

Older Breast Cancer Survivors' Symptom Beliefs

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Older women who have survived breast cancer commonly report multiple symptoms that may be caused by normal age-related physiologic changes, multiple comorbid health issues, or late effects of cancer and its treatment (Heidrich, Egan, Hengudomsub, & Randolph, 2006; Heidrich et al., 2009). However, the symptoms can interfere with daily functioning and reduce quality of life (Deimling, Bowman, Sterns, Wagner, & Kahana, 2006; Deimling, Sterns, Bowman, & Kahana, 2005; Keating, Norredam, Landrum, Huskamp, & Meara, 2005; Sherwood et al., 2005; Yancik et al., 2001). Older cancer survivors are faced with the tasks of interpreting the symptom's meaning (e.g., "Is this just aging, or could this be a cancer recurrence?"), deciding whether and when to seek medical care, and engaging in self-care practices. However, little is known about how women accomplish symptom management when faced with the dual issues of breast cancer survivorship and aging.

Many symptoms experienced by older adults, such as fatigue and sleep issues, are perceived as "normal aging." However, the perception is associated with a decreased likelihood of reporting the symptom, less active engagement in self-care of symptoms, and perceiving medical treatment as less beneficial (Dawson et al., 2005; Hofland, 1992; Maxwell, 2000; Miaskowski, 2000; Morgan, Pendleton, Clague, & Horan, 1997; Schroevers, Ranchor, & Sanderman, 2006). However, for cancer survivors, any symptom can lead to worry about whether to seek care because of ongoing concerns about cancer recurrence (Clayton, Mishel, & Belyea, 2006). Therefore, women's beliefs about their symptoms can affect their choice of coping strategies. Appropriate self-care and health care for symptoms is important for long-term health and well-being. As a result, healthcare providers should understand older women's beliefs about their symptoms and how those beliefs drive their symptom management behaviors. Such knowledge could lead to better assessment and symptom management interventions when caring for older cancer survivors.

Leventhal's Common Sense Model (CSM) (Leventhal & Diefenbach, 1991; Leventhal, Meyer, & Nerenz, 1980)

Purpose/Objectives: To use Leventhal's Common Sense Model (CSM) to describe older breast cancer survivors' symptom representations, symptom management strategies, and perceived barriers to symptom management.

Design: A secondary analysis was conducted using data from three pilot studies that tested a theory-based intervention to improve symptom management in older breast cancer survivors.

Setting: Advanced practice nurses conducted open-ended interviews with older breast cancer survivors either in their homes or via telephone.

Sample: Participants were recruited from the community, an oncology clinic, and a state tumor registry. The women (N = 61, X age = 69.5) were an average of 4.7 years after breast cancer diagnosis and reported an average of 17 symptoms.

Methods: Content analysis was conducted with field notes taken during baseline interviews.

Main Research Variables: Symptom representations, symptom management strategies, and perceived barriers to symptom management.

Findings: Women described their symptoms as chronic, incurable, and uncontrollable, with multiple causes (usually not aging) and numerous negative consequences. Women described an average of six symptom management strategies, most typically self-care. The most frequent barrier to symptom management was communicating with healthcare providers.

Conclusions: The CSM is a useful framework for understanding the symptom beliefs of older breast cancer survivors.

Implications for Nursing: Addressing women's beliefs and barriers may result in better communication with healthcare providers and more effective interventions for symptom management.

has been used extensively to understand "lay theories" of a variety of illnesses, including asthma (Halm, Mora, & Leventhal, 2006), myocardial infarction (Cooper, Lloyd, Weinman, & Jackson, 1999; Lau-Walker, 2004), and sexually transmitted infections (Royer, 2008). According to the CSM, people have common-sense beliefs or representations about their illness that guide coping behaviors. An illness representation is a set of beliefs (medically sound or not) that a person has about an illness, consisting of five dimensions: identity, cause,

timeline, consequences, and cure-control (see Figure 1). Although not previously explored, women also may have representations of their symptoms. For the purposes of exploring symptom representations versus illness representations, the definitions of the five dimensions were slightly reconceptualized for the current study. Identity refers to the attributes (e.g., quality, quantity) used to describe a symptom. Cause refers to an individual's beliefs about the origin of the symptom. Timeline relates to temporal ideas, such as the acute, chronic, or cyclic nature of the symptom. Consequences are ideas about the short- and long-term outcomes of the symptom. Finally, cure-control refers to beliefs about the extent to which one can control or cure the symptom.

