed physician trust and her relationship with her physician differently. Her sense of trust seemed to be connected to reasonable medical decisions that had the most likelihood of effectiveness. As a patient, this participant informed herself regarding available breast cancer treatments; however, she left decisions to her medical team. She said, "I have sufficient information [about breast cancer], but I leave the major decisions to my doctors. They didn't make a decision that wasn't rational to me." This patient did not recognize herself as the primary decision maker in her medical care plan but rather as part of the process. She felt it was reasonable to intercede when she was not comfortable with an intervention or when she wanted a break from treatment to travel or see her family.

In one account, physician trust was breached when the primary care physician was not perceived to be helping one of the participants. The series of interactions with this primary care physician motivated feelings of distrust. One participant said, "I was doing worse and worse. [The physician] did not refer me to a specialist until one day I said, 'I am really upset with you. You are not helping me at all, and this is why I am feeling sick.'" Physician trust for this participant seemed to center around being heard and a part of the medical decision making.

Caregiver to Others

Six of the 12 participants reported that they were the primary caregivers to others while they themselves were enduring a breast cancer diagnosis and treatment. Because many women outlive men by approximately eight years, many women are often the designated caregiver for an ailing husband or partner (Kennedy, Bushhouse, & Bender, 1994). One participant was undergoing chemotherapy when her husband had to undergo heart surgery. The participant rescheduled her treatments until after her husband's initial recovery period. When her husband felt better and regained strength, he resumed his responsibilities, which included driving the participant to her appointments and providing the necessary support.

For some participants, the illness of the spouse or elderly sibling was chronic. One participant's husband suffered from dementia. For this participant, a daughter was able to provide support when treatment-related illness caused problems with caregiving. This woman was one of the few participants who had willing children in close proximity who provided support when necessary.

None of the participants who were once caregivers to a deceased spouse remarked that they missed the caregiver role. All of the participants told of how they filled their time with hobbies and various social activities. Many commented on how difficult and stressful the caregiver role was and how hard it was to witness the dying process of a long-term partner. On several occasions, two of the participants began to cry as they revisited their memories as caregivers. The caregiver role may not be comparable from one experience to another and from one individual to another. Feelings of stress, isolation, and the caregiver's personal illness may be similar, but the roles were often different. Some caregiver roles were temporary, with the role ending with the improved health of the spouse, and others were long-term, permanent situations (e.g., the care of a younger mentally retarded sibling).

Importance of Health

Health was one of the most important aspects of life according to 6 of the 12 participants. For one participant, health was most important, with physical activities such as playing golf and tennis completing a lifelong self-identification as an athlete. The participant reported that she no longer "trust[ed] her body" since her cancer had returned and felt vulnerable because of her physical limitations. For this participant, frailty had somewhat permeated her sense of health.

Independence was connected to the importance of health for many of the participants. Health and independence are defined frequently in gerontologic literature as being more valued as age increases because they are more likely to be challenged (Fried et al., 1991; Goodwin, Hunt, & Samet, 1991). One participant enjoyed frequent traveling and local activities with her husband, activities that have been threatened by her breast cancer. One participant had never been ill or physically compromised prior to the metastatic breast cancer that eventually necessitated the application of a halo, a large metal brace connected to the skull by screws. The brace was highly noticeable and elicited stares from many passersby. The stigma of poor health was exuded overtly to others to the extent that the participant stated that "nobody took [her] seriously" at the doctor's office, expressing a general lack of validation.

Positive Attitude

Participants frequently cited a positive attitude as a component in the recovery from cancer and an important element in "beating" breast cancer. One participant stated that she was determined not to feel any adverse symptoms associated with her cancer treatment and that her positive attitude kept control of her disease. She believed that attitude addressed her disease in a manner that would promote survival.

Unrealistic optimism regarding healing or cure may inspire feelings of failure if the desired outcome is not obtained, especially when others tout the importance of positive thinking. Perhaps others (visitors, friends, and family) can offer the intervention of a positive attitude in the defense of a serious illness because it is one of the few things available and comfortable to discuss. A participant with advanced terminal cancer claimed that she did not want to feel positive any longer and felt frustrated that her son kept repeating the recommendation.

