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**Coping strategies of women with breast cancer**

**Hackman, Marcia Jean, M.S.**

**The University of Arizona, 1988**

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COPING STRATEGIES OF WOMEN WITH BREAST CANCER

by

Marcia Hackman

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A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements  
For the Degree of

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In the Graduate College

THE UNIVERSITY OF ARIZONA

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## APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Margarita A. Kay  
MARGARITA A. KAY  
Professor of Nursing

12 December 1988  
Date

## DEDICATION

This thesis is dedicated to my mother and father, Doris and Delbert Hackman, for their support, encouragement, and love . . .

. . . and to my grandmother, Martha Lovekamp Schone, whose own battle with cancer was a lesson in courage.

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## ABSTRACT

An ethnographic study was utilized to identify coping strategies of women with breast cancer. Five women were interviewed; four were interviewed on three separate occasions, and one was interviewed twice. The data were analyzed for specific coping strategies taken by the women to deal with the stresses of breast cancer. These strategies were compared and organized into categories of coping strategies: Actions Taken, Emotional Support, Positive Outcomes, Getting Control, and Keeping a Positive Attitude. These five categories were integrated as new coping incidents appeared in the data. The original five categories were merged into three categories: Getting Control, Compensating, and Emotional Support. From these three categories the theory was written: Women with breast cancer will obtain support, get control over what they can control, and compensate for what they cannot control.

## CHAPTER 1

### INTRODUCTION

The purpose of this research was to learn the coping strategies used by women with breast cancer. As the investigator, I have long been interested in the experience of individuals with cancer. I have been impressed by the courage displayed by cancer patients. I wanted to learn more of their lives outside the hospital. What were the difficulties they experienced with work, and with their families? What did it feel like to go home to an uncertain future? Cancer has long been the illness most feared by Americans. Jory Graham, a columnist who was a cancer patient herself, felt the public's image of cancer is one of horrible dying and death (Graham, 1982). A diagnosis of cancer sets you apart, it makes you different from other people who have not experienced it. Yet, hospitalization is only a small part of the experience of having cancer. The difficulties cancer patients deal with at home, in their daily lives, was a facet of their lives I was not familiar with. Changed relationships and an altered family life are also part of the experience of having cancer (Graham, 1982).

Those who work with cancer patients would be benefited by an awareness of the coping strategies patients employ. Individuals living with cancer need not only medical treatment, but assistance in coping with daily problems. By enhancing coping skills, individuals with cancer can hopefully better deal with the stressors that accompany this devastating illness. Research accumulated by nursing professionals

should include the individual's perception of his/her illness. Nurses can learn much from their clients and can encourage use of coping strategies that are effective.

#### Previous Studies

I have made two previous studies of cancer patients. One study (Hackman, 1985a) was an investigation into the fears of individuals with cancer. I was interested in determining whether the fear of death or of pain was greater. Certain concepts emerged from the interview data: 1) adjusting to the diagnosis, 2) need for control, and 3) seeking comfort. As the individual attempts to adjust to the diagnosis of cancer she will seek comforting measures, such as comparing herself to other women who seem worse off than she. She will balance her suffering with the belief that something positive was gained from the cancer experience, such as learning ". . . how much my family loves me." Attempts at control were achieved in part by seeking information. By becoming better informed about cancer and cancer treatment, more control was gained. Pain was viewed as an inconvenience; the possibility of pain did not produce as much fear as the possibility of death. The most difficult aspect of living with cancer is that it is a life-threatening disease. I determined from this research that, as long as there is a possibility the cancer can be kept under control, the fear of death is greater than the fear of pain. However, if treatment is a failure and death is inevitable, the individual realizes that pain can still be controlled, even if the death cannot be. Therefore, fear of pain is greater than fear of death.

A second study (Hackman, 1985b) of breast cancer patients was also done. The result of this study was a domain analysis which included the following cover terms: 1) obtaining comfort, 2) getting control, 3) adjusting to the diagnosis, 4) reacting to the diagnosis, and 5) reaction of other people. Within these domains were certain phrases descriptive of the cover terms. For example, "really shocked" is a way to get control, "my sister came" is a way to obtain comfort, "I was going to make the best of it" is a way of reacting to the diagnosis, and "there were two ladies I never saw again" is a type of reaction of other people. From this study I learned that the reaction to a diagnosis of cancer is a very individual one. I also determined that, in dealing with cancer, the individual will seek comfort from others and then attempt to get control over aspects of her life.

#### Statement of Purpose

The purpose of this study was to learn what women who have completed treatment for breast cancer do to cope with the stress of living with cancer. This information was obtained through the process of an ethnographic interview and analyzed by the constant comparative method of data analysis.

#### Definitions

The following definitions are provided to assist the reader in understanding terms found in the research study.

*Coping* -- constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised

as taxing or exceeding the resources of the person (Lazarus & Folkman, 1985).

*Coping strategies* -- general types of behavior that allow an individual to feel better and less distressed (Weisman, 1979).

*Stress* -- psychological stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus & Folkman, 1985).

#### Significance of the Study

Breast cancer has increased sharply in the United States and is the most common form of cancer in American women. In 1969, the incidence in white women was 73.9 per 100,000; in 1977, the numbers had risen to 82.7 per 100,000. In black American women, rates had increased from 62.1 to 71.5 per 100,000 during the same period. Although survival rates are rising, they have not increased as dramatically as survival rates among other forms of cancer. Until 1986, breast cancer had been the major cause of cancer deaths for American women (American Cancer Society, 1987).

Breast cancer is a particularly devastating form of cancer to live with. Not only is the woman faced with the fact that she has a life-threatening disease, but she must contend with the loss (or potential loss, depending on her choice of treatment) of a part of her body that has cultural and personal significance. The female breast is a symbol of femininity, sexuality, and motherhood. The loss of a breast threatens a woman's concept of herself as being able to fulfill her

role. The presence of a breast lump may be the most shattering thing a physician can tell a woman (Budoff, 1984).

In addition to the stress of the diagnosis, choosing among treatment alternatives that are themselves controversial creates even more stress for the woman. The modified radical mastectomy is the treatment of choice. This surgery involves removal of the breast, subcutaneous tissue, and lymph nodes up to the apex of the axilla (Snyder-Chance, 1986). Other types of surgical procedures include the simple mastectomy, lumpectomy, and the quadrantectomy. Radiation therapy without surgery is another option (Eich, 1985). Surgery may be followed by chemotherapy or radiation therapy. Later, the woman may choose to wear a prosthesis, or have breast reconstruction surgery, or neither.

During this time of anxiety and difficult decision-making, the cancer client must deal constantly with the threat of death. Dealing with the diagnosis, surgery, chemotherapy or radiation therapy, and rehabilitation, along with the ever-present specter of death requires tremendous coping skill. Coping is how one deals with stress. Lazarus and Folkman (1985) call stress a particular relationship between the person and her environment that is appraised by the person as taxing her resources and threatening her well-being.

Many nurses feel inadequately prepared to give psychological assistance to patients and their families (Welch-McCaffrey, 1984). The majority of nurses have little knowledge of the experience of living with cancer. Firsthand reports from cancer patients that describe how women deal with breast cancer would be a valuable resource to nurses.

Specific information on the coping strategies women have found beneficial at various points in their illness would assist nurses in teaching other women with breast cancer. It is hoped that the information derived from this research will promote better communication between nurses and patients. It is difficult to be an effective counselor when very little about the experience of having cancer is understood. By becoming more aware of what it means to live with cancer, nurses can develop a greater understanding of the experience.

Nurses, along with surgeons, were perceived by cancer patients in one study as being the least supportive to them, while friends and family were the most helpful (Moetzinger & Dauber, 1982). Another study indicated serious differences in what patients and nurses view as caring behaviors. Nurses identified caring through such behaviors as listening, touching, and talking, while cancer patients viewed caring as monitoring, follow-through, and being accessible (Larson, 1986). By learning from our clients, more appropriate nursing care can be given.

#### Summary

The purpose of this study was to describe the types of coping strategies women with breast cancer use to enable themselves to deal with the stress of having a life-threatening disease. This study is significant because the incidence of breast cancer is increasing rapidly in the United States. Treatment for breast cancer involves a disfiguring surgery and a usually very unpleasant course of chemotherapy. Even when therapy ends, the women must live with the knowledge that cancer can recur. From previous studies I learned that the greatest

difficulty in living with cancer is the threat of death it brings. Accounts from women with breast cancer on coping strategies they found useful will provide insight on dealing with the experience of having breast cancer.

## CHAPTER 2

## CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

In this chapter, the conceptual framework is outlined and information from the literature concerning breast cancer, coping, stress, and cancer nursing is presented. The relationship of stress and breast cancer, and breast cancer and coping, is also discussed.

Conceptual Framework

The four concepts included in the conceptual framework are breast cancer, stress, coping, and cancer nursing. Breast cancer is the second leading cause of cancer deaths among American women (American Cancer Society, 1987). Coping with breast cancer involves dealing with a life-threatening disease and the likelihood of a disfiguring surgery. A mastectomy removes part of a woman's body that has great personal and cultural significance (Brownmuller, 1984). Women are given more information and choices concerning treatment for breast cancer than they were in the past. The controversies that surround treatment choice create even more stress (Sinscheimer & Holland, 1987). With every treatment option, the woman is given survival statistics and information concerning potential undesired side effects of therapy. Chemotherapy, a frequent follow-up treatment to surgery, creates even more stress through increased financial burdens, disrupted family life, and fatigue (Meyerowitz, Sparks, & Spears, 1979). Even when treatment ends, the

individual must live with the anxious realization that, whatever type of therapy is chosen, there is no guarantee of survival (Silberfarb, 1984).

Psychosocial stress is defined as a particular relationship between the person and the environment that is appraised by the individual as taxing or exceeding her resources and endangering her well-being (Lazarus & Folkman, 1985). Psychosocial stress can be caused by the diagnosis, uncertainty about the future, and weakness (Silberfarb, 1984). There are physiological as well as psychosocial stressors associated with breast cancer. Some of the physiological stressors include: loss of physical energy, nausea, hair loss, loss of physical attractiveness, and weight changes (Simmons, 1984).