The CSM also posits that the representations drive how people cope with illness. Individuals may cope through behaviors (strategies) that they employ to manage the impact of an illness or symptoms. Some representations also may act as barriers to symptom management. For example, the belief that a particular symptom is caused by aging and, therefore, is normal and not amenable to intervention could be a barrier to self-care or treatment-seeking behavior. Other barriers besides representations also may exist that interfere with symptom management. Because previous research has shown evidence of positive health behavior change when representations are targeted in interventions (Donovan & Ward, 2001; Donovan et al., 2007; Ward et al., 2008), identifying women's symptom representations may improve symptom management among older breast cancer survivors. To date, few studies have systematically examined the symptom representations of older breast cancer survivors or identified their specific symptom management strategies and barriers (Heidrich et al., 2006). As a result, the purpose of this study was to describe older breast cancer survivors' symptom representations, symptom management strategies, and perceived barriers to symptom management using the CSM as the guiding framework.

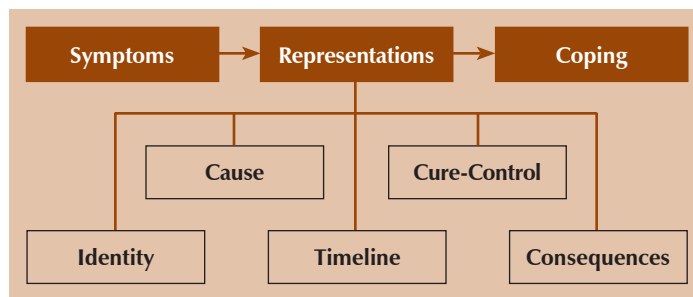


Figure 1. Common Sense Model of Symptom Representations

Note. Based on information from Leventhal & Diefenbach, 1991; Leventhal et al., 1980.

Methods

Design

A secondary analysis was conducted of data collected from baseline interviews with older breast cancer survivors in three pilot studies (Heidrich et al., 2009). The studies tested a theory-based intervention to improve symptom management.

Sample

Inclusion criteria for the pilot studies were women aged 65 years or older with a history of self-reported local or regional breast cancer who were community dwelling, English speaking, at least one year after breast cancer diagnosis, and three months post-treatment (other than hormonal therapies). The age of 65 years was selected because it is typically used to define old age in research on health and aging.

Measures

Self-report questionnaires were used to collect information about age, level of education, marital status, race and ethnicity, income level, breast cancer history, and comorbid health issues. A baseline symptom assessment was conducted using the **Symptom Bother-Revised (SB-R) scale** (Heidrich et al., 2006). The SB-R consists of 34 symptoms common to aging, age-related chronic conditions, breast cancer, and late effects of treatment. Respondents are asked whether they have each symptom and how much they are bothered by it on a scale from 0 (don't have) or 1 (have, but not at all bothered) to 5 (extremely bothered). The SB-R scale has demonstrated reliability ($\alpha = 0.89$) and validity (significant correlations with health issues and quality of life) in older adults with cancer (Heidrich et al., 2006).

Procedure

In the three pilot studies, women were recruited from the community, oncology clinics, and state tumor registry and enrolled in a symptom management intervention study. Information about demographics, breast cancer and health history, and number and kind of symptoms was collected using structured questionnaires at baseline. Advanced practice nurses (APNs) conducted open-ended interviews (see Donovan et al., 2007) in the women's homes ($n = 39$) or via telephone ($n = 22$). The length of the interviews ranged from 48–180 minutes.

The interviews were conducted to gather women's representations of their symptoms. Women were asked to identify a bothersome symptom (the target symptom) and asked, "What is this symptom like for you?" If needed, APNs used open-ended questions to

prompt additional discussion. APNs also asked women to describe strategies they used to manage the symptom successfully or unsuccessfully. APNs used field notes to record the content of the baseline interviews. All three studies received approval from the local health science institutional review board.