Another variation in the meaning of a positive attitude was having a pleasant outlook in which to experience as much QOL as possible without the expectations of a cure or disease remission. Another participant commented several times dur-

ing her interviews that she did not want anyone to "bring [her] down" nor did she want to ponder worrisome possibilities associated with metastatic cancer. She felt that people affected with a serious illness "should go out and enjoy life" and that one way to accomplish that was to have a positive attitude.

Protection of Family

The data represented in the protection of family theme seemed to coincide with some of the thoughts concerned with being a caregiver and the importance of health. One participant wanted to create a facade of enhanced health to reassure her family. Another did the same by not revealing the extent of her diagnosis, even when her cancer metastasized. By not creating a cause to worry, participants were attempting to contribute to the continued welfare of their families. The altruistic aspect of protector also may be a way in which a person with cancer can maintain some normalcy within family and friend interactions. By not disclosing potentially stressful information, conversations regarding everyday occurrences could continue.

One participant felt that because she had been diagnosed with breast cancer, her daughters were at risk for developing a familial malignancy. She tried to protect her daughters by strongly advising regular screening.

Although the manner of protection varied, the participants seemed to willingly undertake this role. Being a protector may be one of the few ways in which patients may feel useful to their families and have a sense of self-empowerment.

No Alteration in Lifestyle

Breast cancer did not alter the roles or activities of many of the participants. Although some participants anticipated feeling ill after treatment, none considered this a problem that altered their lifestyle. Breast cancer, for some, became a chronic condition that tended to have periods of "flare up," as suggested by Strauss and Corbin (1984). Even though one participant died of breast cancer several days after the interviews, she performed many social activities around her treatments. Another participant recounted how fatigue interrupted her activities, requiring her to take frequent rest periods, yet she did not consider her lifestyle to be altered.

The data suggest that many of the women participating in the project were very active despite a breast cancer diagnosis and being in their 70s. However, the sample consisted of a fairly homogenous sample of women who had ample economic resources and support systems, which can contribute to maintaining an active lifestyle. The extent to which breast cancer or treatment affects changes in lifestyle can be considered a dynamic continuum. A person may feel well enough to do activities one day and the next day feel poorly and not participate.

Conclusions

The most crucial finding of the study was the identification of the eight themes and the great amount of variation. The themes have a multidimensional aspect, with each participant designating different meaning for the same terms.

The study also identified that many people who have a serious diagnosis, such as breast cancer, may be caregivers to others. Older adults may find themselves caregivers to a spouse or sibling despite personal limitations to health.

Many of the study participants engaged in active lives despite treatment and diagnosis of breast cancer. Kleinman

(1988) suggested that disease is the medical label and illness is the perception of symptoms and disability. Many participants verbalized periods of illness but resumed activities when symptoms lessened. Many participants demonstrated vitality and the ability to engage in desired activities, despite the clinical label of breast cancer and intermittent periods of illness.

Implications for Clinical Nursing Practice

For clinical nurses, personal and cultural uniqueness of themes was apparent in each of the narratives. Nurses must detect and realize this uniqueness. When a patient discusses the importance of family, for example, the nurse must further assess the personal and cultural meaning associated with that statement. Assessing the extent of family support, family role, and stresses associated with family can help nurses to construct relevant therapeutic interventions.

For this study population, God was a fairly consistent belief and a mode of support for many of the participants. Concerns of prayer and faith were represented in the data second only in frequency to importance of family. A spiritual assessment should accompany health history information, and chaplain services or other spiritual support should be offered when appropriate. Questions regarding personal spiritual beliefs, practices, concerns, and potential interventions would be pertinent to the patient's social history.

The number of research participants who were also caregivers to others has direct nursing implications. Asking patients to describe their role at home and what plans are in place to cover responsibilities while they are unable is an important part of the initial and ongoing nursing assessment. Assisting with caregiving responsibilities and establishing the patient's needs outside the hospital or clinic setting may enhance patient coping and potentially reduce any caregiver problems that may arise. Although the population included in this study was exclusively women, many men are also in the caregiver role while experiencing their own health problems. Nurses must assess caregiver role responsibilities regardless of gender.