Coping assists the individual to meet the demands he/she encounters. It involves constantly changing efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1985). Coping well with stress has physiological as well as psychological benefits and is both a cognitive and a behavioral effort to manage stress (Panzarine, 1985). The goals of nursing are to reduce demands on the patient and to assist the cancer patient to increase her ability to cope with stress (Clarke, 1984).

#### Literature Review

The literature concerning breast cancer, physiological and psychosocial stressors, coping, coping strategies, and cancer nursing is discussed in this section.

### Breast Cancer and Stress

Many factors associated with breast cancer, both physiological and psychosocial, cause stress.

Physiological Stressors. Physical stressors include pain, weight changes, hair loss, and skin reactions associated with radiation therapy. Simmons (1984), utilizing a Loss/Stress Questionnaire, found a significant relationship between perceived life-change losses and stress levels. In a study of 29 women with breast cancer, the major changes they experienced were loss of physical energy, hair loss, nausea, loss of physical attractiveness, and weight gain. All of these changes resulted in higher stress levels. Other physical stressors associated with breast cancer include seromas, hematomas, infection, nerve injury, muscle atrophy, and lymphedema associated with mastectomy; skin reactions, breast tenderness, fibrosis, rib fractures, pneumonitis, and pain associated with radiation therapy; and nausea, vomiting, alopecia, neuropathies, fatigue, diarrhea, weight gain, and bone marrow suppression associated with chemotherapy (Knobf, 1986).

Pain can cause tremendous stress. There is a small but significant positive correlation between perceived pain levels and negative moods; the more pain an individual experiences, the more likely he/she may be depressed. Inverse correlations between pain levels and positive mood states have been found (Shacham, Reinhardt, Raubertas, & Cleedland, 1983). Stressful symptoms associated with breast cancer and its therapies can be managed, but they can seldom be avoided. One of the goals of nursing is to reduce these symptoms to tolerable levels. The individual with breast cancer who is free of symptoms and has adequate

coping defenses is more likely to view her disease as a chronic rather than a terminal illness (Moetzinger & Dauber, 1982).

Psychosocial Stressors of Breast Cancer. Psychosocial stressors of breast cancer include: body image changes, uncertainty about the future, and lack of control over treatment.

Body image changes usually follow a mastectomy. The degree of stress experienced following a mastectomy depends in part on the woman's body image, which is part of her attitude about herself (Carroll, 1981). In this society, a great deal of worth is placed on physical attractiveness. Breasts are the part of the female body most often associated with femininity, sexual attractiveness, and motherhood. Surgical trauma to this part of the body may affect a woman's image of herself as a wife, mother, and woman, and she may be uncertain as to whether she can continue to fill these roles (Brownmuller, 1984). Part of rehabilitation is dealing with this distorted body image.

One of the most difficult aspects of living with cancer is the knowledge that no treatment regimen guarantees survival. Silberfarb (1984) identified uncertainty as one of the five emotional problems that all cancer patients must deal with. The other four are: diagnosis of cancer, absence of control over treatment program, difference between the therapy the physician offers and the history of the disease, and the tiring, weakening effect of treatment. The strong relationship between stress and uncertainty may be due to vague information rather than the event itself (Mischel, 1984). Because uncertainty about the future and about disease recurrence is so great, cancer patients often feel no control over their lives.

Taylor (1983), in a study of 78 women with breast cancer, determined that dealing with events perceived as life-threatening involved three factors: 1) attempts to find meaning in the experience, 2) efforts to get control over the event in particular and life in general, and 3) attempts to restore self-esteem. The search for meaning involved efforts to determine why the cancer occurred, and the vast majority of subjects (95%) found such meanings. Most (41%) of these women attributed the development of cancer to some type of stress -- usually a troubled marriage or divorce. Most (66%) believed they could control the recurrence of cancer. Some of the other one-third believed the physician or therapy would control it. Attempts to regain mastery (control) over the event included direct efforts which were perceived as being beneficial at preventing cancer recurrence: meditation, imaging, positive thinking, self-hypnosis, dietary changes, acquiring information, and decreasing or stopping medication (such as birth-control pills) which may be viewed as being carcinogenic (Taylor, 1983). Attempts to restore self-esteem included beliefs that something positive came from the experience of having breast cancer. The majority (53%) were able to find something positive in the experience.

Weisman and Worden (1977) indicate that 20% of the subjects with breast cancer studied show depression, lowered self-esteem, chronic fatigue, and concern about the future. Bloom (1984) found, however, that most mastectomy patients were physically and psychologically well one year after surgery. The minority who do not cope well with the illness are at higher risk of suicide. As many as 24% of women may have experienced suicidal ideation after a mastectomy (Jamison, Wellisch, &

Pasnau, 1978). Suicide can be a way of coping with stress and may follow depression. Certain characteristics of cancer patients who committed suicide have been identified as: 1) high involvement in therapy with demanding, complaining behavior, 2) greater than normal emotional disturbance, 3) financial or marital difficulties, 4) less pain tolerance, 5) prior suicide attempts, and 6) more distress (Maxwell, 1980).

Stages of Breast Cancer and Stress. The various stages of breast cancer -- diagnosis, surgery, and follow-up treatment -- all produce different stressors. Immediately after discovery of the lump is one of the most stressful times for the woman with breast cancer (Jamison et al., 1978; Moetzinger & Dauber, 1982). Other difficult times include: 1) immediately after surgery, 2) three to four months after surgery (Moetzinger & Dauber, 1982), and 3) at first recurrence of cancer (Silberfarb, 1984). These findings suggest that some of the most stressful moments occur outside the hospital, when the individual may be without any kind of support. The number of women who discover the lump themselves may be as high as 85% (Jamison et al., 1978).

Frank-Stromberg, Wright, Segalla, and Diekman (1984), in a study of 340 cancer patients, found hostility, anger, depression, denial, and withdrawal are common feelings experienced after a diagnosis of cancer. Although many subjects in this study expressed fear, shock, and disbelief (29%), nearly as many (27%) expressed positive reactions to the diagnosis: "I'm going to beat this thing," and "Let's get on with it" (Frank-Stromberg et al., 1984).

The modified radical mastectomy is the treatment of choice in breast cancer. This procedure involves removal of the breast,

subcutaneous tissue, and all the axillary lymph nodes up to the apex of the axilla. The minor pectoral muscle and the major pectoral muscle are left intact (Snyder-Chance, 1986). A simple mastectomy is done if the cancer is localized to the breast. This involves removal of the breast and lymph nodes; muscles are left intact. Surgery is usually followed by radiation therapy.

Women who have had mastectomies may experience diminished quality in their lives after surgery. Taylor (1983), in a study of 78 women with breast cancer, found that the changed body image led to a sense of disfigurement and to difficulty adjusting. Less disfiguring surgeries such as lumpectomy and quadrantectomy may involve easier rehabilitation. Women who underwent lumpectomies showed diminished self-image the first six months after surgery, but the lowered self-image was not as great as that felt by mastectomy patients (Steinberg, Juliano, & Wise, 1985). Those who had lumpectomies adjusted better, and by the second year, showed no indication of a diminished self-image.

The use of cytotoxic chemotherapy with surgery has led to a remission in 50% to 60% of the women with breast cancer (Vogel, 1985). The chemotherapy used is usually a combination of cyclophosphamide, doxorubicin, methotrexate, 5-fluorouracil, vincristine, and prednisone. Conflicting studies exist as to whether the use of chemotherapy is actually beneficial in yielding longer survival rates. Clinical trials are still being conducted and the final answers have not been reached (Vogel, 1985).

Hughes (1982) interviewed 44 women with breast cancer prior to and following the mastectomy. The majority (77%) experienced emotional

distress and all of those who received chemotherapy concluded that it was the worst part of their experience, as bad or worse than the mastectomy. Meyerowitz et al. (1979) found that the psychosocial stressors of chemotherapy included: 1) an increased financial burden (54%) due to lost income or increased medical expenses, 2) less time for socializing (38%) and work (32%), 3) fatigue (96%), and 4) nausea (88%). Chemotherapy patients showed significantly greater depression a year after treatment than those who received radiation therapy (Hughson, Cooper, McArdle, & Smith, 1986). However, radiation therapy is also stressful, partly due to the side effects experienced: fatigue, breast edema/tenderness, and skin reactions (Knobf, 1986).

#### Definition and Function of Coping

Coping, when defined according to the animal experimentation model, is learning what is predictable and controllable in the environment in order to overcome a source of discomfort (Lazarus & Folkman, 1985). Human beings maintain some control over their environment and can perceive the hazards and benefits of coping strategies. Lazarus and Folkman (1985) also define coping as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.

Coping is the most advanced of mature ego processes. It involves choice and flexibility. In distress, the individual will first attempt coping, then try a defense mechanism. If unable to lessen distress with these processes, fragmentation results (Haan, 1977). Weisman (1979, p. 27) defines coping as what "one does to bring about relief,

reward, quiescence, and equilibrium." A potentially life-threatening illness is manifested by losses: loss of control, loss of identity, and loss of relationships (Sourkes, 1982). Coping helps achieve a sense of control. This occurs when the individual realizes his coping ability is equal to or exceeds the demands made on him.

Types of Coping. Lazarus and Folkman (1985) define coping as problem-focused or emotion-focused. Problem-focused coping is those efforts that are directed at defining the problem, generating alternative solutions, weighting the choices in terms of cost/benefit, and choosing among them. Problem-focused strategies may also be directed inward and involve actions such as adopting new behaviors, seeking other means of gratification, or learning new skills (Lazarus & Folkman, 1985). Clarke (1984) identifies problem-focused coping as direct coping which involves actions by the individual that directly affect the demand. These efforts include defensive driving or seeking help for a symptom which is causing discomfort.