Data Analysis

Field notes taken during baseline interviews were transcribed for coding purposes and entered into NVivo (7th ed.). Content analysis then was performed using procedures described by Krippendorff (1980). The units of measure were phrases from the field notes. Two coders independently coded phrases into seven predetermined major categories: the five CSM dimensions (identity, cause, timeline, cure-control, and consequences), symptom management strategies, and barriers to symptom management. The phrases then were coded into minor categories by the coders independently. Inter-rater reliability (percent agreement) for each major and minor category ranged from 64%–95%, according to Krippendorff's formula. Overall inter-rater reliability was 82%. Disagreements were resolved through discussion until consensus was reached.

Results

Sixty-one women completed baseline intervention interviews (pilot study 1: $n = 21$, pilot study 2: $n = 18$, pilot study 3: $n = 22$). The mean age of the sample was 69.5 years ($SD = 5.2$, range = 65–86). Most women were Caucasian (95%), married (62%), generally well educated ($\bar{X} = 15$ years), and of moderate annual income (\$30,000 or more). Women reported multiple comorbid health issues other than breast cancer ($\bar{X} = 4.8$, range = 1–11) and experienced many symptoms ($\bar{X} = 17$, range = 5–30) (see Table 1). The women were an average of 4.7 years after breast cancer diagnosis (range = 1–35). Past treatments for breast cancer included mastectomy (65%), lumpectomy (48%), chemotherapy (23%), radiation (51%), and hormonal therapies (35%). The target symptoms chosen most often were pain (primarily musculoskeletal) ($n = 15$) and sleep disruption ($n = 9$).

Symptom Representations

Major and minor themes of symptom representations identified in the content analysis are shown in Table 2. For the current study, the identity dimension was defined as attributes (e.g., quality, quantity) women used to describe their symptom. However, women did not spontaneously describe their symptom using such attributes. Therefore, the identity dimension did not appear to be present for women in the current study.

Cause was defined as beliefs about the origin of the symptom as well as what exacerbates a symptom. Al-

Table 1. Frequency of Comorbid Health Issues and Symptoms Among Older Breast Cancer Survivors

Characteristic	n	%
Comorbid health issue		
Arthritis	41	67
Hypertension	33	54
Depression	15	25
Bronchitis or emphysema	13	21
Osteoporosis	8	13
Diabetes mellitus	6	10
Heart trouble	4	7
Stroke	1	2
Symptoms		
Stiffness	51	84
Joint pain	49	80
Aching	48	79
Fatigue	47	77
Pain	46	75
Waking too often	41	67
Dry skin	35	57
Memory issues	34	56
Weight gain or loss	32	53
Swelling in hands and feet	29	48
Difficulty falling asleep	29	48
Thinning hair or hair loss	29	48
Depression	28	46
Balance issues	28	46
Decreased sex drive	28	46
Shortness of breath	27	44
Increased urination	27	44
Hot flashes	27	44
Incontinence	26	43
Numbness or tingling in hands, arms, or legs	26	43
Waking too early	26	43
Weakness	25	41
Irritated eyes	24	39
Headaches	24	39
Trouble concentrating	22	36
Itching	21	34
Vaginal dryness	20	33
Nightmares or disturbing dreams	19	31
Feeling anxious	19	31
Constipation	18	30
Thirst	15	25
Dizziness	15	25
Lymphedema	15	25
Vaginal discharge	15	25

$N = 61$

Note. Women could indicate more than one issue or symptom.

most all of the women ($n = 59$, 97%) identified that their symptoms were caused by multiple factors. For example, one participant said that her constipation was the result of several causes.

I wonder if [my constipation] is due to [medication] I've taken for years. . . . [The] more bulk I eat, the worse it gets. . . . When I get anxious or nervous, [I] get more constipated. . . . [My doctor] said my colon is all corkscrewed around, and it's hard for things to move through. . . . My metabolism is slow, making me constipated. . . . [I] don't think it's related to aging.

Table 2. Frequencies and Percentages of Women's Symptom Representations

Category	n	%
Cause		
Multiple factors	59	97
Chronic or comorbid conditions	41	67
Cancer or cancer treatment	21	34
Aging	5	8
Timeline		
Chronic	35	57
Cyclic	7	11
Acute	6	10
Cure-Control		
Uncontrollable	21	34
Controllable	18	30
Incurable	17	28
Have to learn to live with it	10	16
Consequences		
Negative effect on life	60	98
Limited physical activity	38	62
Negative effect on mental health	32	52
Negative effect on relationships	21	34
Constant need to be vigilant	7	11
Not limiting	5	8

N = 61

Note. Responses could be coded into more than one category.

