Difficulties Faced by Young Mothers with Breast Cancer Nicole Todorovich

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Difficulties Faced by Young Mothers with Breast Cancer

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This thesis for honors recognition, completed by Nicole Todorovich, has been approved for the Department of Nursing.

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ABSTRACT

Breast cancer is extremely prevalent in today’s society, yet little research has been done to investigate the effects a breast cancer diagnosis may have on a young mother and her family. The purpose of this qualitative study was to examine the difficulties experienced by young mothers with breast cancer. Grounded theory methodology was used to analyze data obtained from three women interviewed after completing treatment for breast cancer. Each woman was under the age of forty at the time of diagnosis, was married, and had at least one dependent child. The themes: (a) finding a breast lump, (b) taking an active role, (c) facing stress, and (d) looking to the future were identified as part of the breast cancer experience for each of the women interviewed. These four themes came together to create the core concept of taking control. Further research on the problems faced by young mothers and their families is needed to determine how nurses and other healthcare providers can prepare and educate patients and reduce or prevent some of the difficulties faced by the women in this study.
Young Mothers with Breast Cancer

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Fellow honors thesis students were also helpful throughout the project. Not only did they provide a support network but also were great resources for research tips, proofreading, and increasing creativity.
DEDICATION

This honors thesis is dedicated to my mother Valerie. Breast cancer took her from me when she was only thirty-six, yet her memory is with me everyday. She was loved by many for her strength and love of life and remains an inspiration to me even from heaven.
CHAPTER 1

INTRODUCTION

Women in the United States have a 1 in 7 chance of developing breast cancer (American Cancer Society, 2004). Currently, 250,000 women in the United States under the age of 40 are living with breast cancer. In one year, an estimated 11,000 women under the age of 40 will be diagnosed with breast cancer and 1,300 of those will die from the disease (Young Survival Coalition, 2004). Many women under the age of 40 have at least one dependent child. The Center for Disease Control (2002) announced that in the year 2000, the average American woman had her first child at the age of 25. Mothers diagnosed with breast cancer will face telling, teaching, and coping with breast cancer with their spouse and children. Health care providers, especially nurses, need to be aware of the family issues and concerns that can potentially occur because of a breast cancer diagnosis. The purpose of this research is to identify and investigate the problems and difficulties faced by young mothers with breast cancer.

Risks for Breast Cancer, Etiology, and Pathophysiology

There is no single etiologic agent for breast cancer. Researchers and physicians conclude that it can be attributed to multiple factors (American Cancer Society, 2004). One important predictor of risk for breast cancer is age; as age increases so does risk. Women with personal or an immediate family history of breast cancer are also at an increased risk for breast cancer. Starting menarche before the age of 12, a first pregnancy after the age of 35, and not beginning menopause until after the age of 55 all increase a women’s risk of breast cancer (Lowdermilk, Perry & Bobak, 2000). Other questionable risk factors still under investigation are long-term estrogen replacement therapy, a diet
high in animal fats and low in fiber, physical inactivity, and alcohol abuse (Ignatavicius & Workman, 2002).

Incidence and death rates from breast cancer are normally higher in Caucasian and African American women than in other racial and ethnic groups. Before the age of 40, African American women have a slightly higher incidence and mortality rate than Caucasian women. However, after the age of 40, Caucasian women’s incidence rate increases above those for African American women (American Cancer Society, 2000).

Breast cancer originates in the breast, which is made up of lobules or milk production glands, ducts that connect the lobules to the nipple, fat, connective tissue, and lymphatic tissue. There are several pathologic types of breast cancer. The most common type of breast cancer is ductal carcinoma. Other types include lobular carcinoma and nipple carcinoma, also called Paget’s disease (Ignatavicius & Workman, 2002). Breast cancer can either be invasive or noninvasive. Noninvasive, or in situ breast cancers are confined to the area at which they originated. Ductal carcinoma in situ is confined to the mammary ducts and lobular carcinoma in situ is confined to the lobules. The majority of these types of cancers will not become invasive and are easily cured. Invasive, also called infiltrating breast cancers actually grow through the mammary ducts or lobules and spread into the surrounding tissues. The rate of growth is dependent on hormonal influences and the seriousness of the invasion is dependent upon the stage at which the cancer is in when it is diagnosed (Lowdermilk et al., 2000).

Signs, Symptoms, and Complications

The most common initial symptom of breast cancer is a lump or mass in the breast. The lump may feel hard, fixed, soft, or spongy and the edges of the lump may be
well defined and smooth or very irregular. Also, bloody or clear nipple discharge, nipple inversion, and nipple tenderness may be present (Lowdermilk et al., 2000). A dimpling orange peel appearance on the skin of the breast is known as peau d’ orange and is also a common sign of breast cancer (Ignatavicius & Workman, 2002). Diagnosing breast cancer in younger women, or women under the age of 40, is more difficult because their breast tissue is often thicker, therefore making it more difficult to palpate a mass or tumor. Often, by the time a tumor is detected in a younger woman, the breast cancer is advanced enough to decrease the woman’s chance of a positive treatment outcome (Susan G. Komen Breast Cancer Foundation, 2003). Many young mothers also find it difficult to integrate a monthly self breast exam into their busy schedule or simply do not feel it is crucial to perform these exams at such a young age. It is very important however, that all women complete monthly self breast exams and become familiar with how their breasts look and feel so that early detection of any irregularities is possible.

*Impact of Breast Cancer on Young Mothers*

*Ethical.* Genetic testing can be done to help determine a person’s risk for developing breast cancer. Ten percent of breast cancer cases are a hereditary form of the disease. Inherited alterations in the genes BRCA1 and BRCA2 are involved in a large number of breast cancer cases. Women who inherit the BRCA1 or BRCA2 gene have an increased risk for developing breast cancer. Genetic testing can determine whether or not a person carries the BRCA1 or BRCA2 gene (National Cancer Institute: Genetic Testing, 2002). While genetic testing has brought about widespread interest because of its ability to screen for cancer genes, those considering testing must consider some important questions: Are they ready to handle the emotional responses to learning their genetic
makeup? How accurate are the genetic tests? How expensive is the testing? What are their health care choices after genetic testing?

