SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON

EXPERIENCES OF WOMEN WITH ADVANCED BREAST CANCER: A STUDY AT THE KUMASI METROPOLIS

BY
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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL NURSING DEGREE

JUNE 2013
DECLARATION

I declare that this thesis is my own work produced from research undertaken under supervision. This thesis/dissertation has not been submitted in any form for any degree or diploma at any university or other institution of tertiary education. Authors and Publishers whose works have been utilized in this study have been duly acknowledged in the text and list of references.

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DEDICATION

This thesis is dedicated to all advanced breast cancer survivors. It is also dedicated to my family for their continual support and prayers.
ACKNOWLEDGEMENTS

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<th>Description</th>
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<tbody>
<tr>
<td>ACS</td>
<td>American Cancer Society</td>
</tr>
<tr>
<td>AJCC</td>
<td>American Joint Committee on Cancer</td>
</tr>
<tr>
<td>BCAWG</td>
<td>Metastatic Breast Cancer Advocacy Working Group</td>
</tr>
<tr>
<td>DHMCS</td>
<td>Department Health, Macmillan Cancer Support</td>
</tr>
<tr>
<td>KATH</td>
<td>Komfo Anokye Teaching Hospital</td>
</tr>
<tr>
<td>MMDT</td>
<td>Merck Manual of Diagnosis and Therapy</td>
</tr>
<tr>
<td>NCI</td>
<td>National Cancer Institute</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
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<tr>
<td>SBCT</td>
<td>Secondary Breast Cancer Taskforce</td>
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<tr>
<td>TNM</td>
<td>Tumour Lymph node Metastasis</td>
</tr>
<tr>
<td>U.S.</td>
<td>United States</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

The purpose of this study was to explore and describe the experiences of Ghanaian women living with advanced breast cancer in the Kumasi Metropolis. The study employed a qualitative exploratory descriptive design. A purposive sampling was used and data was saturated with 10 participants varying in age between 32 years and 65 years. All interviews were audio-taped and transcribed. Data was analyzed based on the techniques of content analysis. During the study, anonymity and confidentiality were ensured. Research supervisors audited data to ensure credibility. Eight major themes describing the participants’ lived experiences emerged: impaired activities of daily living, malignant wound, body image, physiological effects, emotional reactions, support, coping, and lost hopes. The women indicated that they experienced distress because of concerns about body image and worries about the effect of stress on their illness. The stress emanated from fear of dying, fear of disease progression and debilitation, the loss of their future, and practical concerns. The women also experienced a decline in their daily activities due to physical symptoms of the illness and the side effects of the treatments. Most of the women had emotional, social, financial, and spiritual support from spouses, families, churches, work place, and health professionals. It was recommended that health care providers involved in breast cancer management need opportunities for training to enhance effective and holistic care of women diagnosed with the disease. Also, patients with advanced disease should be given multidisciplinary management by trained oncology and palliative care team.
CHAPTER ONE

1.0. Background

1.1. Introduction

This chapter presents the background of the study, the problem statement, purpose of the study, objectives of the study and the research questions that will guide the researcher to achieve the set objectives. The significance of the study as well as the operational definitions are also captured in this chapter.

Breast cancer, the most common malignancy among women is an important health concern of women. Worldwide, breast cancer comprises 22.9% of all cancers in women; about 1.38 million women were diagnosed with breast cancer in 2008, while about 458,000 (13.7%) women died from the disease (World Cancer Report, 2008). Worldwide, breast cancer is the second most common type of cancer after lung cancer (10.4% of all cancer incidence, both sexes counted) and the fifth most common cause of cancer death (Lewis, 2005). In 2008, approximately 47,700 women were diagnosed with breast cancer in the United Kingdom (UK) with about 12,000 deaths a year (Cancer Research UK, 2008; World Health Organisation [WHO], 2008).

Breast cancer mostly develops in women; however, men also develop breast cancer (Giordano, Cohen, Buzdar, Perkins, & Hortobagyi, 2004; National Institute of Clinical Excellence [NICE], 2006). Male breast cancer accounts for 5% of all diagnosed breast cancers (National Cancer Institute (NCI), 2011). Studies from the United Kingdom indicate that breast cancer in males is rare with an estimation of 1% cases diagnosed annually, though other studies also suggest that
the incidence may be increasing (Cancer Research UK, 2004; Giordano et al., 2004). According to NICE (2006), breast cancer is about 100 times as frequent among women as among men, but survival rates are equal in both sexes.