Emotion-focused coping does not affect the demand, but alters the individual's perception of the demand (Lazarus & Folkman, 1985). These coping efforts are cognitive processes that lessen distress, such as avoidance, distancing, selective attention, positive comparisons, and forming positive responses from negative events. These methods are used in situations that cannot be changed, such as a terminal illness or the death of a loved one. Clarke (1984) identifies this as indirect coping, of which there are three types: 1) methods which change the bodily experience when confronted with the demand, such as muscle relaxation; 2) methods which change the meaning of the situation, such as

interpreting a heart attack as a warning of too much hard work; and  
3) methods which strengthen coping by removing uncertainty, which occurs when patients are given information about an upcoming procedure.

Such methods are potentially beneficial because they allow the individual to deal with a stressful situation in which the demand cannot be altered. Palliative coping is a type of indirect coping which has potentially harmful effects because the individual temporarily sees her coping strengths and/or the demand more positively (Clarke, 1984). This can be done through drugs, drinking, and smoking. When the effects wear off, the demand remains the same.

Factors Affecting Coping. Sinscheimer and Holland (1987) identified three factors that determine how a woman will adjust to breast cancer: 1) age and the developmental tasks the cancer threatens, 2) personality and coping strategies usually employed in facing life stresses, and 3) social supports that are available, such as partner, family, and friends. Women between the ages of 25 and 40 who have breast cancer have more emotional and physical problems due to stress, possibly because they have more roles to fill as mother, wife, and career woman (Griffith, 1983).

Previous ways of coping with stress will also indicate how well an individual will cope with breast cancer. Women who coped well with stress in the past will probably cope well with breast cancer (Carroll, 1981; Sinscheimer & Holland, 1987). Individuals who are pessimistic are more likely to suffer from feelings of worthlessness or depression and will probably have more difficulty adjusting to the illness (Krumm,

1982). Prior or present illnesses that must be dealt with in addition to cancer will also make coping more difficult (Krumm, 1982).

### Coping Strategies

Coping strategies are general types of behavior that allow an individual to feel better and less distressed (Weisman, 1979). Some of the coping strategies found in the literature include: using social support, seeking information, and comparing themselves to other women with breast cancer.

Support from other people is one of the most important methods a person with cancer utilizes to cope with her disease. One of the most effective coping activities may be talking to a good listener (Smith, Redman, Burns, & Sagert, 1985). The individual who provides the most support to women with breast cancer is the spouse. Subjects in one study (Bullough, 1981) identified family and friends as being the main source of support (83%), while only 38% perceived any support from health professionals. Social support can help the woman deal better with depression following a mastectomy (Woods & Earp, 1978), decrease fears of cancer recurrence (Northouse, 1981), positively affect her outlook on life (Bloom, 1984), and lengthen survival time (Marshall & Funch, 1983). Northouse (1981), in a study of 30 women with mastectomies, found those with fewer significant others had greater fears of cancer recurrence.

Widows and women who are separated or divorced are more likely to have difficulty adapting to cancer, and more likely to feel isolated (Krumm, 1982; Smith et al., 1985). In one study, 21% of the widows and

23% of the separated/divorced women reported feelings of loneliness and isolation, as compared to 14% of the married women and 15% of the single women (Smith et al., 1985). Spouses are the most important source of support for married women (87%), followed by friends (81%) and relatives (73%); separated/divorced women found friends (84%) most supportive.

However, Northouse (1981) found that there were certain things women with breast cancer would not discuss with their family for fear of worrying them, such as mastectomy-related affairs and death. They would, however, discuss these concerns with a health professional (Northouse, 1981).

Groups are an important source of support, as the woman may be able to learn new coping strategies (Herzoff, 1979). Many women may feel only another individual who has undergone a mastectomy could empathize with her feelings (Northouse, 1981). Social involvement is an important factor in survival time, especially among younger women (Marshall & Funch, 1983). This involvement may be difficult to achieve due to beliefs and feelings among the public concerning cancer patients. Peters-Gordon (1982) found breast cancer patients felt they were treated differently (72%) after the cancer diagnosis. Many reported feelings of being avoided (52%), pitied (14%), and isolated (61%). One reported having no one to rely on for support (Peters-Gordon, 1982).

Seeking information is another useful coping strategy. Those who cope successfully will most likely seek information, while less adequate copers avoid it (Orr, 1986). This strategy is more likely to be found among younger cancer patients and by patients early in their illness (Hopkins, 1986).

Social comparisons are often used as a coping strategy, and may be downward or upward comparisons. They will likely be upward if the woman who seems to be coping better uses methods that are instructive and can be copied (Taylor, 1983). The comparisons tend to be downward (the individual comparing herself to women who do not seem to be coping as well as she) if there is a need to enhance self-esteem (Taylor, 1983; Wood, 1985). Even terminally ill patients make downward comparisons. One woman felt fortunate that she had found something in life many people never find -- peace and meaning (Taylor, 1983).

There are many other coping strategies that may be utilized to deal with the various stressors of breast cancer. Weisman (1979) discusses coping strategies derived from case studies, that people use to deal with stressful situations. Among these strategies are information-seeking, sharing concerns, trying to forget it, distracting oneself, taking action, isolating oneself, blaming someone or something, and using excessive drink, drugs, or danger to cope. Rickel (1987) identifies other strategies that include denial, humor, television, church, reading, work, and friends. In one cancer education program, called "Living with Cancer: A Patient Education Program," one of the main goals is to help each individual determine his/her own coping strategies. The coping strategies that the patients discovered are faith and prayer, talking to other cancer patients, thinking positively, keeping busy, family and friends, reading, a good diet and exercise, helping others, work, and setting goals (Fredette & Beattie, 1986).

### Nursing and Cancer Patients

The role of nursing is to relieve or reduce the physiological and psychosocial stressors of breast cancer and to assist the individual to cope with the stressors that remain (Clarke, 1984). The coping strategies described in the literature can be summarized as: 1) giving social support, 2) providing information, and 3) relieving stressors. In the case of women with breast cancer, the stressors are those previously discussed, including fatigue, nausea, pain, and lack of control. Therefore, the role of nursing can be summarized as: 1) monitoring and relieving symptoms, 2) teaching, and 3) providing support.

Monitoring and relieving symptoms are provided by nurses in the acute care setting of hospitals. Stress can be partially relieved by dealing with the symptoms that accompany breast cancer and its treatment: pain, arm edema, and hematomas that can occur after surgery; nausea, vomiting, fatigue, susceptibility to infection, and bleeding that is associated with chemotherapy; and skin damage that may occur with radiation therapy.

Teaching women how to deal with these side effects and others once she is discharged is also a nursing role. This knowledge will enable her to achieve some control in her life. The three objectives of the cancer education program previously discussed focus primarily on teaching. The goals are: 1) teaching the participants a basic knowledge of cancer, 2) increasing knowledge of coping strategies, and 3) increasing their awareness of supports (Fredette & Beattie, 1986). By sharing accounts of how others dealt with cancer, the nurse is passing on knowledge of coping strategies (Welch-McCaffrey, 1984).

Almost half of the subjects (47%) in one study felt nurses gave them "little or no information and support" (Bullough, 1981). Only 42% felt their information needs were adequately met (Bullough, 1981). Such negligence toward teaching and support may be due to the fact that nurses do not feel well-prepared to teach coping methods to cancer patients or the nurses may have more pressing priorities and do not have time to give to teaching. The subject in one study excused them by noting, "Of course they were busy" (Bullough, 1981, p. 223).

It is not only physical symptoms that cause distress for women with breast cancer. Throughout the course of the illness, emotional support is critical in helping women cope with breast cancer. Both the husband and patient experience distress and need support (Northouse, 1987). Empathizing with the patient is helpful by providing support and understanding (Welch-McCaffrey, 1984). Dramatic changes in attitude can result with empathy and giving. Nearly half the subjects in one study said the nurse gave them little or no support (Bullough, 1981). The need for this type of giving has been voiced by patients: "I became very upset when I learned the diagnosis of my ailment. When the doctor left, I had a good cry -- then I asked to talk to the nurse, who was wonderful. She made me see things in a different way. I then made up my mind I was going to fight and make the best of what was left for me" (Frank-Stromberg et al., 1984, p. 21).

#### Summary

In this chapter, I have presented information on the conceptual framework of my study. The concepts include breast cancer, stress,

coping, and cancer nursing. Both physiological and psychosocial factors can cause stress in women with breast cancer. Some of these factors include breast amputation, pain, hair loss, fatigue, uncertainty of treatment results, fear of cancer recurrence, and fear of death. Some of the most stressful periods within the experience of breast cancer are discovery of the lump, surgery, and chemotherapy. Coping is how an individual deals with stress, it is efforts to manage the demands the person encounters. Coping can be problem-focused or emotion-focused. Coping strategies are varied, but include seeking support from others, getting information, social comparisons, distraction, taking action, denial, and use of alcohol or drugs. The role of nursing is to reduce stressors and assist the individual to cope with the stressors that cannot be reduced. This centers around relief of symptoms, teaching, and emotional support.

## CHAPTER 3

### METHODOLOGY

Included in this chapter is information on research design, sample and setting, data collection and procedure, data analysis, validity and reliability, and human subjects.

#### Research Design

The design I chose for my study was a small-scale ethnography which focused on a specific area of inquiry (Leininger, 1985). The area to be studied was women with breast cancer. An ethnography is a study of a culture, of people. It is a system of observing, detailing, describing, documenting, and analyzing the lifeways of a particular pattern of a culture or subculture in order to understand the lifeways of the people within their own environment (Leininger, 1985). Such a design provides a way to obtain broader categories of information than would other study designs.

The study of human cultures is the purpose of an ethnography. Culture is the acquired knowledge that people use to interpret experience and generate social behavior (Spradley, 1979). Through this method of learning, the views of the informants and the meanings of their actions can be understood. An ethnography is an appropriate study design when there is little or no knowledge of a phenomenon or when a view of a lifestyle from the perspective of the informant is desired

(Leininger, 1985). It is also useful as a way to develop theories and concepts.