Tamoxifen has been used for the past 20 years to prevent recurrent cancer in breast cancer patients and is currently being studied for the use in the prevention of breast cancer. Estrogen promotes the growth of breast cancer cells and Tamoxifen acts against the effects of estrogen in the breast tissue. A study funded by the National Cancer Institute known as the Breast Cancer Prevention Trial found a 49 percent reduction in the diagnosis of invasive breast cancer and a 50 percent reduction of noninvasive breast cancers among women who took Tamoxifen. Tamoxifen is not without its risk however and the decision to take the drug should be carefully considered (National Cancer Institute: Tamoxifen, 2002).

Women with a high risk of breast cancer can choose to have a prophylactic bilateral simple mastectomy. A simple mastectomy usually includes surgically removing all the breast tissue including the nipple but leaving the lymph nodes intact (Ignatavicius & Workman, 2002). Meijers-Heijboer, van Geel, van Putten, and Henzen-Logmans (2001) found that after a median follow-up of 14 years, 76 women who had a prophylactic bilateral simple mastectomy had reduced their risk of breast cancer by 90 percent. While the surgery does reduce a woman’s chance of getting breast cancer, it is not a guarantee breast cancer won’t develop in the very small amount of tissue remaining after the surgery (American Cancer Society, 2004).

Financial. Woman diagnosed with breast cancer may be faced with a tremendous financial burden. Besides hospital bills, cancer treatment can include many expenses not covered by insurance including some medications, transportation, complimentary
therapies, and child care. If the patient is also losing income or does not have insurance a
cancer diagnosis can quickly become a financial crisis (Cancer Care, 2003). Because of
the higher costs of cancer care nurses can play an integral role in helping patients find
alternative sources or financial assistance. Nurses may explore less expensive
complementary and integrative therapies for cancer patients or direct patients to
“company-sponsored ‘medications for the indigent’ programs,” (Ignatavicius &
Workman, p 435). Nurses may also suggest patients search the Helping Hand Resource
Database and contact the American Cancer Society or their local United Way (Cancer
Care, 2003). There are many other financial assistance resources available through
hospitals, the government, and other private organizations (National Alliance of Breast
Cancer Organizations, 2004).
CHAPTER TWO

REVIEW OF LITERATURE

The cancer experience is not an independent event but instead one that affects the family unit as a whole (Matthews, 2003). For nurses, providing care to cancer patients and their families can be challenging (Ignatavicius & Workman, 2002). Nurses must assess at the time of diagnosis and throughout treatment the patient and family’s needs for emotional support and information.

The Diagnosis

*You have cancer.* Being diagnosed with breast cancer can be overwhelming for both the woman and her family (Hilton, Crawford, & Tarko, 2000). Guernsey (2003) interviewed several breast cancer survivors about their feelings at the time of diagnosis. Feeling shocked and angry were common themes. One woman stated that after learning of her diagnosis she felt she “had wasted her life; there was so much more I’d meant to do” (Guernsey, 2003, p 146). Another woman expressed how everything happens so quickly and there are inevitable thoughts of dying (Mellon, 2002). Kirsch, Brandt, and Lewis (2003) found that many mothers focused on limiting the intrusion of breast cancer into their families.

*Telling the husband.* Husband’s distress levels concerning their wives breast cancer are highest at the time of diagnosis. Shock, fear, and feeling overwhelmed were some of the men’s reactions to the diagnosis. Some men admitted to fits of outrage after the realization of the illness. Once the terror and emotional roller coaster subsided, the men began to focus on the family and how to keep life normal through the cancer treatments (Hilton, et al., 2000).
**Telling the children.** Kirsch et al. (2003) found that mothers with breast cancer and their husbands had the most difficulty telling their children the diagnosis. Many parents worry they will scare their children (Kirsch et al.). The Massachusetts General Hospital Cancer Center supports a counseling center to help parents with cancer talk to their children. The program has also developed and published a set of guidelines that any parent with cancer can use to help them and their children get through the challenging time. The guidelines focus on teaching parents to use honest, open, and age appropriate communication skills. It also aids parents in deciding when and how to tell their children, recommending that parents be straightforward and avoid withholding information. Parents are also told to encourage the children to ask questions and allow them to attend doctor visits or the hospital (Rauch, Muriel, & Cassem, 2002). Kirsch et al. found that after receiving a cancer diagnosis, instead of privacy, a family wants immediate assistance in providing age appropriate information to children and enhancing parent-child relationships. Nurses can be a useful resource for parents who are having difficulty telling their children about a cancer diagnosis.

**Treatment Options**

Breast cancer treatment is aimed at prolonging the length of life for the patient or enhancing her quality of life (Ignatavicius & Workman, 2002). Over the past several years there have been great increases in variety and improvements in the quality of breast cancer treatments. These changes give women diagnosed with breast cancer and their families more treatment options (Breast Cancer.org, 2004).

**Surgery.** The oldest, most widely used treatment for cancer is surgery (Ignatavicius & Workman, 2002). Several surgical options for breast cancer patients
include lumpectomy, simply mastectomy, modified radical mastectomy, and radical
mastectomy. In a lumpectomy, the surgeon actually removes the breast cancer tissue as
well as some of the surrounding tissue. To determine if the cancer has spread, the lymph
nodes may also be removed (National Cancer Institute: Treatment, 2003). Radiation
treatment nearly always follows a lumpectomy in order to completely eliminate any
cancer cells that may be remaining in the breast tissue (Breast Cancer.org, 2004). When
cancer is found in more that one area of the breast, the breast is too small for a
lumpectomy, or the woman does not want radiation therapy, a mastectomy is
recommended. In a simple mastectomy, the entire breast is removed as well as some
lymph nodes under the arm. With a modified radical mastectomy, the entire breast is
removed along with lymph nodes and the lining of the chest muscles. Radical
mastectomies include removal of the entire breast, all lymph nodes under the arm, the
lining over the chest muscles, and part of the chest wall muscle (National Cancer
Institute: Treatment). All surgeries contain risks and uncertainties. These can include
infection, bleeding, excessive scar tissue, and reaction to the anesthesia (American
Society of Plastic Surgeons, 1993).