In Sub-Saharan and South Africa, breast cancer is the second most common cancer among women after cancer of the cervix (South African Medical Research Council, 2007; WHO, 2008; WHO & International Union against Cancer [UICC], 2005). Ghana lacks a National Cancer Registry, however, according to Globocan (2010), Ghana is ranked 10th in the world’s burden list of breast cancer. In 2010, over 1, 300,000 women died from breast cancer globally, 2,062 (21.0%) women were diagnosed with the disease in Ghana and 1,137 (16.5%) women died from breast cancer in Ghana (Globocan, 2010). Records from the Oncology Directorate of the Komfo Anokye Teaching Hospital (KATH) indicate that about 1,184 cases of breast cancer out of 5,066 of all cancer cases were registered from 2004 to December, 2012. This accounts for approximately 23.4% of all registered cancers; 8.5% of breast cancer was diagnosed in 2004, 7.2% in 2005, 8.7% in 2006, 13.3% in 2007, 12.6% in 2008, 11.6% in 2009, 13.6% in 2010 13.6% in 2011 and 11.0% in 2012. The nine year percentage distributions indicate the dramatic increase in the disease. A little drop in some of the years may be attributed to education and awareness creation about the disease.

Cancer is a disease that is characterised by uncontrolled and unregulated growth of cells in any part of the body (Brunner & Suddarth, 2004; Lewin, Heitkemper, & Dirksen, 2004). Breast cancer is cancer that originates from the breast tissue (Sariego, 2010; Stephen, 2001). The exact cause of breast cancer remains unknown. However, scientists have identified a number of risk
factors that increase a person's chance of getting the disease (Althuis et al., 2003; Brody et al., 2006; Carpenter, Ross, Paganini-Hill, & Bernstein, 2003; Gilani & Kamal, 2004; Weir, Day, & Ali, 2007). Some of these risk factors include age, gender, and heredity which are non-modifiable; and others like contraceptive pills, infections and drugs which can be modified (Althuis et al., 2003; Brody et al., 2006; Carpenter et al., 2003; Gilani & Kamal, 2004; Weir, Day, & Ali, 2007).

The first noticeable symptom of breast cancer is typically a lump or an area that feels different from the rest of the breast tissue. More than 80% of breast cancer cases are discovered when the woman feels a lump (Merck Manual of Diagnosis and Therapy [MMDT], 2003). Indications of breast cancer other than a lump may include changes in breast size or shape, skin dimpling, nipple inversion, or abnormal nipple discharge (American Cancer Society [ACS], 2007; MMDT, 2003).

Staging is a means of describing the extent of cancer growth. Breast cancer is 'staged' after diagnosis by information that is obtained from clinical, radiological and pathological findings and helps to predict how an individual will fare over time. Stage 0, I, II and IIIa constitute early breast cancer whiles stages IIIb and IV are referred to as advanced breast cancer, the lower the stage, the better the prognosis (Cancer Research UK, 2004).

Another staging classification that describes the extent of spread in greater detail is the Tumour-Node- Metastasis (TNM). This classification was devised by the American Joint Committee on Cancer (AJCC) in collaboration with the National Cancer Institute (NCI) in October, 2004.
Within the TNM system, "T" refers to tumour size, "N" refers to lymph node involvement, and "M" refers to the extent of metastasis. The TNM classification is ranked within one of the following categories in the table below:

Table 1: Four basic stages, labeled stage 0 through stage IV.

<table>
<thead>
<tr>
<th>Stage</th>
<th>TNM Classifications</th>
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<tbody>
<tr>
<td>Stage 0:</td>
<td>in situ breast cancer - Tis, N0, M0</td>
</tr>
<tr>
<td>Stage I:</td>
<td>T1, N0, M0</td>
</tr>
<tr>
<td>Stage IIa:</td>
<td>T0-1, N1, M0, or T2, N0, M0</td>
</tr>
<tr>
<td>Stage IIb:</td>
<td>T2, N1, M0, or T3, N0, M0</td>
</tr>
<tr>
<td>Stage IIIa:</td>
<td>T0-2, N2, M0, or T3, N1-2, M0</td>
</tr>
<tr>
<td>Stage IIIb:</td>
<td>T4, N (any), M0, or T(any), N3, M0</td>
</tr>
<tr>
<td>Stage IV:</td>
<td>T(any), N(any), M1</td>
</tr>
</tbody>
</table>