Another important implication for clinical nursing practice is to understand the heterogeneity of aging. Not all older people are in failing health, and not all older people with cancer are ill and dependent. Many of the participants continued to live active lifestyles despite having cancer and being older. Nurses should avoid ageisms and negative stereotypes that are hurtful and harmful and assess how patients actually function while undergoing cancer treatment. Nurses should be watchful for treatment decisions based solely on chronologic age without regarding functional status or comorbidity.

The second nursing implication is the application of narrative research methodology. Qualitative methodology can be helpful in augmenting clinical nursing practice by identifying and noting the frequency of a certain theme and developing interventions to address the issue. Two examples of published qualitative nursing studies are Dow, Ferrell, Haberman, and Eaton (1999), who assessed the meaning of QOL in cancer survivors and compared the data to themes represented in the QOL literature, and Ferrell et al. (1998), who concentrated on psychological and spiritual well-being relating to QOL. Clinical nurses should not avoid qualitative methods because of the false belief that narrative types of research cannot be integrated into clinical practice.

Nurses tend to be the story-gatherers for the healthcare team because they spend a great deal of time with patients and often engage in conversations outside of the formal assessment questions (Ferrell et al., 1997, 1998; Sandelowski, 1991). Not only is the information that the interviews provide useful to enhancing clinical practice, but the interview process itself also can be therapeutic (Frank, 1995; Pennebaker & Seagal, 1999). As the interviews were conducted for this research project, it became apparent that many participants were eager to tell their stories. The question "Tell me about your cancer diagnosis" was the launch pad for many participants to share their experiences with a cancer diagnosis. As the interviews progressed, participants responded to the complete attention of the researcher. Many would assess the researcher's facial expressions as they conveyed their stories to search for signs of interest and evidence that their story was being heard. This was determined by the participants' facial expressions, body language, and continued asking if they were being understood. Researcher interest often would stimulate further elaboration of details, feelings, and other information that participants felt willing to discuss. The interviews began a sort of therapy for many of the participants, as noted by Pennebaker and Seagal. A participant's emotional account of the discovery of recurrent breast cancer highlights how an interview can be therapeutic. The story revealed how trust eroded from the physician-patient relationship and how the role of patient engulfed her roles as businessperson, property owner, and friend.

It took a while for the family physician to refer me to a specialist. That started the trouble. She should have read the blood chart. She finally referred me to a specialist when I told her off. Oh my God, I had to sell my properties. I had two duplexes. I was the landlady . . . I had to put them up for sale.

At the conclusion of the interview, the participant's daughter said, "She hadn't talked about this in a while." The participant remarked, "It has been a while since I talked." The daughter then concluded that "the timing [of their interview] couldn't have been better."

The interview seemed to allow the participant to retell her story and have it recorded, perhaps providing a sense of additional validation. According to Pennebaker and Seagal (1999), "Constructing stories facilitates a sense of resolution, which results in less rumination and eventually allows disturbing experiences to subside gradually from conscious thought" (p. 1243). The act of disclosure, although at the core of psychotherapy, may aid in the enhancement of mental and even physical health (Pennebaker & Seagal). Pennebaker (1997) reported that not expressing emotions and feelings is unhealthy because it promotes stress to the immune, cardiovascular, and neurologic systems. The interview, as conducted in this project, may contribute to reducing some of the physical and emotional stress that many patients experience as a result of the cancer diagnosis. The interview allowed participants to share their personal experiences with cancer to someone who was actively listening.

Limitations

The data retrieved as a result of this project are not intended to be representative of all women with breast cancer aged 70 or older. Because of the relatively small number of people included in this project, these data can only be reflective of the

participants included in the study. An additional limitation is that 11 of the 12 women did have metastatic breast cancer and the sample participants were largely culturally homogenous.

Future Research

Future research would be helpful in determining whether needs vary among age, gender, site of original cancer, and forms of treatment. Including more older people by obtaining the same type of information with in-depth interviews specific to the cancer experience would expand the body of knowledge of aging and cancer. The present research used more broad, life history questions that, in further research, could be streamlined to reflect the specific cancer experience. This would allow for a larger sample population.

Another possibility of further research would be to interview a more heterogeneous population. The participants in the present study were all Caucasian, medically insured with adequate financial resources, and with generally good social support. Future research could include healthcare clinics elsewhere in the community that represent people with reduced financial means and other challenges that coincide with poverty.

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