Radiation. Ionizing radiation is most commonly used to treat malignant tumors
(Ignatavicius & Workman, 2002). A machine directs radiation beams at the breast and
sometimes the lymph nodes and collarbone. The radiation beam damages all cells within
its path, including normal cells (Breast Cancer.org, 2004). The radiation oncologist will
base each woman’s treatment dose on size and location of her tumor, past mammograms,
pathology, and lab reports (Ignatavicius & Workman). Radiation therapy is normally
scheduled for 5 days a week for 5 to 6 weeks. (National Cancer Institute: Treatment,
2003). This series of divided doses is to allow multiple opportunities to kill the cancer cells that may have varying responses to the radiation. The short and long term side effects of radiation are restricted to the tissue exposed to the radiation (Ignatavicius & Workman). Fatigue and altered taste are the most commonly reported side effects. Skin problems are also common and include redness, soreness, darkening, peeling, decreased sensation, and heaviness. Shape changes can also occur (National Cancer Institute: Treatment).

Chemotherapy. Chemotherapy treats cancer systemically, killing cancer cells that may have escaped surgery or radiation. It is the use of strong chemical agents to cure, increase survival time, and decrease cancer spreading (Ignatavicius & Workman, 2002). Chemotherapy is given intravenously or orally in cycles, with days to weeks allowed for recovery. The type, dose, and length of treatment are based upon the extent of the cancer. (National Cancer Institute: Treatment, 2003). Chemotherapy affects all rapidly dividing or fast growing cells in the body including the cells of the gastrointestinal tract. As a result, nausea and vomiting are the most commonly reported and often the most severe side effects of chemotherapy (Dibble, Israel, Nussey, Casey, & Luce, 2003). Fatigue, hair loss, and mouth sores also commonly occur (de Jong, Courtens, Abu Saad, Schouten, 2002). Immunosuppression, anemia, and decreased platelets are other serious side effects (Ignatavicius & Workman).

Breast reconstruction. Surgically reconstructing the breast immediately after a mastectomy is a relatively new practice (Ignatavicius & Workman, 2002). The option to rebuild the breast can be especially important to young women with breast cancer. The patient can choose to wait and have her breast reconstructed after weighing her options
and completing cancer treatment. The reconstruction can also occur immediately after the mastectomy so the patient would wake up with the breast reformed and would never experience seeing herself without a breast. There are several options in post mastectomy reconstruction. One option is skin expansion. In this procedure a skin expander is placed beneath the skin after the mastectomy and is periodically filled with a solution to stretch the skin preparing it for a more permanent implant to be inserted later. Another option is flap reconstruction, which includes several different approaches. Flap reconstruction includes using donor tissue from other body sites. All breast reconstructions involve several procedures over a period of time. Because there are many options for breast reconstruction, a woman considering the procedure should explore with her doctor what is best for her. Side effects of breast reconstruction are those that accompany all surgeries including scars and capsular contracture (American Society of Plastic Surgeons, 1993).

*Patient participation in decision making.* A wide variety of treatment options result in more difficult decision making for the breast cancer patient and her family. Patients defined their participation in decision making as asking questions, obtaining information, and actually choosing from alternative treatments (Sainio, Eriksson, & Lauri, 2001). A family member’s response to treatment options can either enhance or impede a patient’s decision-making ability (Sahlberg-Blom, Ternestedt, & Johansson, 2000). Factors that may influence a patient’s participation in decision making include encouragement from a physician or nurse, the patient being treated as an equal by health care professionals, and having enough time to weigh all options (Sainio et al.). Budden, Pierce, Hayes, and Buettner (2003) found that 36% of women felt that choosing the fastest treatment option was important while 55% felt being an active participant in the
treatment decision was more important. Nurses must assess for individual factors that may encourage or impede patient and family decision-making abilities and they should never force their personal values on the patient (Wilkes, O’Baugh, Luke, & George, 2003).

The Husband as Caregiver

A majority of husbands become actively involved in their wives breast cancer treatment and recovery. Few husbands provided direct care, instead focusing on household chores, taking care of the children, and keeping the family together and as normal as possible (Hilton et al., 2000). Stress accompanies the increase of everyday responsibilities. In addition to stress the caregivers experience loss of sleep, decreased health, feeling trapped (Grbich, Parker, & Maddocks, 2001), fear of losing their loved one (Matthews, 2003), and changes in their family’s quality of life (Dow & Lafferty, 2000).

A roller coaster of emotions. In one study, the experience of breast cancer for the caregiver of the women with breast cancer was strongly influenced by the severity of the illness and the treatment of choice. Grbich et al. (2001), found caregivers’ emotions concerning the process of caring for a loved one with cancer was nearly always observed as both negative and positive. Most negative emotion was during the caregiving experience where caregivers felt tired, unable to cope, lonely, and stressed. Positive emotions were expressed after the care giving experience such as caregivers being proud of themselves for being able to manage taking care of a sick loved one as well as maintaining normal life. Others were happy they were given the chance to take care of their loved one and knew the loved one was appreciative (Grbich, et al.).
*Family Learning*

In past research on breast cancer patients and their families, obtaining knowledge and family learning emerged as important aspects of the breast cancer experience. There are endless sources of information including health care providers, books, support groups, websites, and brochures. One woman who felt angry and hopeless just after her breast cancer diagnosis, later had a revelation and became overwhelmed by the amount of knowledge she could obtain by doing research and stated, “I felt an obligation to be well informed,” (Guernsey, 2003).