#### Sample and Setting

The informants were women with breast cancer who had undergone at least one of the three treatment modalities that are currently being used to treat the disease: surgery, radiation therapy, and/or chemotherapy. I interviewed five subjects, four of whom were interviewed three times; the fifth was interviewed twice. I obtained my subjects through the assistance of friends and acquaintances, who in turn asked other acquaintances if they would agree to be interviewed. All five subjects consented. I introduced myself and told them I was interested in learning what it is like to live with breast cancer. The criteria for selecting informants were: 1) ability to communicate in English, 2) a diagnosis of breast cancer, and 3) completion of one or a combination of the three treatment modalities.

#### Human Subjects

The rights of the informants were taken into account during this research study. Permission to do the study was obtained from the Human Subjects Committee (Appendix C) and a subject disclaimer form was utilized (Appendix B).

#### Data Collection and Procedure

The interview proceeded according to the protocol outlined by Spradley (1979) for the ethnographic interview. After introducing myself and stating my purpose, the interview commenced as a friendly

conversation. This was done to develop rapport with the informant and to gain her trust. The interview formally began with a "grand tour question." This is a general question that allows the informant to begin the interview with an area she is comfortable discussing. A grand tour question used was "Tell me what it is like to have breast cancer." Beginning the interview with less-threatening questions yielded more information. Once rapport was established between informant and interviewer, more personal areas could be explored. It is the informant who gives the clues as to when she is ready to proceed to other areas. The interview was guided by what the informant said; new areas were explored as she brought them up. The informant's feelings and sensitivities were kept in mind. If one question or area seemed particularly sensitive to the informant, I "backed off." If the informant becomes too uncomfortable, she may wish to terminate the interview and the ethnographer will be left with little or no data.

Descriptive questions are one type of ethnographic question. Other types of questions used by an ethnographer include structural questions and contrast questions. Descriptive questions ask the informant to describe something, such as what it is like having breast cancer. They allow the ethnographer to collect samples of the informant's language and build on this information to ask other questions. Examples of descriptive questions include:

1. Tell me how your family reacted to the diagnosis.
2. Tell me what your greatest adjustment has been.
3. Tell me how your feelings about yourself have changed.

Structural questions allow an ethnographer to discover domains of knowledge the informant holds. These questions are derived from what the informant said. Some examples are:

1. What types of fears do you have?
2. Which people were the most difficult to deal with?
3. Which people gave you the most support?
4. What do you do when you want to feel good?

The tools necessary for doing an ethnographic interview include a tape recorder and pencil and paper. Obtaining permission from the informant to tape-record the interview enables the researcher to concentrate on the interview and still obtain all of the information. A good interview involves getting information not only in words, but also in voice inflections, body language, and facial expressions. This means paying close attention to the informant. Field notes were kept along with the notes made before, during, and after the interviews. A new area of study to explore may come to mind through something the informant says. An expression of discomfort by the informant may tell the ethnographer that a particularly sensitive area is being discussed. A competent interviewer must be alert to everything that takes place during the interview.

The choice of the interview setting was made by the informant; it was either in her home or at her office and always in private. Privacy was important, as the informant was more open and honest about expressing herself. If another family member had been present, certain delicate areas of her experience may not have been revealed.

### Data Analysis

The method of data analysis used was the constant comparative method. Data were analyzed after each interview and notes were made alongside the data. In this manner, interviewing strategies could be adjusted during the process of data collection. The constant comparative method allowed the investigator to place more emphasis on those areas which were most pertinent to the experience.

Glaser and Strauss (1967) describe four stages of constant comparative analysis:

1. Compare incidents applicable to each category. Code incidents into as many categories of analysis as possible. While coding, the incident is compared with previous incidents in the same and other categories.
2. Integrate categories and their properties. Instead of comparing incident with incident, compare new incidents with properties of established categories.
3. Delimit the theory by fixing limits at two levels: a) by reduction of terminology and generalization, and b) by reduction of the original set of categories for coding.
4. Write the theory.

Good (1977, p. 39) suggests a "social free association" as a way of learning about an individual's experience. By looking for the most powerful elements of experiences and exploring words, phrases, and situations, the meaning of the illness for the subject can be understood.

### Validity and Reliability

Sandelowski (1986) suggests four factors that should be the determinants of rigor (exactness) in qualitative research: 1) truth value (credibility), 2) applicability (fittingness), 3) consistency (auditability), and 4) neutrality (bias). The truth value of qualitative research is based on its credibility. A study is credible if it portrays such a true representation of a human experience that individuals who have had that same experience can identify with it. It is also achieved when other readers of the study can later recognize the experience after having only read about it (Sandelowski, 1986). Credibility was achieved in this study by having a co-worker (a woman who had a mastectomy in the past) read part of it. After reading the data analysis she commented, "I can relate to this." Reflexivity is another way to gain credibility in a study. When the researcher reflects upon how the informants affected her and she in turn affected the informants, credibility is enhanced. I discuss reflexivity in Chapter 5.

Applicability, or the relevance of a qualitative study, is determined by fittingness (Sandelowski, 1986). A study meets this criterion when it can fit situations outside the area of study. Applicability is achieved through several factors: an explanation of the researcher's interest in and view of the subject being studied, the purpose of the study, data collection procedure, setting in which data were collected, length of time spent collecting data, methods of data analysis, and how the informants and researcher influenced each other (Sandelowski, 1986). My interest in the study and the purpose of the study were discussed in Chapter 1; data collection procedure, setting,

and data analysis were discussed previously in this chapter; length of time spent collecting data is discussed in Chapter 4; and how the informants and researcher influenced each other (reflexivity) is discussed in Chapter 5.

Auditability is the criterion of merit relating to consistency. A study is auditable if another researcher can follow the decisions made by the investigator and reach the same, or like, conclusions with the data (Sandelowski, 1986).

Neutrality refers to the lack of bias in the research. Confirmability is the criterion that is followed to achieve neutrality in qualitative research. Confirmability is achieved when truth value and applicability are achieved.

Credibility and fittingness are achieved by ensuring that the data are representative as a whole, by looking for agreement among the data findings, by having the informants confirm the data, and by trying to disprove inferences made about the data (Sandelowski, 1986). Often during data collection, I asked the informants, "Is this what you mean?" to verify the data. I also searched for areas of agreement in the data findings and discussed this in data analysis.

#### Summary

In this chapter, I have discussed research design, sample and setting, data collection and procedure methods, data analysis, information on validity and reliability, and information concerning human subjects' rights. The design is a small-scale ethnography through which I was able to learn the views of the informants. The sample consisted of

five women with breast cancer who had completed therapy. The interviews took place in their homes and workplaces. Interviews were recorded and transcribed onto computer disks. Data were analyzed by the constant comparative method used in grounded theory research. Validity and reliability were determined by the criteria of truth value, applicability, consistency, and neutrality.

## CHAPTER 4

### DATA ANALYSIS

In this section, I will discuss data collection, informants, presentation and analysis of the data, and theory development.

#### Data Collection

Four of the informants were selected through friends and contacted by phone. The fifth was contacted through a cancer support group meeting which I attended. Prior to the interviews, I introduced myself and explained the study. During the first interview, the subject disclaimer form (Appendix B) was given to the informants, questions were asked, and answers given.

Subjects ranged in age from 46 to 53. They had all completed therapy. The time since completion of treatment ranged from six months to three and one-half years. Interviews of the first three informants were conducted in their homes, in either the living room or bedroom. The interviews of the fourth subject were held in her office and the interviews of the fifth subject in a meeting room at her workplace. Privacy was obtained for all interviews. Four subjects participated in three interviews; one subject participated in two. The first interview was initiated with a grand tour question such as "Tell me what it is like to have breast cancer." Other interviewing techniques were discussed in Chapter 3.

Informants were interviewed over an eight-week period. The interviews were usually held a week apart. Sessions were recorded with subject permission. None of the subjects were previously known to the interviewer. After the first interview with each subject, the tape recording was transcribed onto a computer disk and a written copy was made. The copies were printed on the left side of the page so that the right side could be used for analysis of data and for memos. Following the analysis of the first interview, areas that needed elaboration and clarification were identified, and questions were planned for the next interview.

#### Informants

In this section, I will give a brief description of each of the informants.

#### Amy

Amy is a 53-year-old woman whose therapy was completed three and one-half years before the interview. I met her at a cancer support group and she consented to take part in my study. She is a pleasant, talkative, and articulate individual. She also has a keen perception of her feelings during the year she received chemotherapy treatments. She is close to her family and acknowledges that it was their encouragement which persuaded her to have surgery. Her prognosis at the time of diagnosis was poor: the tumor involved the whole breast; without surgery, she would live only three to six months. Amy vacillated about surgery and wondered if there was any point to it. Chemotherapy treatments lasted one year. A six-month checkup after surgery indicated she was

free of cancer. She also had radiation therapy, from which she sustained burns that still cause pain. She has learned to deal with this by believing "The pain is the price I pay for still being around."

### Billie

Billie is a 52-year-old woman who completed therapy two and one-half years ago. She regretted having the mastectomy and indicated she had to forgive herself for doing it: "I would have preferred to die rather than go through the surgery. I didn't want to be mutilated." Billie said she wished she had tried other methods of dealing with the cancer and feels she could have healed herself "spiritually." Billie believes the mind controls the body; therefore, she can keep the cancer from recurring. Since the diagnosis of cancer, she has made a great change in her life. She had always wanted to be a painter, but was discouraged from doing so when she was young because of uncertain financial support. After the surgery, she quit her job as a school librarian and began painting full time. She is very happy with this change and says now of the experience of having cancer and surgery, "I was able to turn it around to a positive thing."