Source: ehealthMD.com, October, 2004

Early stage breast cancer (stage I, II & IIIa) relatively has small tumour sizes which have not yet spread to other sites and have a good prognosis (Cancer Research UK, 2004). By contrast, advanced stage cancer (stage IIIb & IV) tumour size is large and has metastasized to the lymph nodes as well as other locations with poor prognosis. The symptoms of metastatic breast cancer vary by the location of the metastases. Breast cancer primarily metastasizes to the bone, lungs, regional lymph nodes, skin, liver and brain, with the most common site being the bone (Lacroix, 2006).

Cardinal symptoms of metastasis are pain and dyspnoea (MMDT, 2003). Baako (1999) indicated the importance of early detection of breast cancer before metastasis as having a good
response to therapy with possible breast conservation. The author further indicated that, early
detection with positive response to treatment reduce psychological trauma (Baako, 1999).
Findings from the NCI (2006) indicate that 5-year survival rates are 96% for early - stage breast
cancers (stage 0, I, & IIa), 75% for breast cancers that have invaded the surrounding tissue (stage
IIb & IIIa cancers), and only 20% for breast cancers that have metastasized (stage IIIb & IV
cancers).

According to the National Breast Cancer Centre UK (2001), advanced breast cancer is the term
used to describe cancer that has spread from the original site in the breast to other organs or
tissues in the body. It is also referred to as metastatic or stage IV or late breast cancer. In one of
the earliest studies in Ghana by Archampong (1977) on breast cancer, 75% of women with breast
carcinoma presented with stage III and IV disease. Another study in Ghana on breast diseases at
the surgical clinic of the Korle Bu teaching hospital over a 12 month period indicated that among
300 women presenting with breast complains, approximately 16% (47) had breast cancer, out of
which 47% presented stage III and IV cancers (Asumanu, Vowotor, & Naaeder, 2000). A more
recent study in Ghana at the Korle Bu Teaching Hospital reports of 91 (57.6%) of patients
presenting with stage III-IV disease (Clegg-Lamptey & Hodasi, 2007). These results indicate
that, patients in Ghana present at the late stage of their disease resulting in poor prognosis
(Archampong, 1977; Asumanu et al., 2000; Clegg-Lamptey & Hodasi, 2007). It is well
documented that early detection of breast cancer improves prognosis (Price, 2004). Late
detection of breast cancer will in effect progress to advanced breast cancer.
In high income countries, nearly 30% of women diagnosed with primary breast cancer will eventually develop distant metastatic disease (Johnston & Swanton, 2006; O’Shaughnessy, 2005). In the United States, (U.S.) about 15,500 women are living with metastatic breast cancer and this was projected to rise to 162,000 in 2011 (ACS, 2008). In 2008, almost 49,000 Americans, including 1,990 men, were diagnosed with metastatic breast cancer (ACS, 2008). In the United Kingdom (U.K.), a significant proportion of the 550,000 women predicted to be alive with a diagnosis of breast cancer will be living with advanced breast cancer (Maddams, Moller, & Devane, 2008).

In low income countries, the majority of breast cancers are diagnosed at later stages. For 5% of American patients, the disease has already progressed to stage IV when it is first diagnosed; a rate that is higher among minority and poor women (Horner, Ries, & Krapcho, 2006). There are few studies focusing on metastatic breast cancer in Africa (Adisa et al., 2011). A study in South Africa has shown that locally advanced and metastatic disease occurred in up to 77% of blacks compared to 30% in non-black patients (Vorobiof, Sitas, & Vorobiof, 2001). Reports of breast cancer patients in Ibadan, a state in Nigeria, showed a rising hospital incidence of breast cancer in Nigeria with about two thirds of the patients presenting with locally advanced or metastatic disease (Adebamowo & Ajayi, 2000). Various studies conducted on pattern of breast diseases in Ghana also confirmed that the majority of breast cancer patients report at the late stage of their disease resulting in poor treatment outcome (Archeampong, 1977; Asumanu et al., 2000; Baako, 1999; Clegg-Lamptey & Hodasi, 2007).
Different reasons are often cited for the late presentation of breast cancer in Africa. Among the major concerns are socioeconomic factors which have been noted to influence the choice and outcome of treatment among women with late stages of breast cancer (Adisa et al., 2011; Adisa, Lawal, & Adesunkanmi, 2008; Bradley, Given, & Roberts, 2002; Rosenzweig, Wiehagen, Brufsky, & Robert, 2009). Also, in the African society, medical decision-making among breast cancer women is further compounded by the cultural influence of the husband and family members on their choice, acceptance and adherence to treatment options (Ajekigbe, 1991; Aziato, 2009; Nour, 2003).