Forty-one (67%) stated that their symptoms were caused by a chronic health issue other than cancer. For example, a woman had been told that osteoarthritis was causing her joint pain. Twenty-one (34%) participants believed that their symptoms either were related to a cancer recurrence or were a result of their cancer treatment. One woman believed that radiation may have caused some of her arm pain. Only five women (8%) attributed their symptom to aging.

The timeline dimension was defined as beliefs about the expected future course of a symptom (i.e., whether it is acute, chronic, or cyclical). Most women (n = 35, 57%) identified that their target symptom was chronic (e.g., "I see [my weight concern] as a long-term chronic problem."). The remainder of the women believed that their symptom was either cyclic (n = 7, 11%) or acute (n = 6, 10%). For example, one woman with difficulty sleeping explained that she "feel[s] [that] this is all temporary and I'll be able to get back to normal."

The cure-control dimension was defined as the belief about whether a symptom can or cannot be controlled or cured through medical treatment or one's own behavior. Seventeen women (28%) believed that their target symptom was incurable; one woman stated, "[I] felt it will always be there." Ten (16%) believed that they will simply have to learn to live with the symptom. For example, one woman told the APN, "I've given up and adjusted my life to less activity. . . . [I] have to live with it." Twenty-one (34%) indicated that they were not able to control their symptom. However, 18 (30%) believed that they could control their symptom. One woman said, "[I] can try to

have it cause less disruption in my life." Interestingly, perceptions of control or lack of control did not appear to be symptom specific; women reporting symptoms of fatigue, pain, urinary incontinence, and constipation were found in both groups.

The consequence dimension was defined as beliefs about the short- and long-term outcomes related to the symptom. Functional, psychological, and social consequences of symptoms were mentioned by the participants. Thirty-eight women (62%) indicated that their symptom caused them to limit their physical activities. For example, one woman explained that her pain "limits me in vacuuming, heavy lifting, [and] carrying." Thirty-two women (52%) indicated that their target symptom negatively affected their mental health. One woman explained that joint stiffness resulted in feelings of "worthlessness." Twenty-one (34%) indicated that the symptom had a negative effect on a personal relationship. A participant told the APN that her relationship with her husband was strained because her knee discomfort "limits my husband and I doing things together." Seven (11%) identified the constant need to be vigilant in managing the symptom. For example, a woman with a fear of falling said,

Well, I really worry about falling, especially when I'm outside. . . . I never was so worried before. . . . I used to be able to get up if I fell, but not anymore, and that is scary. . . . [It] makes me afraid. . . . I have to pay attention to the weather and sidewalk.

Although 60 women (98%) reported negative consequences of their symptoms, five (8%) stated that their target symptom had not had "much impact" on most of their lives.

Symptom Management Strategies

Symptom management strategies were coded as self-directed (e.g., self-care strategies) or healthcare-provider directed (e.g., a medical treatment). Fifty-five women (90%) identified strategies that were self-directed. For example, one woman discussed managing her fatigue by developing the ability to "prioritize and let things go." Another woman with fatigue said,

[I] take a nap after lunch every day . . . and I cut down a bit on the really heavy work, like hauling wood. . . . I still do everything, but I pace myself or do less at a time.

Forty-one (67%) described symptom management strategies that were healthcare-provider directed. One woman explained that to manage her joint pain, she had been "using pain pills . . . cortisone shots . . . the heart rehab program."

Women reported using an average of 6.2 strategies (range = 1–15) to manage their target symptom. A woman with sleep issues stated,

[I] cut down on caffeine . . . from 7 pm on, [I] don't drink much liquids to keep myself from having to get up for the bathroom during the night. . . . I prioritize and pace myself to get done what I can. . . . [I] do only what has to be done [until] I'm too tired to do more. . . . An hour or so before bed I try to keep things quiet. . . . [When I wake at night], I walk around the house . . . I pray the rosary . . . I lay down in the spare bedroom. I tried mild sleeping pills but did not renew the prescription.