### Cassie

Cassie is a 43-year-old woman who had finished chemotherapy 18 months before the interview. She is a registered nurse. She was able to use her nursing knowledge to make choices about her treatment. After the mastectomy, she was told by her surgeon that she did not need follow-up therapy. She had one positive lymph node. Not comfortable with that plan, she sought opinions from two other oncologists as to

whether she should have chemotherapy. They concurred with her belief that she should have it. She chose the oncologist she was most comfortable with, someone who would answer her questions: "I wanted someone who would see through the tumor and see Cassie." She underwent what was to be a six-month treatment period, but tolerated the therapy poorly and became very toxic. The therapy was discontinued after two months. Subsequent checkups have been negative. As part of her recovery, she has tried a holistic approach to her health which included changing her diet and getting more rest.

#### Decora

Breast cancer was diagnosed in Decora about a year ago, when she was 46. She completed chemotherapy six months before the interviews began. The first interview was quite emotionally distressing for her. She was close to tears much of the time. After having a mastectomy, she had a six-month chemotherapy course. She had nine positive lymph nodes: "That was as bad as finding out I had cancer." She feels that she has changed since her experience with cancer: "I'm more up front . . . I will say what I think." She is working to not let the fact she has cancer overwhelm her life. She does not want it to be the most important thing in her life. She is very concerned about it recurring: "If you just live from checkup to checkup, you might as well be dead."

#### Esther

Esther is a 46-year-old woman, also a registered nurse, who completed treatment six months ago. She had a mastectomy and chemotherapy. She worked throughout her course of chemotherapy and found work an

effective way of dealing with stress. Checkups following surgery have been good. She took an active role in decision-making after her diagnosis. She sought a second opinion when her surgeon suggested a mastectomy of the uninvolved breast as a precaution against cancer in that breast. She decided against the second mastectomy. She feels that having cancer has deeply affected her lifestyle and her relationships with other people, which are more open than in the past: "I just had a sudden realization that life is limited . . . I don't know what is coming after I die, so I wanted to make the best of what I've got now."

#### Coding Incidents into Categories

Identification of coping strategies was the purpose of this study. I searched for specific incidents within the data that would indicate attempts at coping. These coping strategies may be either attempts at coping with the experience of having breast cancer or with specific stressors within that experience, such as pain, nausea, fatigue, and fear. After a few interviews, I began placing the incidents into categories. Some of these incidents are presented in the following discussions. A more complete list of incidents which describe coping can be found in Appendix A.

#### Actions Taken

Amy talked a great deal about things she did to deal with the side effects of chemotherapy and the pain that continues even today. She took action to deal with the unpleasant things that occurred. I called this category Actions Taken. Amy dealt with continuing pain by being aware of the degrees of pain and getting it under control before

the pain worsened. She made a scorecard of the severity of pain, then either rested, used hotpacks, or took aspirin, depending on the score. She also tried to "outwit" the chemotherapy-induced nausea by having someone else cook for her when the smell of food made her ill. Cassie used creative visualization and meditation to deal with nausea: "I could meditate my nausea away."

### Emotional Support

Amy, Billie, and Cassie discussed how beneficial emotional support was in helping them deal with their fears and concerns. Amy admitted she probably would not have had the surgery if not for her family, who convinced her to try, even though her prognosis was poor: "They made me feel that it was very important to them that I stay around." Billie commented, "My friends were the biggest help in getting me through this." Cassie was disappointed in the amount of support she received from her friends; but said she may have been partly to blame because she discouraged talk about her cancer. She did not want to burden her family and friends with her illness. However, Cassie's need to share her concerns was strong, for she found herself telling complete strangers about her surgery:

I wanted to talk to someone so badly, I really did. I didn't necessarily want someone to talk back -- just to listen. I don't know what I was going to say, I just found myself thinking over and over, "I had this mastectomy, I'm having this God-awful chemotherapy, I feel so shitty. Please care."

I called this category Emotional Support.

### Positive Outcomes

Another category was evident from the first few interviews. All of the informants discussed at length how cancer affected their lives positively. They valued their time and their opinions more than in the past. Amy stated that having cancer made her ". . . learn what was important and what wasn't. I found I was much loved." She copes with pain (caused by radiation-induced skin damage) with the belief that "pain is the price I pay for still being around." Billie made a tremendous change in her life after the cancer was diagnosed; she quit her job as a school librarian and devoted her time to painting, something she had wanted to do all her life: "I was able to grow from it [having cancer]. I turned it around to a positive thing." Billie feels that having cancer makes her live in the present; previously, she had been looking forward to retirement so that she could begin painting. When cancer was diagnosed, she decided not to put off her life-long dream of painting until retirement. Cassie also felt her life had changed greatly since the cancer diagnosis: "I don't think you can have a potentially life-threatening illness without being changed. You put more emphasis on day-to-day living, you try to make each day count." I initially called this category Positive Attitudes.

### Getting Control

I continued to search the data for categories. Certain phrases contained a word that seemed important in coping -- control. Amy said, "I took control by driving to chemotherapy and by planning activities." She used the word control again when discussing her medication schedule.

She took her Cytoxan in the evening so that she could get at least two meals down without nausea and vomiting. Although she acknowledged that it may not have been the schedule change which enabled her to eat, she said, "I believe an illusion of control helps." Billie also used the word control. "Our minds control our bodies," she said. Cassie's description of how she selected a surgeon and obtained second and third opinions concerning her need for chemotherapy strongly suggests attempts to obtain control. By turning down social invitations she does not wish to attend, Cassie describes another way of getting control. She stated,

I believe stress contributed to my developing this illness . . . lack of stress will keep me from developing it in the future. If I don't feel like spending time with people I say, "No, I'm not going." In the past I would have, I would have put a smile on my face and played the role.

These incidents were placed in the category called Getting Control. This is a new type of category. Getting Control emerged from the language of the informants. The previous categories (Actions Taken, Emotional Support, Positive Outcomes) were all constructed by the investigator as attempts to explain behavior of the subjects. The fourth category, Getting Control, is itself a behavior. At this time, after five interviews of three subjects, I had four categories and discovered flaws in my interviewing technique which I would make attempts to correct in future interviews.

#### Keeping a Positive Attitude

With subsequent interviews, I added incidents to the established categories and formulated a new category. This was also one that resulted from the language of the data: Keeping a Positive Attitude.

Amy said, "A good attitude affects the outcome." It kept her trying through the long, difficult months of chemotherapy. Cassie stated, "I tried to keep a very positive attitude. I think I had such a positive attitude that I just decided I wasn't going to die from cancer. Decora said she deals with cancer by not letting the illness "totally encompass" her life. She does this by "trying to be positive."

At this point, I had five categories: Actions Taken, Emotional Support, Positive Outcomes, Getting Control, and Keeping a Positive Attitude. Although theory development at this point was immature, I drew certain inferences about the various categories. Actions were taken to deal with the negative effects of treatment, such as controlling pain and nausea. The emotional support of others was important in helping the women deal with the stress of having cancer and receiving cancer therapy. The women had strong beliefs that positive outcomes evolved from their experience with cancer, including what they viewed as positive changes in their attitudes and beliefs about their lives. The informants made attempts to get control over their lives, control which they felt had diminished since the cancer diagnosis. These attempts involved making choices about their therapy and planning who they would spend time with. Throughout therapy, the women felt that keeping a positive attitude would help them better endure the treatment. It was evident after studying the properties of these categories that there were similarities among the categories. This awareness led me to the next process of data analysis: integration of categories.

### Integration of Categories

I began to integrate the categories while continuing the interviews. I decided to focus on the five categories in the final interviews. The category Actions Taken did not yield much information; it did not seem to be as strong a category as I originally thought. It occurred to me that a lot of what the subjects cope with is more emotional stress than physical stress. Emotional stress was dealt with by support from others and by the belief that they received something beneficial from the experience of having cancer. The actions taken to deal with stress were essentially actions to deal with the side effects of treatment: nausea, fatigue, and hair loss. The only informant who continued to use actions to cope was Amy, who was dealing with the continuing pain. The other women did not have ongoing physical effects other than the mastectomy, but emotional ones: the possibility of cancer recurring and death. Control seems to be especially important early in the treatment process, during surgery and chemotherapy. When therapy ended, the women had gained some control. Coping with fears of cancer recurrence and death became the next challenge.

Within the category Emotional Support were instances of what the women did to seek support: they told people they had cancer, they called friends for their support, cried with their families, and expressed their fears to their families. Incidents within the category Keeping a Positive Attitude involved attempts to control their feelings and thoughts, in order to better cope with the experience of cancer. The category Actions Taken described incidents in which the women dealt

with unpleasant aspects of having cancer, such as side effects of chemotherapy.

All of the coping strategies within the three categories Actions Taken, Getting Control, and Keeping a Positive Attitude seemed to be used by the women to achieve the same goal: more control over their lives and the stressors of the cancer experience. The actions taken to counteract the negative physical effects of cancer and cancer treatment (nausea, hair loss, fatigue, pain) were all attempts to get control over their lives. Even Keeping a Positive Attitude was an attempt at control because it controlled feelings: fears and anxieties about possible cancer recurrence. I therefore integrated these three categories into the single category of Getting Control.

At this point, theory development involved three categories: 1) Getting Control, 2) Emotional Support, and 3) Positive Outcomes. The category heading Positive Outcomes did not adequately describe the incidents within that category. It seemed there were more than mere attempts to achieve a positive outcome. There was need to believe that the suffering and anxiety were worthwhile -- that something positive had come from it. While the women could have looked back on the experience with memories of only the negative aspects of it, they chose to also look back and say, "I got something worthwhile out of this!" Billie explained her need to believe that she had some control over the cancer recurring (mind controlling the body) by stating, "You don't want to feel you're at the mercy of the elements." While the women had some control, over the nausea, pain, fatigue, and over their attitude, they could not control what they wanted to control most: cancer recurrence.