Current treatments for women with breast cancer include surgery, radiation therapy, chemotherapy, biological therapy, and hormonal therapy. Treatment methods are classified as local or systemic. Local treatments such as surgery and radiation therapy destroy or control cancer cells in a specific area. Systemic treatments such as chemotherapy, biological and hormonal therapy destroy or control cancer cells throughout the body. Depending on the condition, patients may receive a single treatment or a combination of therapies given at the same time or in succession (NCI, 2006). Effects of treatment are not limited to only cancer cells; treatment also damages healthy cells and tissues causing unpleasant side effects. The side effects of cancer treatment vary. They depend mainly on the type and extent of the treatment. Additionally, each person reacts differently (MMDT, 2003; Eure, 2006). Physical side effects of cancer treatments documented include pain, lymphoedema, changes in body image, anaemia, muscle ache, tiredness, skin reactions, loss of appetite, nausea, vomiting, diarrhoea or constipation and risk of developing secondary cancer. Other side effects are immune suppression leading to opportunistic infections, delayed blood clotting time, hair loss, tiredness, mouth sore,
hot flashes, vaginal dryness, peripheral neuropathy, weight gain, insomnia and interrupted menstrual periods (MMDT, 2003; Eure, 2006). Psychosocial effects of cancer treatment include distress, anxiety, depression, fear of the future, impotency, loss of sexual desire and loss of fertility (MMDT, 2003; Eure, 2006).

The psychosocial experiences of breast cancer patients are well documented, but very few researches focused on the experiences of women with advanced breast cancer (Aranda, Schofield, & Weih, 2006; Bottomley & Therasse, 2002). Most women find the diagnosis of advanced disease to be more distressing than the diagnosis of early stage breast cancer (Edelman, Bell, & Kidman, 1999; Mahon, Cella, & Donovan, 1990). The prognosis of metastatic disease is, in general, poor (Price, 2004), so women with metastatic disease live with the fear of impending death (Vilhauer, 2008). Treatments such as surgery, radiotherapy, hormone therapy, biological therapy and chemotherapy are used to control symptoms, improve quality of life, and prolong survival, but these can result in perceived disfigurements and debilitating side effects such as loss of hair, nausea and vomiting, and weakness (Booth, 2006; Colozza et al., 2007; Dodwell, Wardley, & Johnston, 2006; Smith, 2006; Vilhauer, 2008; Von Minckwitz, 2006).

Most studies that focus exclusively on advanced breast cancer patients have explored differences in quality of life or psychosocial symptoms when different medical treatments or psychotherapy interventions are used (Costantino, 2002; Goodwin, Leszcz, & Ennis, 2001), rather than on how metastatic disease affects women (Vilhauer, 2008). The few quantitative and qualitative studies that have examined the quality of life in women with advanced breast cancer indicate that they are prone to psychiatric morbidity and problems related to sexuality, body
image, physical, social, role functioning, pain, fatigue, insomnia, concern about people close to them, and uncertainty about the future (Aranda et al., 2006; Kissane, Grabsch, & Love, 2004; Vilhauer, 2008; Warren, 2010). Many experience traumatic stress symptoms (Butler, Koopman, & Classen, 1999).

In Ghana, it appears there are no published studies on how advanced breast cancer affects women life. Therefore a qualitative study is needed to provide rich, detailed information about how advanced breast cancer affects women’s lives. Although quantitative studies provide important information about areas in which women’s quality of life might be compromised, these studies have not captured many issues of concern to women (Luoma & Hakamies-Blomqvist, 2004). Qualitative research is primarily naturalistic, interpretative, and inductive which allows the study of naturally occurring phenomena without manipulation (Mayan, 2009). The use of qualitative approach will offer women with advanced breast cancer the opportunity to explore their thoughts and provide in-depth and rich information about their living experiences.