Thirty-seven (61%) indicated that one or more of the strategies were unsuccessful. One participant said, "[I] have tried most things [the doctor] know[s] of" to manage her constipation, without success.

Barriers to Symptom Management

Although not specifically elicited during the interview, six major barriers to symptom management were identified: communication issues with the healthcare provider, medication concerns, difficult symptom management, lack of resources, physical or psychological distress, and fear of diagnostic or surgical procedures (see Table 3).

The most common barrier to symptom management was communication issues with the healthcare provider (n = 23, 38%). Six minor categories of communication issues were identified: concerns minimized by provider, perceived symptoms too minor to mention, inadequate information, disagreements with provider over management, unsure of which provider to report symptoms to, and limited time with provider.

Eight women perceived that their concerns were minimized by the provider. One woman with lymphedema recalled her provider telling her, "I just have to live with it and I am lucky it's not worse." Eight women perceived that their symptom was too minor to mention to their provider; a woman with constipation indicated that "[I am] not sure it's really a problem major enough

to tell [the] doctor." Six women believed that they did not have adequate information regarding symptom management. One participant recalled mentioning her concern about knee pain to her provider, yet "[she received] no recommendation for exercise or physical therapy from the doctor." Five women had difficulty communicating with their provider because they disagreed on the best way to manage their symptoms. A woman with weight concerns explained that she and her provider did not agree about the obesity medication: "Being on [the recommended medication] helped so much, why shouldn't I keep taking [the medication]?" Four women were unsure of which provider to report symptoms to; one woman with knee pain mentioned that her provider "was a sports medicine doctor and I think I need to see someone more attuned to dealing with older people with arthritis." Another barrier was the perception that appointment times were limited and discussing the symptom would be a waste of valuable time (n = 3, 5%). For example, a participant reported,

Doctors are usually so busy and in a hurry and ready to rush out the door that it's hard to ask all my questions and expect to get answers, especially regarding nutrition and exercise in regard to my colon problems.

The second most common major barrier was concerns about medications (n = 19, 31%), such as worrying about side effects, medications being ineffective, or fears related to taking medication. The following comments are reflective of medication barriers.

[I] tried over-the-counter sleeping pills, but it made my heart race and I never used it again. I'm on lots of medications for [shortness of breath], but sometimes the medications don't work. Usual arthritis meds are too dangerous, [they] scare me."

Another patient said, "[The provider] gave me a prescription, but I haven't filled it yet because I'm a bit worried about getting dependent or addicted to it."

The third barrier was that women found the plan too challenging, unacceptable, or too difficult to integrate into a daily routine (n = 16, 26%). For example, one woman with lower abdominal cramping found that "drinking all that fluid is so difficult [it] puts me off from doing it." A woman with constipation struggled with her treatment plan because, "[I] hate drinking water . . . [I] have never been a water drinker and just can't fit in the 8–10 glasses of water I understand is recommended." When attempting to manage her weight concerns, one woman stated, "[I have] tried things, [but] not much has really helped or been feasible to maintain."

A fourth barrier was a lack of resources for social support, finances, or symptom management (n = 13, 21%). One woman explained that to manage her fear of falling, she wanted to implement a walking program but

Table 3. Frequencies and Percentages of Women Who Described Barriers to Symptom Management

Barrier	n	%
Communication with healthcare provider	23	38
• Concerns minimized by provider	8	13
• Perceived symptom too minor to mention	8	13
• Not adequate information	6	10
• Differences with provider over management	5	8
• Unsure of which provider to report symptom	4	7
• Limited time with provider	3	5
Medication concerns	19	31
Symptom management too difficult	16	26
Lack of resources	13	21
Physical or psychological distress	12	20
Fear of diagnostic or surgical procedures	7	11

N = 61

Note. Responses could contain more than one barrier.

was “reluctant to walk outdoors without a friend and it’s not always possible to find someone who wants to go walking when I do.” One participant needed to purchase pads to manage her urinary incontinence but found the “pads expensive, [which is] a big problem for me since [I am] on [a] limited income.” Others were unable to manage their symptom because of difficulty accessing healthcare providers. One stated, “I don’t see any specialists because it’s nearly impossible for me to get to where all the specialists are,” whereas another explained, “[The insurance company] wouldn’t pay . . . [they] would only pay every two years, not for a one-year follow-up.”