*Interactive family learning.* Interactive family learning involves gathering a substantial amount of information from many resources to increase knowledge. It also includes attempting to bring many pieces of the breast cancer puzzle together to form a larger picture that will help the family get through the breast cancer illness. One of the easiest, most accessible modes of learning for families is comparing and reflecting on past experience. By sharing past experiences, both positive and negative memories surfaced and the family was able to use these memories to plan how they will act in the future. Sharing information gathering is another mode of family learning. Each family member actively sought information from several sources and then shared the information with the rest of the family. Experiential learning is one of the more difficult modes of learning. Research has found that this type of learning is interactive and patients and their families learn from their own experiences. This includes what to expect after treatment and how to handle new schedules and family roles. Interactive family learning facilitates knowledge building as well as trust between family members and confidence in the health care providers (Friesen, Pepler, & Hunter, 2002).
School's role in providing information to the children. Chalmers, Kristjanson, Woodgate et al. (2000) found that adolescent children of women with breast cancer received minimal information and support from school and even less from the health care system where their mothers were being treated. Many adolescents suggested teachers and guidance counselors be trained to enhance their skills in responding therapeutically to students' emotional needs (Damore-Petingola, Lightfoot, Vaillancourt, & Mayer, 2002). While it is not realistic to expect the classroom to provide specific needed information and support for adolescents of women with breast cancer, the school system, including teachers and other professionals, can potentially be helpful in a variety of ways. These include providing factual information about cancer disease process and statistics, positive information on cancer prevention, and acting as a communication network between school, adolescents, family, and the health care system (Chalmers et al.).

The Nurses Role

Nurses are information sources on treatment's mechanism of action and side effects. Providing information can enhance coping and decrease anxiety (Mellon, 2002). One major nursing intervention for patients, especially those undergoing chemotherapy, is to help manage negative symptoms. Nurses can also teach women and their families about other treatments such as stem cell transplants, bone marrow transplants, hormonal therapy, and immunotherapy (Breast Cancer.org, 2004). The use of alternative therapy is increasing. Nurses can assess for and learn about the most commonly used and sought after alternative therapy so they may educate patients about the safe use of these therapies (Lengacher, Bennett, Kip, Beraducci, & Cox, 2003).
Nursing staff is an important aspect of the caregiver support system. Kozachik et al. (2001) found that consistent nursing interventions including care monitoring, family education, emotional support, and coordination of services, could actually slow the rate of depressive symptoms commonly experienced by caregivers. Because recent changes in the dynamics of the American family have increased the number of children being put into the caregiver role, nurses need to educate the families of women with breast cancer that children and adolescent age caregivers can potentially suffer in school, have behavior changes, and spend significantly less time with friends just being a kid (Lackey & Gates, 2001). Nurses must assess the family and caregiver’s coping styles in order to balance the extent of provided information and support (Nikoletti, Kristjanson, Tataryn, McPhee, & Burt, 2003). Nurses can also suggest ways to manage stress such as taking breaks and leaving the house, asking for help, listening to music, and talking to someone (Grbich et al., 2001).

The families of cancer patients rate the need for information from health care providers even higher than that of emotional support (Eriksson & Lauri, 2000). Saninio & Erickson (2003) found that half their research subjects felt they had not received enough information about the illness, prognosis, treatments, side effects, and alternative therapies. Chelf et al. (2002) found the most favored method for learning about cancer topics was talking with the doctor followed by brochures and booklets, talking with nurses, self selecting other reading material, and talking with cancer survivors. Age, gender, family support, and employment status also affect patients desire to obtain information and willingness to learn (Saninio & Erickson). Nurses must assess early on the patient’s preferred way of learning and use that information to access favored
resources and maximize total learning (Jahraus, Sokolosky, Thurston, & Guo, 2002).

Health care providers, especially nurses, have a great deal to offer breast cancer patients and their families but play an especially vital role in education (Ignatavicius & Workman, 2002).

A Lack of Research

Wright and Leahey’s Family System Theory states that when one family member experiences a change, the change affects the entire family (Lowdermilk et al., 2000). Most cancer patients state that the single most important coping strategy was family support (Kyngas et al., 2001). There is minimal research on the role and importance of family during the breast cancer experience of a young woman. Also, much of the research that does exist only makes general suggestions in the way a nurse can intervene and improve family coping through this difficult time. There is a substantial void in the research concerning specific ways nurses and other health care professionals can have a positive impact on the family of a young mother with breast cancer.
CHAPTER 3

METHODOLOGY

The purpose of this qualitative grounded theory study is to examine the experience of young mothers diagnosed with breast cancer and to identify a central theoretical framework for nursing practice.

*The Basics of Grounded Theory*

Barney Glaser and Anselm Strauss developed grounded Theory in the 1960s. In contrast to other research methods, Grounded Theory does not begin with a theory but instead accumulates data in a specific interest and then formulates and suggests a theory based on the findings (Fain, 2004). Using this methodology, the researcher progresses in the direction of an interest area without a specific research question or problem in mind. Through theoretical sampling and analyzing by constant comparison, a research focus will emerge (Glaser, 1992). Grounded Theory study usually focuses on a process, such as people’s actions and interactions, related to a topic with the ultimate goal of developing a theory about that process. The concluding theory is grounded in the data (Norton & Fowler, 2004).

There are many advantages of this research method including that it provides a structured and relatively systematic way of trimming a large body of data into a concise conceptual framework that describes and explains a particular phenomenon. Also, this method can be applied to many fields of study for very diverse topics. However, Grounded Theory does require extreme precision and insight on the part of the researcher. Consequently, the novice researcher who aspires to use this methodology is at a great disadvantage (Davidson, 2002).
Sampling Procedures

A purposeful sample of three, English speaking, Caucasian women residing in the Western part of Montana were the subjects for this research study. The participants were obtained through referrals from individuals who became aware of my interest to study young mothers with breast cancer. Participation was voluntary and all volunteers signed an informed consent form indicating the purpose of the research, confidentiality, and the risks and benefits of contributing. At the time of their diagnosis, each woman was younger than 50 and was still caring for dependent children at home. The mothers varied in age, marital status, number of children, occupation, economic status, and length of time since the diagnosis.