That may happen despite their best efforts. So you learn to live with this fear because you have to. You simply cannot put the experience of having cancer behind you and forget it. As Decora said tearfully, "It's always there, it's always there." So this attempt to find compensations for this experience seems a necessary part of the healing process. While others who have never dealt with cancer have the luxury of believing that life is forever, the individual who has cancer must deal with the agonizing fact that life is limited: human beings are mortal. For the emotional pain this knowledge brings, they feel they must have a compensation, a gift that counterbalances the emotional distress. This gift is a certain awareness, which for Amy meant, "I've had a good life, an interesting life, lots of love and affection." Billie's compensation was the belief that "having breast cancer makes you live in the present, it [cancer] was absolutely necessary for me to learn." Cassie believes she "put more emphasis on day-to-day living." Decora said, "I had always valued relationships, but what was I doing about them? I had to spend time creating those relationships that were of value to me." I chose the term Compensating rather than Positive Outcomes to describe this category.

#### Theory Development

Three categories remained: 1) Getting Control, 2) Compensating, and 3) Emotional Support. Because these are categories of coping strategies, I changed the term Emotional Support to Obtaining Support. While control was very important, the subjects were not able to control everything about their experience. The informants could control some of the

unpleasant aspects of treatment -- nausea, vomiting, fatigue, and pain. They could control their attitudes to a great extent by being as positive as possible about having cancer, but they could not control cancer recurrence. The women could not control other individuals' behavior toward them. They dealt with these factors by compensating for them.

If these categories of strategies are looked at as a process, which Lazarus and Folkman (1985) suggest coping is, the individual with breast cancer obtains control over what she can control and compensates for what she cannot control. Obtaining support appears to be very important at diagnosis, surgery, and during chemotherapy. This coping strategy seems to be a way of bolstering one's defenses before a fight: at the shock of hearing the diagnosis, and before and during treatment. This may strengthen the individual so that she can fight. She fights by getting back control over her life. She can get control over certain unpleasant aspects of the experience: nausea, pain, fatigue, and, to a certain extent, fear. As treatment nears completion, she faces an important realization. Although treatment has ended, she will have to live with cancer -- treatment does not bring a guarantee of survival. She compensates for this with the belief that cancer has led her to make positive changes in her life.

#### Summary

I have discussed data collection, informants, incident coding, integration of categories, and theory development. Data were collected from five subjects in 14 interviews. Interviews were recorded and transcribed onto computer disks. Informants all had completed treatment.

Time since treatment completion ranged from six months to three and one-half years. Incidents of coping described by the informants were coded into five categories: Actions Taken, Emotional Support, Positive Outcomes, Getting Control, and Keeping a Positive Attitude. Gradually, the categories were integrated from five to three: Getting Control, Obtaining Support, and Compensating. The incidents within these categories suggest that coping is a process which begins by obtaining support when the diagnosis of cancer is made, getting control over life during the treatment of cancer, and, as treatment nears completion, compensating for what cannot be controlled.

## CHAPTER 5

## CONCLUSIONS

This chapter presents the conclusions of this study. Included are discussions on theory, relationship of theory and conceptual framework, relationship between ethnographic data and theory, relationship between ethnographic data and information presented in the literature review, reflexivity, recommendations for nursing practice, and recommendations for further research.

My theory was developed from the data. Women with breast cancer will obtain support when diagnosed, get control over what they can control during therapy, and compensate for what they cannot control as therapy continues. The statement within the theory "will obtain support" is derived from such statements as: "I called friends around the country to generate positive thoughts," "I talked to my family about the possibility of not having a very long life," and "I found myself telling complete strangers that I had recently had a mastectomy." These statements express the importance of emotional support, of having people available with whom to discuss fears and concerns. The statements were made while the informants discussed incidents that occurred early in the cancer experience: at diagnosis, and prior to and immediately after surgery.

The statement "get control over what they can control" was elicited from such statements as: "I try getting the pain under control before it gets bad," "Knowing the side effects of chemo helped me endure

them," "Our minds control our bodies," "I got control by making as many choices as I could," and "I changed my schedule, I did things early in the morning when I was less fatigued." These are expressions of how the physiological stressors (pain, fatigue, nausea) and the psychosocial stressors (living with the fears of cancer recurrence and death) are dealt with.

The third part of the theory, "will compensate for what they cannot control," is drawn from such statements as: "Pain is the price I pay for still being around," "I was able to turn it around to something positive," "Something positive has come out of it," "I'm more assertive, I stand up for myself," and "You're aware that time on earth is limited, so you decide what is important." All of these statements indicate that there are certain things about the experience of having cancer that cannot be controlled. Amy's pain was not completely controlled. The memory of a frightening, difficult experience was something they had to live with. The constant realization that the cancer could recur was also stressful. The women compensate for these stressors by believing something positive was derived from the experience of having cancer.

#### Theory and Conceptual Framework

The following discussion relates theory to conceptual framework. The concepts that ground the research include breast cancer, stress, coping, and cancer nursing. Statements that summarize the conceptual framework follow. Breast cancer is a life-threatening disease, the treatment for which is a disfiguring surgery. Treatment also includes chemotherapy or radiation therapy, both of which have very unpleasant

side effects. Even with treatment, there is no guarantee of survival. Stress is a relationship between an individual and the environment that is appraised by the individual as taxing or exceeding her resources. There are physiological and psychosocial stressors associated with breast cancer. These stressors include nausea, pain, breast loss, fears of cancer recurrence, and fears of death. Coping is what the person does to meet the demands she encounters. Coping involves constantly changing efforts to manage these demands. The role of the cancer nurse is to help the individual improve her ability to cope with the demands made upon her. This role includes teaching, emotional support, and providing relief of symptoms.

#### Ethnographic Data and Theory

The following statements describe the relationship of theory and ethnographic data. The phrase within the theory "will obtain support" was elicited from statements informants made concerning the helpfulness of what people did for them. These episodes of support were especially important during the most difficult times of the illness: at the time of diagnosis, prior to and immediately after surgery, and during the initial weeks of chemotherapy. Emotional support as described by the informants included sending cards, bringing meals, expressing concern, and listening. One informant said her husband held her and told her things would be better, and co-workers told her she was missed. Such emotional support helped the informants deal with the experience of breast cancer. As one woman said, "Talking is like a catharsis. It

made me feel better." Another stated, "My friends were the biggest help in getting me through this."

The statement "will take control over what they can control" indicates that control is an important part of coping with breast cancer. Getting control can involve actions to deal with the physical stressors, such as controlling nausea by having someone else cook, controlling pain with medication and hotpacks, and controlling fatigue by carefully scheduling activities. Taking control can also include obtaining information. Cassie and Esther were both aggressive in obtaining information about breast cancer and treatment. Amy was curious, but asked her husband to read for her since her prognosis was bad. She knew he would filter out the disturbing parts. Decora started to read, but stopped when the information she read became too distressing. Taking control can also involve efforts at changing a lifestyle so that it is healthier. This is done to prevent cancer from recurring. Lifestyle changes may involve reducing stress by getting more rest, turning down social invitations, or improving one's diet. Taking control can also involve attempts at controlling emotions and fears by rational thinking. After her diagnosis, Cassie experienced a headache. She immediately thought the pain was caused by cancer metastasis to her brain. Then she decided if there was metastasis it would have shown up on the tests and she said to herself, "Hey, Cassie, don't be dumb. Don't fall into that crap!" Having a positive attitude was another way of taking control. For Amy, such an attitude kept her trying through the long, difficult months of chemotherapy. Regaining control appears

to be a valuable coping strategy in dealing with the stress of breast cancer.

The third part of the theory is "they will compensate for what they cannot control." This phrase was formulated from certain statements the informants made concerning the positive effects of cancer on their lives. The women could not control what they wanted to control most: the fact that the cancer may recur. They had to live with this. Despite surgery, therapy, and their best efforts, cancer may recur in any of these women. The need to find meaning in this experience is a way of getting compensation for their suffering. Believing something positive came from this difficult experience made the experience easier to live with. The positive result for Amy was "finding out my family loves me." Billie was motivated to change her lifestyle and make painting a priority, something she had always wanted to do. Cassie was able to appreciate day-to-day living more. Decora stands up for herself more. Esther feels the cancer gave her time to "improve the quality of relationships and of my life."

#### Ethnographic Data and Review of the Literature

The loss of control over one's life and the need for some control during the experience of living with cancer is discussed in the literature. Both Cassie and Esther did take an active role in determining their therapy. When Cassie did not agree with her surgeon's opinion that she did not require chemotherapy after her mastectomy (she had one positive node), she sought second and third opinions from oncologists who told her that her survival time would be greater with

chemotherapy. Esther's surgeon wanted to remove her non-cancerous breast as a precautionary measure. She sought an opinion from another surgeon who told her that such a precaution was unnecessary, and she declined the surgery. These attempts at control illustrate what Lazarus and Folkman (1985) identified as "problem-focused" coping strategies. Such strategies are aimed at solving the problem that is causing distress. Emotion-focused strategies, those strategies that do not affect the demand but alter the individual's perception of that demand, are demonstrated by compensating. By compensating, the women could deal with those stressors that could not be affected by problem-focused strategies (fears of cancer recurrence and fears of death).

Factors that affect coping include how the family is utilized for emotional support. Northouse (1981) found that some women would not use their families to discuss the mastectomy or concerns about death and dying. Cassie elaborated on this: she did not want to burden her family and friends with her problems, but would be willing to talk to a stranger about the surgery and her fears -- "You don't burden strangers, you burden family and friends." She was also very careful not to be ill around her daughter. Decora also indicated that she tried very hard not to cause concern for her teenage daughter. The literature suggested support groups were helpful for some women, and Amy found this to be so. Three of the informants, whose friends had previously undergone mastectomies, found their support invaluable.