The fifth barrier was physical restrictions or psychological distress that interfered with symptom management ($n = 12, 20\%$). For example, one woman explained that, “Because of problems with breathing, I can’t exercise and do anything regarding my weight.” Another woman who was implementing a symptom management plan that included walks with friends became discouraged with the activity because she “doesn’t like to have to stop and say [to her friends that] I need rest.”

The final barrier to symptom management was fear of diagnostic or surgical procedures necessary to manage symptoms ($n = 7, 11\%$). One woman reported that, “Because of past experience with [a] breast needle biopsy being inconclusive and having breast cancer, I am not reassured by a negative biopsy and ultrasound this time.” A woman in need of surgery reported, “I was so surprised and distraught about the mention of surgery, I didn’t hear or understand what [the surgeon] said about it.”

Discussion

The current study described older breast cancer survivors’ symptom representations, symptom management strategies, and perceived barriers to symptom management using the CSM as the guiding framework. The current study has established that women do have representations of their symptoms that are consistent with many of the dimensions of the CSM. Healthcare providers may be able to provide better care if they understand and take into account the representations that act as barriers to effective symptom management strategies. Previous research provided evidence for the effectiveness of this approach in improving health outcomes in other patient populations (Donovan & Ward, 2001; Ward et al., 2008). Future research could use this approach in symptom management interventions.

The CSM has been useful in understanding patients’ beliefs about many health issues, including asthma (Halm et al., 2006), HIV and AIDS (Keller, 1993), hypertension (Horne, Clatworthy, Polmear, & Weinman, 2001; Leventhal, Brissette, & Leventhal, 2003), myocardial infarction (Cooper et al., 1999; Lau-Walker, 2004), sexually transmitted infections (Royer, 2008), and many others. In

a meta-analytic review of empirical studies based on the CSM, Hagger and Orbell (2003) reported that the CSM dimensions of consequences, control-cure, identity, and timeline were supported across many different illness types. The results support the dimensions of the CSM as useful categories for describing women’s beliefs about their symptoms. The only dimension that was not consistent with the CSM was identity. Historically, the CSM has defined identity as beliefs regarding the symptoms attached to an illness. However, the identity dimension did not appear to be salient for the women.

The most salient dimension of the CSM in the current sample was consequences. Sixty reported negative consequences of their symptom, which underscores findings from previous research suggesting that symptoms have a major, negative impact on quality of life in older adults and cancer survivors (Heidrich et al., 2006; Heidrich, Forsthoff, & Ward, 1994; Kurtz, Kurtz, Stommel, Given, & Given, 1999). Women described a broad negative effect on life in general as well as more specific consequences for physical activity, mental health, and relationships with others. In addition, some women viewed the need to be vigilant about symptom management as a negative consequence. The findings suggest the importance of developing new interventions to address and improve symptom management for older breast cancer survivors given the high prevalence of negative effects on quality of life.

Almost all women believed that their symptoms were chronic; however, few women attributed their symptoms to aging. The finding was contradictory to previous research in which symptoms experienced by older adults often were perceived to be normal aging and, therefore, little effort was made to resolve the symptom (Dawson et al., 2005; Hofland, 1992; Maxwell, 2000; Miaskowski, 2000; Morgan et al., 1997; Schroevers et al., 2006). Interestingly, most of the women attributed their symptom to multiple causes, which may explain why the women reported using, on average, six different strategies to manage a symptom. The findings suggest that a single-strategy symptom management intervention for a patient will be less likely to resolve the issue. As a result, managing symptoms believed to be the result of a variety of causes may require ongoing communication with the healthcare provider, including addressing women’s beliefs and misconceptions about the cause of the symptom.

Women also identified chronic or comorbid health issues as well as cancer or cancer treatments as the causes of their symptoms. The finding is logical given that the women reported an average of 4.6 chronic health conditions, the most common being arthritis. Because most health issues in older adults are age-related and chronic, some overlap exists between beliefs about cause and beliefs about timeline. In addition, breast cancer is considered a chronic illness and also is age related in older adults. In older breast cancer survivors, the cause

dimension may be salient and potentially more useful than timeline for understanding how women perceive and manage symptoms.