Data Collection

Formal interviews, informal interviews, and participant observation are three ways in which data may be generated when using Grounded Theory (Fain, 2004). For this research study only informal interviews were used. The interviews began with the general open-ended question, “Please tell me about your breast cancer experience.” As a theory began to emerge more specific questions were asked to help saturate the categories already established. All interviews were conducted at a mutually agreed upon location and tape-recorded for later analysis. To further protect the rights of the participants, once the interview process began, the women’s names were no longer used and each was given a pseudonym to represent their interview data. For the purpose of this study, each participant will be referred to as Ann, Barb, and Cathy.
Data Analysis

In Grounded Theory, data collection and data analysis are often completed simultaneously. The first step of data analysis is open coding (Fain, 2004). Each transcribed interview was read line-by-line and general repetitive patterns and concepts were identified. Each pattern or concept was coded, or named, and its properties were described. Lines of the transcribed interviews were coded as many ways as possible. A small notebook was kept containing a list of every code, the code’s description, and in what interview the code was found.

The second step of data analysis in Grounded Theory involves axial coding. During axial coding the codes were examined and compared. Relationships between codes were discovered and clusters formed. The clusters of codes were then analyzed and themes began to emerge. Related themes consistently seen throughout the data contributed to the development of a core category.

Once a core category was discovered, axial coding ended and the third step began (Fain, 2004). This third step, called selective coding by Strauss and Corbin (1998) and theoretical coding by Glasser (1992), involved discovering a structural relationship between the core category and other categories (Kendall, 1999). The categories were systematically refined and a new construction of categories was built around the core category. This type of analysis helped to piece back together all the codes and formed an outline or framework for the problem or story relevant to each of the research participants. Once a final theoretical framework was discovered each interview was examined again to ensure the core category was relevant and applicable to each participant. The core category and its framework served as a foundation for the
generation of a theory (Byrne, 2001). The outline formed by the core category and its subcategories also began preparation for the writing stage.

**Biases and Limitations**

Fain (2004) recommends completing a review of literature after all data has been collected and a theory has emerged. This is to avoid the researcher having preconceived notions of themes or concepts about the data that may or may not be relevant. I began an extensive review of literature before beginning any data collection. The review of literature was broad however, covering many topics related to young mothers who experienced breast cancer.

Cancer is very prevalent and therefore nearly everyone has experienced cancer because either they or someone close to them has been diagnosed. I myself have a strong interest in this subject of research due to my mom’s experience with breast cancer when I was 11 years old. My childhood experience may have biased this study. Although, Glaser (1992) states, “Professional experience, personal experience, and in depth knowledge of the data in the area under study truly help in the substantive sensitivity necessary to generate categories and properties” (p. 28).

This research study has several limitations. First, the study was based on a small convenient sample of only three women. Because of this small sample size, the results may not coincide with the experiences and feelings of all young mothers diagnosed with breast cancer. Secondly, each woman was only interviewed once. Grounded theory suggests interviewing each participant more than once in order to saturate themes derived from previous interviews (Fain, 2004). Thirdly, this study was not reviewed by any Ethical or Institutional Review Board. However, a thesis committee of three Carroll
College faculty members supervised the entire study to ensure proper use of methodology and to ensure respect for each participant's information.
CHAPTER FOUR

RESULTS

Difficulties Faced by Young Mothers with Breast Cancer

The three women interviewed for this research project were all mothers with dependent children living in their home during a breast cancer diagnosis and throughout treatment. Because their perspectives and past experiences vary greatly, it would be realistic to anticipate different feelings and reactions to their similar situation. Each woman shared a very different story about their experience, expressing the difficulties they faced as a young mother. Even though each experience was different, common themes about their difficulties emerged.

Finding a Breast Lump

A perfectly healthy breast can be smooth or lumpy and even vary from month to month. For this reason, many women choose not to panic if they feel an abnormal mass in their breast. However, because the risk of getting breast cancer is so high, it is natural to be concerned when a lump is found. Two of the women who participated in this research took the initiative to visit their physician because of the lump they found in their breast. The third woman went to see her physician because of other female concerns and the physician found a breast lump while performing an exam. Once the physician acknowledged a lump, referrals were made and each woman took action to have the lump tested for cancer.

Remembering exact details. While sharing their breast cancer story, it appeared very important for each of the women to explain how they were told they had breast cancer and their initial response to the diagnosis. Each woman could remember exact
details about the day they learned of their diagnosis. They could recall the physician’s facial expression and or precisely what and how they were told the diagnosis. Ann remembered waiting exactly one week to get the results back from her biopsy and then her physician called her on the phone and said, “Yes it’s breast cancer.” Cathy also recalls when she was told about her breast cancer diagnosis.

Even during that surgery, because I was awake, he gave me the impression that the tissue was all nice looking so I didn’t have any fears that it was cancer. I didn’t have any cancer in my family or anything. So then two weeks later, and I didn’t even think about it during those two weeks…I went back to get the results and didn’t even take my husband with me. I guess my doctor, when he looked out and saw I was solo thought, ‘Do I call him in and then she’ll instantly know its cancer or do I just tell her?’ Well he called me in and said ‘I am kind of surprised you came by yourself.’ And I said, ‘Well I’m not really worried about it.’ Then he said, ‘Well I do need to tell you, you have cancer.’

Learning of a breast cancer diagnosis can stir up endless amounts of extreme emotions. A breast cancer diagnosis can be an overwhelming and stressful event. Each of the women interviewed could recall their initial reactions to the breast cancer diagnosis. Ann stated her first thought was “What do we do next?” but also recalls being “kind of in a daze.” Barb and Cathy however, needed more time to internalize the diagnosis and therefore remained silent at first. Barb remembers her diagnosis was “frightening” to her. Cathy said she was “kind of shocked…like wow.” Cathy also stated she did not want to cry in the doctor’s office because she did not want anyone to know the diagnosis was not what she expected.
Taking an Active Role

Educating myself about treatment options. Once the women learned they had breast cancer they were given all possible treatment options. All the women interviewed actively sought more information to increase their knowledge about their specific cancer type and available treatment options. Ann recalls her physician giving her a huge book about breast cancer. She said that while it gave her a lot of facts on her type of breast cancer it “also helped me know what kind of questions I should be asking.” She felt her healthcare providers were very helpful in providing information and said, “they answered any questions I had...when I asked for research backing up the medication she was prescribing, she got it for me.”

Barb also remembers how she felt the need to increase her knowledge of breast cancer treatment options. She sought resources and asked questions.