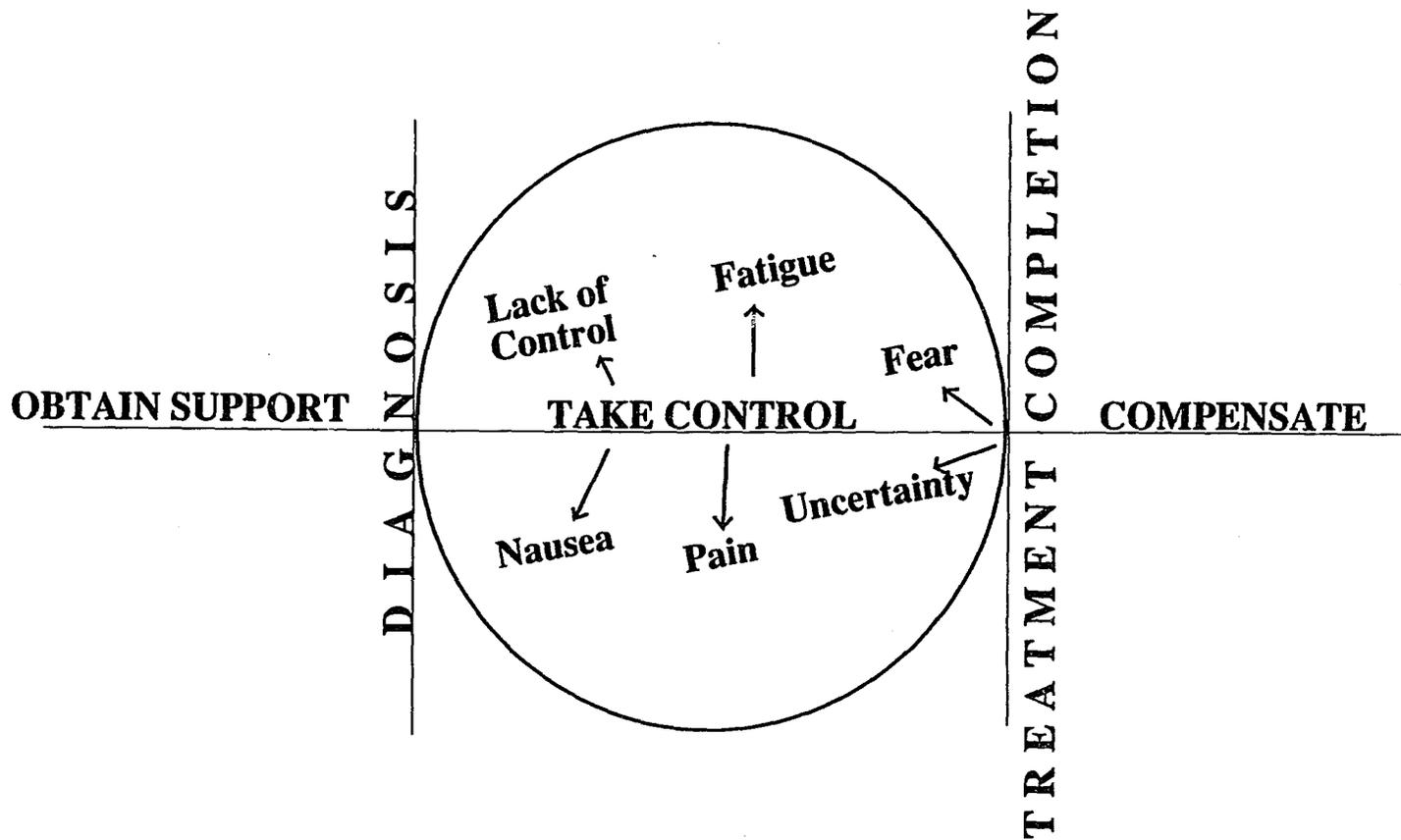
### Nursing Model

A woman begins the experience of breast cancer at diagnosis, at which time she utilizes the coping strategy of obtaining support. This support enables her to deal with the stresses of cancer -- fatigue, hair loss, pain, lack of control, uncertainty, and emotional distress. Many of these stressors, such as fatigue, pain, and nausea, can be controlled. There are other stressors that cannot be controlled: uncertainty about the future and the emotional distress of living with a life-threatening disease. As treatment nears completion, the woman realizes that treatment does not bring a guarantee of survival. She will have to live with the threat of cancer recurrence. She compensates for this with the belief that something positive was gained from the experience of having breast cancer. This compensating continues after treatment has been completed. (The nursing model is illustrated on page 61.)

### Reflexivity

According to Sandelowski (1986), credibility is enhanced when the researcher describes her own experience in relation to the experiences of the subjects. I began this research with several years' experience caring for cancer patients. Listening to them, I became interested in their experiences. I was curious about their ability to remain so cheerful and considerate in the face of living with a life-threatening illness. There were so many aspects of the cancer experience I was not familiar with. I had closely observed people during the acute phases of cancer treatment: surgery and chemotherapy. I was not

# BREAST CANCER EXPERIENCE



familiar with the experience of returning home after surgery, of trying to put a life back together after such a tremendous emotional assault as cancer. I began this research in an attempt to find answers to the question of how women with breast cancer cope with this disease. I learned of the tremendous courage in their ability to persevere under circumstances of fear and uncertainty. Although there were times when the women were quite distressed, they overcame this anguish and persevered. Only one informant had difficulty accepting the mastectomy. The rest of the women found the greatest difficulty of the experience was living with cancer and the threat of recurrence.

#### Limitations

Since several of the interviews were held outside the home in public areas, obtaining privacy for the interview was once a problem. In that case, the informant began to give me an interview while her co-worker was still in the office. I suggested we wait 30 minutes until her co-worker went to lunch, so that the interview could be held in private. In earlier interviews, I sometimes allowed the informant too much freedom in taking control of the interview instead of keeping it focused on my area of inquiry: coping strategies. I dealt with this by taking more control over the progress of the interview. Transcribing the interviews from cassette tape onto computer disk proved an invaluable method of analyzing my interviewing technique and determining ways to improve it. After analyzing five or six interviews, I ascertained that my technique had several flaws: I occasionally interrupted the informant for more clarification while she was still talking, I gave advice

and suggestions on areas they had difficulty with, and I gave them emotional support and some counseling during the interview. I found myself in the interesting position of being a nurse who was trying to be a researcher. I feel these actions may have prevented me from getting as much information as I could have if I had persisted in obtaining data instead of giving advice and reassurance. I changed my technique to overcome these flaws, and I believe the quality of my interviews improved because of these changes.

#### Recommendations for Nursing Practice

Emotional support appears to be of primary importance at the time of diagnosis and surgery. At diagnosis, prior to surgery, and in the early weeks of chemotherapy, the need to express fears, concerns, and anger is tremendous. There appears to be a reluctance among women with breast cancer to discuss the mastectomy and fears of death with their families. The availability of a good listener at this time is of great value. As Cassie said, "I wanted to talk to someone so badly, I really did. I didn't know what I was going to say, I just wanted someone to listen!" Nurses are present at the time of surgery and should make listening a priority. Even five or ten minutes of listening can be very beneficial in helping the woman deal with the fears and concerns of a cancer diagnosis. Encouraging the expression of their fears is often a good beginning. When the woman expresses her fears, the nurse may be able to identify concerns that can be alleviated immediately through knowledge (such as fears about pain and nausea). The nurse can also assure the individual that a cancer diagnosis is not an automatic death

sentence, as many people yet believe. Some women may be able to obtain the emotional support they need through family and friends. Others will not and outside sources of support, such as counseling and support groups, should be encouraged.

By assisting women with breast cancer to identify what can be controlled, the nurse will also help her in coping with her illness. Stressors that can be controlled include nausea, pain, fatigue, and, to a certain extent, fear. An important role of nursing is to provide information on how to achieve control in these areas. This can include information on medication, relaxation and rest, and creative visualization and meditation. Teaching is important, not only because information on how to control stressors is provided, but also because women will be aware that certain outcomes such as nausea and hair loss are expected. This in itself provides relief of anxiety when these stressors do appear.

Monitoring and relief of symptoms are often necessary only in the acute phase of the illness. Yet, much of nursing care in hospitals is comprised of this, while emotional support and teaching receive little attention. My informants indicated that their major needs throughout the illness were emotional support and information on how to deal with the negative effects of breast cancer, chemotherapy, and radiation therapy once they are home.

#### Recommendations for Further Research

The following recommendations are made with regard to further research:

1. Repeat study with subjects who are currently going through treatment. This may provide more intense, accurate information with what they are feeling.
2. Repeat study five years later at the cure point.
3. Study coping strategies of children and husbands of cancer patients.

## APPENDIX A

## COPING STRATEGIES IDENTIFIED BY INFORMANTS

The following sections list coping strategies identified by the study informants. The strategies are excerpted from the interview transcriptions.

Actions TakenAmy

I tried to outwit the side effects of the chemotherapy by having someone else cook for me when the smell of food made me sick.

I became aware of degrees of pain, and aware of getting it under control before it got bad.

I set limits on my activity, so that the pain wouldn't be intolerable. Most afternoons I lie down for two hours. I try to sleep or read. I used hotpacks to deal with the pain.

Cassie

I feel I need a holistic approach to my well-being. I do this with diet and exercise and by changing my lifestyle, by decreasing stress. I went to a class and learned to meditate.

Creative visualization and meditation helped. I could meditate my nausea away.

I visualized my body producing all of these good white cells, then just turning them loose . . . going through my body and zapping anything they came across. If there were cancer cells in my body I would mentally terminate them.

Decora

My hair came back white after the chemotherapy. I had it colored because I couldn't stand it.

Work helped, I got a lot of support there.

I took a trip to Mexico with my husband to get away.

I made a chart on what comes up -- if one day is worse, I think about what happened that day. If my back ached it was because I wore high-heeled shoes.

It was very hard when the chemotherapy stopped. In one way I was relieved. In another . . . I want to do something to make sure it [cancer] doesn't recur. I knew the therapy was doing something positive. Now there is nothing I can do. Then I decided that even though the treatment stopped there are things you could do for yourself -- join a health club, exercise, and maintain a proper diet.

#### Emotional Support

##### Amy

I discovered that life is worthwhile even with discomfort. I learned how nice people were.