The cure-control dimension reflects the chronic nature of most women's symptoms. Almost all women stated that their symptoms were either incurable or uncontrollable. The belief that the symptoms were incurable probably is medically accurate for most symptoms reported. For example, the most frequently occurring target symptoms were musculoskeletal pain and sleep problems, both of which are age-related, chronic, and typically not curable. However, those symptoms and many others experienced by the current sample can be managed effectively to lessen their effect on quality of life or prevent worsening of symptoms. The results suggest that older breast cancer survivors may have some misperceptions about the controllability of their symptoms. One implication is that asking women about their symptoms and beliefs on cause, timeline, and cure-control may provide healthcare providers with information they can use to provide better symptom management.

The CSM suggests the beliefs that symptoms are incurable or uncontrollable prevent patients from seeking treatment or engaging in self-care behaviors. The current study could not address that question directly. However, almost all women in the sample engaged in self-care behaviors to manage their symptoms. Most women also used medical treatments to manage their symptoms. As a result, the women seemed to be motivated to engage in behaviors to lessen the effect of the symptoms on their lives, but their efforts often were unsuccessful. The authors could not ascertain whether the symptom management strategies used were appropriate or why many strategies were unsuccessful. However, the women clearly continued to try to manage their symptoms, despite beliefs that would have inhibited their efforts (e.g., that symptoms are chronic and uncontrollable).

The barriers to symptom management described by the current sample provide some insight into why women have difficulty managing symptoms. The most frequently mentioned barrier was communication issues with healthcare providers. The barrier included numerous issues, such as not having enough time, concerns about symptoms being minimized by the provider, perceiving that the symptom was too minor to mention, and not getting enough information from providers. Some of the barriers may reflect age-related stereotypes on the part of healthcare providers. Previous research suggests that healthcare providers often perceive that older adults are unwilling to try new treatments or that, because of their age, interventions would not be effective (Kane, 2006; Knopf, 2007; Lovell, 2006; Miaskowski, 2000; Ory, Kinney Hoffman, Hawkins, Scanner, & Mockenhaupt, 2003). Unfortunately, older adults reported that their healthcare providers

communicate negative attitudes to them (Miaskowski; Ory et al.).

The two most common communication barriers were the belief that concerns were minimized by the provider and the perception that the symptom was too minor to mention to the provider. Although not examined, a relationship may exist between those barriers. Women may feel that the symptom is too minor to mention because a provider minimized their concerns in the past. Some barriers also have been identified in research on symptom management in patients with cancer (Avis, Crawford, & Manuel, 2005) and in older adults (Miaskowski, 2000; Morgan et al., 1997). For example, both populations may think that discussing symptoms may detract from more important topics (Avis et al.), distract the physician from essential care (Miaskowski), or result in being labeled as a "problem patient" (Hofland, 1992; Maly, Leake, & Silliman, 2004; Maxwell, 2000; Miaskowski). For cancer survivors, communication barriers may detract from better symptom management as well as prevent healthcare providers from addressing patients' ongoing worries that symptoms may suggest a cancer recurrence.

Addressing barriers to symptom management may be necessary to provide patient-centered care (Lauver et al., 2002); that is, care that takes into account patient preferences and values. If a patient does not agree with the symptom management strategies proposed by the provider but the differences and preferences are not communicated, effective care will not occur. If patients' preferences or goals are clearly communicated and discussed, many barriers mentioned by women in the current study may be eliminated.

Limitations

The current study was a secondary analysis of interviews conducted during three pilot studies, and the content analysis was based on field notes rather than verbatim interviews. The sample lacked ethnic and racial diversity, although the sample was diverse in terms of socioeconomic and health status. Women in the current sample were volunteers in a study aimed at testing an intervention for symptom management and may have been highly motivated to address their symptoms. Therefore, a selection bias may exist that should be taken into account when considering the results.

Conclusion

The current study's findings suggest that the CSM is a useful framework for identifying and describing older breast cancer survivors' beliefs about symptoms and symptom management. Specifically addressing women's beliefs and barriers may result in better communication with healthcare providers and more effective interventions for symptom management.

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