I visited with the oncologist and asked his opinion...I also had a friend who was an RN...for an oncologist down in California and I sent her all...the information and said this is what the plan is...and she worked with her oncologist and it just made me feel better that that was exactly the path they would go down.

Barb works in a facility that also employs nurses. Many of her coworkers and other friends sent her an abundance of literature on breast cancer and different treatment options. She said, “I think I just tried to read as much as I could so I knew what I was going through.”

Cathy also received information from her physician but did a majority of her researching on the Internet. She also said, “when you get diagnosed, you all the sudden
find all these pamphlets you never knew existed...and there are all these great books out there to help explain what it is and what causes it.”

_Making my own decisions._ While each woman spent a considerable amount of time researching their type of cancer and treatment options, they ultimately chose their treatment based on individual beliefs. Ann based her decision largely on the outlook she had about breast cancer treatment before she was diagnosed. She said “symmetry means something to me” and therefore chose to have a lumpectomy instead of a mastectomy. Because she opted for a less invasive surgical procedure she also had to have chemotherapy and radiation. Barb discovered her type of cancer, because of factors such as her age and tumor size, would respond statistically the same to a partial mastectomy, chemotherapy, and radiation as it would to more dramatic surgery and no chemotherapy or radiation. Because Barb did not want to go through reconstructive surgery later, she also chose to have a lumpectomy followed by chemotherapy and radiation. Cathy actually told her physician she, “needed a couple of weeks to think” about her diagnosis and options. She spent nearly three weeks deciding to have a lumpectomy followed by chemotherapy and radiation.

Even after two of the women had chosen treatment, they still sought reassurance from research articles and suggestions from friends and healthcare providers. While each woman discussed her breast cancer diagnosis with her husband, she ultimately made the final decision about treatment. Cathy recalls her husband’s involvement, “He really thought it was my decision and he would go for whatever I thought was best. He didn’t make decisions, I think he just wanted me to make a decision that I could live with because he could live with whatever.” In none of the cases were the children involved. In
fact during when Ann was asked if her children were involved in the decision-making process and she replied, “No! I am not going to ask them how to treat me. No they don’t have a say in that.” It was evident that in each of the women’s experiences, deciding treatment was not a family process.

*Facing Stress*

All the women interviewed endured at least some physical side effects from the cancer treatment. While the common physical side effects were a stressor, every other aspect of each woman’s life was also affected by the breast cancer illness and treatment.

*Dealing with treatment side effects.* Each of the women that participated in this study chose a breast conserving surgical procedure referred to as a lumpectomy. Each woman also needed radiation therapy and chemotherapy after the surgical procedure. The most unfavorable side effects of the treatment shared by all the women were nausea, fatigue, hair loss, and pain. Ann recalled her memory of chemotherapy.

"To this day I can’t eat lemon Jell-O because it looks just like that stuff they put into you…it’s the same color as the infusion stuff...The pills were like rat poison, turquoise with speckles. I don’t know all the names. I didn’t mind them the first few months but towards the end yeah I was pretty sick. It was a chore to take them."

Barb stated she controlled the nausea and vomiting after chemotherapy by drinking lots of water. She felt dealing with feeling really tired after radiation was more difficult than the nausea and vomiting. She later stated, “I could stand the treatment and I could stand being sick because I would get over it and work kind of kept me focused. The
biggest thing for me was losing my hair...I think what it did was make me not feel like myself.” Hair loss was also the most memorable side effect for Cathy.

The first time you go in, they shoot this one drug into you and...they say here goes your hair. And within three weeks, it's usually twenty one days...I could do this, and see hair coming out so I said uh, its going to be time...so I went home and...we let the kids pull it out...then afterwards we took a razor to it. And my head is not, some of these ladies have beautiful baldheads...and mine didn’t ever seem to be like that. I always wore hats...my mom bought me a couple wigs but it just wasn’t natural enough for me. I wish I was comfortable enough to just go without anything and just walk bald, but I never was, not even at home.

Radiation therapy was painful for two of the women. Barb said that while she was sore from the radiation, she was thankful she never had any skin breakdown. However Cathy stated, “The first five weeks were fine but the last week was horrendous. Your skin starts to burn and it gets really painful...lasted about two weeks...I thought this really is having an effect.”

*Maintaining normalcy.* There were many stressors discussed in the women’s interviews. The effects of these stressors rippled throughout all areas of the women’s life including home, family, and work. The most commonly shared stressor was trying to maintain normalcy throughout the breast cancer treatment. It was very important for Barb to continue working. She described how she had to adjust her work schedule to accommodate her weekly treatment schedule.

I didn’t take a lot of time off work. Following the surgery I took a week and half off. Then I came back. Then during the course of chemotherapy I would work
until noon on Thursday and then I would go and have treatment at one. Then I would have Friday off and by Monday morning I was ready to come back to work. During radiation I worked it out so I was their first appointment...they started at 8:15...so I would just go there and that was only like a 15 minute procedure so I got dressed and was back to work by a quarter to nine.

Trying to look as natural as possible, she wore a wig the entire time she was taking chemotherapy, “I didn’t want everyone in the world to know I was going through a breast cancer treatment. I was like, I am going through it and I am going to get through it. I just didn’t want the whole world to know too.”

Cathy recalled the day she learned about her breast cancer diagnosis, “I remember coming home that night and driving down the driveway. It was my son’s tenth birthday so I didn’t want to think too much about myself, I wanted to have my son’s birthday party.” She also said that her husband was so worried about her and their future that he, “was nonexistent at that time so a lot of it for me was not pretending but not making [the cancer] a major focus of my life”

*Accepting financial burden.* Cancer treatment can be extremely expensive. It can change a family’s financial stability almost overnight, especially if the family does not have health insurance. While one of the women interviewed had health insurance and felt she had no financial burden, two of the women interviewed did not have insurance at the time of their breast cancer diagnosis and both had to find other resources to help pay for medical costs.