My family helped, they made me feel needed. I couldn't let them down. I would have stopped chemotherapy if it hadn't been for them.

I took an overdose of aspirin. No one listened to me when I told them how much I hurt.

##### Billie

My friends were the biggest help in getting through this.

You know how much you love your parents. You don't know how much your parents love you until something like this happens.

##### Cassie

I got support from some friends but not all of them and that was very, very disappointing and very distressing. Quite honestly, it was. Having someone recognize my suffering would have made me feel better.

I am an extremely private person, but at this time I found myself telling complete strangers that I had recently had a mastectomy. Under normal circumstances I would never have done that. I just wanted to talk to someone so badly. I really did. I didn't necessarily want someone to talk back -- just listen. I don't know

what I was going to say. I just found myself thinking over and over, "I had this mastectomy, I'm having this God-awful chemotherapy, I feel so shitty, please care."

I got comfort, I needed more. I wouldn't let myself make my needs known to those around me.

One friend was so supportive, always pushing me in the right direction.

The support of family and friends helped me keep giving to others.

### Decora

People were telling me, "You look good." I wanted to say, "Hey, inside I don't feel so good." I wanted people to sympathize with me.

People focus on the physical, they don't understand the emotional stress. People concentrated on how well I looked.

### Esther

I talked with my family . . . about being afraid, about not having a very long life.

People sent cards; brought meals, all kinds of things. I really felt cared for. At work [when she went back] people said, "You're staying too long. Go home!"

My family never treated me like I was ill. That was helpful. They expected me to get well.

My husband held me and told me things would get better.

People at work let me know I was missed.

When I found I was going to have surgery, I called friends around the country to generate positive thoughts.

I stopped people in the hall [at work] to let them know I was having surgery. I was trying to generate as much support as possible.

Talking is like a catharsis. I wanted to get rid of it. Talking made me feel better.

Positive Outcomes (Later Became Compensating)

Amy

I do things now because I want to do them, not because I feel I should.

Pain is the price I pay for still being around.

I realized [when she thought she didn't have long to live] that there are worse things than dying when you are hale and hearty. You could be old and have all of your friends gone.

I thought of the things I wouldn't have to put up with any longer. I wouldn't have to endure income tax and bad weather!

I lived in the present and didn't plan ahead far. I didn't make plans for more than six months at a time. That way, if cancer recurred, it wouldn't have been as big an adjustment.

I realized [after going through the experience of having cancer and reviewing her life] that I'd become the sort of person I admire.

Having cancer made me learn what was important and what wasn't. I found I was much loved.

One lady [at Reach-to Recovery] told me I had made a difference. That meant my pain and suffering was worthwhile.

I have resolutions [if the cancer returns]. I've had a good life, an interesting life. I've had a lot of friends and a lot of affection.

Billie

Breast cancer made me focus my life on painting. I was able to grow from it, to turn it around to a positive thing.

I realized we want certain outcomes, but not necessarily the way they come to us.

It [cancer] changed me inside, having cancer was absolutely necessary for me to learn.

Cassie

I put more emphasis on day-to-day living. I try to make each day count. I pick my fights much more carefully.

I think about my daughter and realize: I may not have much time to spend with this young person. The time I have with her I want to be a good time. I want her to remember me in a positive manner.

### Decora

I started being more assertive in therapy. I was very angry, I was looking for an outlet for my anger. Now if people tell me something I know isn't right, I answer right back.

When I found I didn't have forever, I started doing things for me.

I'm more assertive, I stand up for myself. So something positive has come out of it. I think I handle my own life better than I did a year ago.

### Esther

I do find I'm more open with people in general.

Time has become more valuable. I'm less of a procrastinator. I live life to the fullest.

It [cancer] gives you time to improve the quality of your life and of your relationships. You realize you are mortal. I realized that relationships were important to me, but I didn't do much about them.

I'm more sensitive, I think more about how my actions will affect other people.

I try to let other people know I care about them as people. I'm sure my friendships have improved.

I'm more organized. I waste less time.

I talk to my parents every day. I called friends I haven't seen in awhile.

I've become aware that there is just a limited time on this earth. I needed to decide what is important to me and how I am going to spend that time.

### Getting Control

#### Amy

I was afraid of reading [about breast cancer] because my prognosis was so bad. I had my husband read for me instead.

I took some control by driving to my chemotherapy treatments and by planning activities.

I believe an illusion of control helps. By changing my medication schedule and taking Cytoxan in the evening so I could keep two meals down. I'm not sure if that really helped but I like to believe it did.

Before surgery, I went to a lawyer and had a new will made up.

Knowing the side effects of chemo were expected helped me endure them.

I was at a party recently and I was having pain. I left early, went home, and took aspirin and put hotpacks on. I told my husband to stay and make apologies to our hostess while I slipped away. I didn't want to make a big thing of it.

#### Billie

I believe our minds control our bodies. I believe we are responsible for what happens to us. So it [your life] can be whatever you want it to be. It makes you feel good to have more power and not be at the mercy of the elements.

I feel I brought this [cancer] on myself and I could have taken it away without the surgery.

#### Cassie

I asked my husband to ask the nurses he knew for the name of a good surgeon.

I obtained second and third opinions about the need for chemotherapy.

I chose the oncologist I was most comfortable with, someone who would look beyond the cancer and see me.

I called the American Cancer Society and asked for a book on exercises.

I was able to cope with having cancer because of my knowledge. I knew a cancer diagnosis wasn't an automatic death sentence.

If the mind can make you sick, it stands to reason that the mind can make you well.

I think a lot of illness is based on stress in our lives . . . I think stress contributed to my developing the disease. I believe a lack of stress is going to keep me from developing it in the future. I lower the stress in my life by turning down social functions. If I don't feel like spending time with people I say, "No, I'm not going." In the past I would have put a smile on my face and played the role.

I made a point of never being sick around Kristen [her teenage daughter].

### Decora

I made an effort to get dressed when I went to chemotherapy treatments. I thought if I didn't look sick, I wouldn't feel sick.

I told my physician I wasn't having back pain [even though she was] because I couldn't face one more thing. [She understood he was concerned with metastasis.]

You have to learn to think with your intellect rather than your emotions. When I get pain and immediately think it may be metastasis, I tell myself, "Hey, knock it off."

I got control by making as many choices as I could.

Initially [after the diagnosis], I felt a real loss of control in my life. I felt nothing I could have done would affect the outcome.

I believe in another dimension [God], that there is something there. It may be a cop-out or a crutch, and it is, but it helps . . . It feels as if there is someone who might have control. It's comforting.

### Esther

Knowing what is going to happen beforehand helps. You can put up with almost anything knowing the outcome will be different.

I worked the entire time, staying busy, working, feeling needed was important. It helped.

I learned tricks while taking chemotherapy. I found if I had something to eat right away in the morning, or had something in my stomach every two hours, I felt better.

I changed my schedule. I worked on papers and talked to my son early in the morning when I felt better and was less fatigued.

I got my hair cut short when it was falling out. That helped control it.

### Keeping a Positive Attitude

#### Amy

A good attitude affects the outcome; it keeps you trying.

I helped myself by being cheerful and living as normally as I could.

I look for the bright side in the clouds. I look for the pleasant things in what happens.

I would think at the end of the day, "Well, it's been a good day."

#### Cassie

I tried to keep a very positive attitude. I think I had such a positive attitude that I just decided I wasn't going to die of cancer.

I recognized in both situations [the death of her father and her own cancer diagnosis] that life goes on.

Then you recover [after the diagnosis of cancer] and the thoughts leave your mind. You don't think about it [having cancer] constantly. It's like a grieving process.

I get fleeting thoughts about the pain being metastasis . . . but then I think, "Hey, Cassie, don't be dumb. Don't fall into that crap."

I have a goal and that is to see my beloved little girl grow up. It means more to me now because it may not happen.

I wanted to talk about it. Then you start feeling sorry for yourself and thinking no one cares . . . and they do. Then you take control again.

You keep people around you by being cheerful. Otherwise you drive people away.

### Decora

You might as well be dead if you are living from checkup to checkup. I avoid that by trying to be positive. I try to not let this totally encompass my life.

When I have pain, I first think it's [cancer] in my liver. Then I think, if it is there it would have showed up two months ago in my bloodwork.

After the surgery, I was Miss Morbid for a week. I didn't dress, I didn't wash my face, brush my teeth. I looked depressed. Then I went back to work and got myself together.

By making an effort to look good, you are less apt to internalize things and feel sorry for yourself.

I find myself gravitating toward people who are doing well and have been in remission for five years.

### Esther

I don't know what is coming after I die . . . if there is a heaven or hell. If there is nothing else, I want to make the best of what I've got now.

**APPENDIX B**

**SUBJECT DISCLAIMER**

**SUBJECT DISCLAIMER**

You are being asked to participate in a study of women with breast cancer who have completed treatment. The title of the study is "Coping Strategies of Women with Breast Cancer." The purpose of this study is to obtain information on specific coping strategies used by women who have breast cancer. There are no known risks associated with this study. I will require about 45 minutes of your time for the interview. By participating in the interview you will be giving your consent to participate in the study. You may feel free to not answer any of the questions and to terminate the interview whenever you wish. Your identity will not be known, as I will not take names and the information will be coded. I and the three members of my thesis committee will be the only individuals who will have access to this data. You may feel free to ask questions at any time and have them answered.

Marcia Hackman, BSN, RN  
Graduate Student  
University of Arizona

APPENDIX C

HUMAN SUBJECTS APPROVAL



## THE UNIVERSITY OF ARIZONA

TUCSON, ARIZONA 85721

COLLEGE OF NURSING

## MEMORANDUM

TO: Ms. Marcia Hackman

FROM: Linda R. Phillips, PhD, RN, FAAN *LRP*  
Director of Research

DATE: March 3, 1988

RE: Human Subjects Review: Coping Strategies of Women with Breast Cancer

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee of the Research Committee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

LRP/ms

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