I didn’t feel I needed support groups, what I really needed was financial help. And that they couldn’t come up with. They could hold your hand but the money wasn’t
there. We ended up taking a second mortgage out on our house to pay off the bills...no matter what; you still have your house payments coming in, college tuition, all kinds of things. Your income goes down because you are unable to work...if you can’t pay the bills eventually someone just writes it off...but that doesn’t do a whole lot for your dignity and your self esteem when you have to beg for medical treatment.

Ann tried to decrease her financial burden by looking for a job that would offer her some insurance benefits. She even tried to take control of her financial situation by enrolling as a student in the Montana university system so that she could purchase student insurance. She stated, “I never worried about the disease itself because I couldn’t do anything about it except what I was doing. So what I worried about was paying my bills.”

Cathy, who also had no health insurance, stated she and her husband, “Just figured [the hospital and physicians] are just going to have to work with what we can pay them.” Not long after her breast cancer diagnosis a good friend put her in contact with a government funded program that pays for the cancer treatment of women who meet specific financial criteria. The program paid for her surgery, chemotherapy, and radiation. She stated the program “helped us tremendously” especially since both she and her husband were unemployed at the time of her diagnosis and had several small children to care for.

*Finding the cause of the illness.* During the story telling process in the interview, it became obvious that each of the women had attempted to rationalize why they had gotten breast cancer. Even though she did have a family history of cancer, Ann determined she got breast cancer because of her exposure to DET as a child.
Uterine cancer is a given in my family, you either have a hysterectomy or you have uterine cancer...it’s a given. I am still convinced that my breast cancer came from the DET I was exposed to...in the South DET was sprayed from the back of trucks to kill mosquitoes and the truck went up and down the road spraying and you would be outside playing. They have proven now...well see DET is very similar in chemical structure to estrogen. My particular cancer was estrogen cancer.

Cathy said “At some point you start asking why but you don’t always get those answers...I was so surprised with no cancer in my family. I think it really had a lot to do with stress. The whole cancer deal in my life I think was related totally to stress.” While each of the women attributed their cancer to a different cause, being able to attribute their illness to something physical was part of their story telling process and possibly helped them emotionally by providing an answer to an unknown.

Looking to the Future

The women interviewed experienced breast cancer between one and twelve years ago. Since their diagnosis and treatment, each of the women have had a chance to reflect back on their experience and also take a look at the future for themselves and their families. While all three women expressed concern about their children’s increased risk of getting cancer they also discussed what areas of their life they are taking control of to improve their health and lead a happier life. Barb had several thoughts about her and her family’s future.

Well I think about my girls all the time...I think about the age of my girls. And we’ve talked about how they need to be very conscious about doing breast exams
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and getting mammograms earlier than recommended. I am just a huge proponent of making sure that you are checking and are diagnosed early; self-exams and just taking care of yourself.

Cathy’s entire family has made a commitment to improve their eating habits and try to be healthier. When she was asked about her feelings and outlook for the future she said she was “really optimistic.” She went on to say

When I got cancer we started looking at all the things that really aren’t very good for you, say French fries or pop or whatever...I think we just want to make that whole change for our family to get rid of all the processed stuff and start eating more naturally...its healthier for our family. I always felt like we ate healthy but when I started reading labels I realized there is a lot of bad stuff in there too...At this point I am going to continue doing what I am doing, I enjoy my job...some people think it’s too stressful but it’s not too bad. Plus part is the insurance thing because I feel more comfortable sticking with the insurance I have.

Ann was greatly concerned with her financial situation during her breast cancer experience. She took action and started looking for a job that had insurance. She currently is employed at Montana State University and says, “I have very good insurance. Now every year I know what is going to be covered.” She will never forget the financial hardship the cancer caused her family and wants to try and prevent it from happening again.

Each women interviewed also shared a recommendation for improving the healthcare provided to future breast cancer patients. Ann feels more emphasis needs to be placed on educating patients about what to be aware of and look for in case of a cancer.
reoccurrence. Barb took action and tried to make changes in follow up care. She thought it was an unnecessary waste of time and money for patients to visit two or three different physicians for the same checkups. Cathy feels a need to improve communication and awareness between organizations and the public so more people will be aware of all the resources available for cancer patients and their families. Ann and Cathy both feel there is a great need for a spouse support group.
CHAPTER FIVE
DISCUSSION

Taking Control

The emerging themes in this research share one commonality. Within each theme, the women were trying to maintain a sense of independence, by taking control of her health situation. Past research has found similar results. Dow, Ferrell, Haberman, and Eaton (1999) interviewed breast cancer survivors and found that many of them described their quality of life as dependent upon one, having a balance between increasing dependence on others while maintaining independence, and two, being in control of their daily life rather than allowing the cancer to control them. Breast cancer can bring about a future of uncertainty for any women diagnosed so it would seem normal that a natural reaction would be attempting to regain control. The woman experiencing breast cancer knows best what her needs are and taking responsibility for her physical and mental health can be empowering. Facing a breast cancer diagnosis is a challenge but can also be an opportunity for growth.

Finding a breast lump. Recalling the reason for going to the physician and reliving how they found out about their breast cancer diagnosis was an important aspect of the story telling process for the women in this research study. A study by Mellon (2002) found similar conclusions. The meaning of the illness to breast cancer patients and their families nearly always included telling the initial reactions at the time of diagnosis. Some women and their families can give detailed accounts of the diagnosis delivery; exact details of the place and time and even the look on the face of the physician (Freedmen, 2003). This is evidence that the initial emotions and reactions at the time of
diagnosis have a profound affect on the patient and her family throughout the illness process. The interview and story telling process allowed the patient and family members to express the feelings they had at the time of the diagnosis and then look back to see the progress they have made throughout the illness (Mellon).

_Taking an active role._ Each of the women in this research study took an active role in educating themselves about their specific diagnosis and treatment options. This discovery is consistent with other research findings. Lyons and Shelton (2004) found most women, regardless of race, income, or rural or urban residence, are very knowledgeable about their diagnosis. Fallowfield (2004) found most breast cancer management and treatment decisions are based on traditional outcomes of survival rate and clinical side effects rather than other patients’ self reports of side effects and quality of life. The women in this research study had varying individual reasons for making their treatment decision. Hamilton and Sandelowski (2004) found contrary to past assumptions that patients prefer obtaining information from healthcare providers, fifty four percent of their research participants reported actively seeking their own information. Also, over one quarter of Hamilton and Sandelowski’s research participants “mentioned turning to their social network members to validate the accuracy of information received from their health care providers” (p. 797). Hamilton and Sandelowski’s results support the results of this research study.

Women diagnosed with breast cancer at a young age are faced with unique personal, family, professional, and quality of life issues that can create complications while making a cancer treatment decision (Curigliano et al., 2004). The three women involved in this study made the treatment decision making process their own. Consistent
with these findings, Mastaglia and Kristjanson (2001) found only thirty six percent (n=59) of their research participants wanted to share the decision making process with someone else, while fifty-four percent (n = 89) wanted the decision about surgery to be entirely their own. They also found however, that individuals who preferred a more active role in the decision making process were more likely to chose a breast conserving surgery over a modified radical mastectomy. Similarly, each of the young mothers in this study chose a breast conserving surgery.

Facing stress. Traditional breast cancer treatment usually results in undesirable but common side effects. The extent and severity of side effect symptoms, as well as how the side effect alters the woman’s quality of life, differs for each woman undergoing treatment. The women in this research study reported experiencing common symptoms of breast cancer treatment including nausea, hair loss, fatigue, and pain. One study interviewed twenty-one breast cancer patients immediately after completing chemotherapy and found twenty of those women reported hair loss and or nausea and fifteen reported fatigue as a significant side effect symptom (Beisecker et al., 1997). De Jong et al. (2002) conducted a review of literature to investigate fatigue in breast cancer patients undergoing chemotherapy and found it to be one of the most commonly reported side effects of treatment.

While the physical side effects of treatment provided some difficulty for the women in the study, maintaining normalcy was the most commonly shared stressor during cancer treatment. Maintaining normalcy would seem to be significant for most breast cancer patients and their families because breast cancer treatment has a large impact on the day-to-day life of those going through a breast cancer illness. Members of
the family experienced numerous role changes throughout the diagnosis and treatment
and often these changes lead to role confusion and role conflict, resulting in a weaker
spousal relationship (Stricker, Drake, Hoyer, & Mock, 2004). In contrast, a study
conducted on older women with breast cancer found half the women denied role changes
or alteration in activities during the breast cancer diagnosis and treatment (Overcash,
2004). This is evidence that the difficulties faced by older and younger breast cancer
patients can be significantly different.

Two of the three women in this research study stated finances as a significant
stressor. It would seem normal that women diagnosed with breast cancer that did not
have insurance or previously held the role as sole financial provider for their families and
now unable to work, would be the most impacted by financial stress. One study reviewed
surveys of over 4,000 women with breast cancer and discovered women underinsured or
covered by Medicaid presented with more advanced disease at the time of diagnosis
(Andrews, 1997). Reviewing past research yields little information about the frequency
and severity financial hardship has on women with breast cancer and their families.

The women interviewed for this research study described putting an emphasis on
going through the cancer but not making it a huge focus in their lives. Overcash (2004)
discovered that many women diagnosed with breast cancer make numerous attempts to
maintain normalcy for their families and friends. Some women actually tried to protect
their family and friends by avoiding discussions and or not disclosing information that
would cause them worry or stress.

Coping with the stress associated with breast cancer can be difficult for many
women. It is beneficial for some, including the three women in this study, to find
distractions to take their mind off breast cancer and related stressors (Hamilton & Sandelowski, 2004). Maintaining a positive attitude, thinking positive thoughts and having a will to live for self and others can also assist some breast cancer patients to cope (Henderson, Gore, Davis, & Condon, 2003).

*Looking to the future.* Being a breast cancer survivor means something different for every woman. Experiencing breast cancer has both negative and positive long-term effects on all aspects of the human body and spirit (Ott, 1997). While the women in this study mentioned some long term physical side effects of breast cancer treatment, they primarily shared how they took the lessons they learned from their breast cancer experience to improve their future and the future of their family. One woman and her family made a strong commitment to eat only healthy and organic foods. A study by Beagan and Chipman (2004) found that the family members of breast cancer survivors are more supportive of healthful eating when compared to family members of women who did not have breast cancer.

One woman interviewed in this study worried about her daughters getting breast cancer at a young age but also directed energy to helping educate others in the importance of self breast exams and “just taking care of yourself.” Having concerns for children is a common finding among young breast cancer survivors (Siegel, Gluhoski, & Gorey, 1999). Also, past research has found that the values and priorities of a breast cancer survivor and her family often shift, resulting in healthier eating habits, increased exercise, and relaxation (Beagan, and Chipman, 2004; Latimer, 1998). For most young women, having breast cancer was a transforming experience, bringing about a sense of vulnerability but helping them discover what is truly important in life (Strote, 2004).
Nursing Implications

The nurse’s role can be endless in the care of a woman with breast cancer. The needs of a young woman diagnosed with breast cancer are often unique to those of her older counterparts. Also, caring for a woman with breast cancer requires additional effort and time spent on family dynamics, especially if the family is young and growing. The individual needs of both the woman and her family fluctuate throughout the illness and often lead to unanticipated effects (Stricker, Drake, Hoyer, & Mock, 2004). Continual assessment of the woman and her family is vital to determining needs and appropriate interventions in order to have excellent outcomes.

Most breast cancer patients emphasized the importance of trust in the relationship between the care provider and patient as well as personalized assistance and information (Unruh, Bowen, Meischke, Bush, & Wooldridge, 2004). Nearly any education interventions can alter health outcomes in health promotion for breast cancer patients (Kelley, 2004). Healthy lifestyle changes are more supported by the family members during and just after an illness diagnosis and therefore this may be an ideal time for the nurses to introduce healthy eating and encourage physical activity (Beagan & Chipman, 2004). Nurses can also teach patients about the concerns they may potentially face as a breast cancer survivor including worries about body image, questions concerning HRT and Tomoxifen, and fears about recurrence (Macleod, 2000). Increasing a woman’s awareness of the difficulties she could potential face as a young mother with breast cancer may not only help her cope, but possibly aide her journey to regain control of her life.
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