1.2. Problem Statement

Worldwide, breast cancer is the leading cause of cancer death among women, accounting to an estimated 465,000 annual deaths, a figure that represents nearly 36% of 1.3 million cases of breast cancer each year (Bray, Ferlay, & Pisani, 2002; WHO, 2003). In Ghana, the studies reported higher percentage of stage III and IV of the disease (Archampong, 1977; Asumanu et al, 2000; Baako, 1999; Clegg-Lamptey & Hodasi, 2007). At the Oncology Department of KATH, about 51.4% of breast cancer women seen from 2004 to 2008 presented with stage IV breast cancer (KATH Records, 2009). The researcher, a nurse at the Oncology Unit (KATH) observed that advanced breast cancer presents physical, psychological and social problems for women but
these had not been explored to afford any scientific statement on the experiences of women. The researcher further observed that, patients with advanced breast cancer were given the same nursing care as those with early stage disease; however, there is no established end of life and palliative care service for patients with advanced disease/life threatening illness. Within the Ghanaian clinical context, general nurses and doctors care for cancer patients. There is no palliative care programme for nurses and doctors in the country. A review of the curricula for general nursing and medical school indicate that there are no specific course for palliative care which presupposes that the educational preparation for Ghanaian nurses and other health workers in the area of palliative care is inadequate to meet the needs of patients living with advanced disease.

Based on the findings from this study, appropriate interventions will be designed to improve the management of women with advanced breast cancer. Furthermore, this study will illumine the need for the establishment of end of life and palliative care services in Ghana to improve the quality of life of women with advanced breast cancer. Additionally, the literature reviewed so far showed that the impact of advanced breast cancer on women goes underreported, underestimated and under-researched especially in Ghana. It has also been observed that women with advanced breast cancer experience adverse effects from the various therapies and are psychologically affected.

Women with advanced breast cancer report a broader sense of social stigma that may even create a sense of guilt about having developed advanced disease (Mayer & Grober, 2005). Most people believe that those with metastatic disease will die very quickly after diagnosis so there is no point
exploring their experience. However, it is realised that women with advanced breast cancer could live for a number of years (Conlin & Seidman, 2008), and therefore, their experiences are worth exploring. It is for these reasons that the researcher seeks to conduct a qualitative study with the aim of exploring the experiences of women diagnosed with advanced breast cancer in the Kumasi Metropolis, with a long term view to establish appropriate facilities for their care in Ghana.

1.3. Purpose of the Study

The purpose of this study is to explore the experiences (physical, psychosocial and treatment effects) of women with advanced breast cancer at the Kumasi Metropolis.

1.4. Significance of the Study

It is anticipated that, knowledge gained about the experiences of women diagnosed with advanced breast cancer would guide nurses and other health professionals’ in the provision of quality care to meet the needs of women with metastatic breast cancer. This is because women with advanced breast cancer may have needs different from the needs of the general category of people with cancer. Understanding these women and their concerns can help in the design of interventions to improve upon the quality of life of women. Additionally, it is hoped that the findings of the study would help to develop educational materials for women with advanced breast cancer to assist women cope with the diagnosis. Based on the findings, training programmes will be organized for health professionals to enhance patient care. Finally, it is hoped by the researcher that the findings of the study will add knowledge to the discipline of nursing on how to support women with advanced breast cancer.
1.5. Objectives of the Study

- To describe the physical experiences of women diagnosed with advanced breast cancer.
- To explore the effects of cancer treatment in women diagnosed with advanced breast cancer.
- To describe the psychosocial experiences of women diagnosed with advanced breast cancer.

1.6. Research Questions

- What are the physical experiences of women with advanced breast cancer?
- What are the effects of cancer treatment on women with advanced breast cancer?
- What are the psychosocial experiences of women with advanced breast cancer?

1.7. Operational Definitions

- Cancer: abnormal growth of body cells.
- Breast cancer: abnormal growth of cells arising from the breast.
- Metastasis: spread of breast cancer cells to other parts of the body
- Diagnosis: the process of identifying breast cancer through symptoms and laboratory/radiological/pathological investigation
- Early stage breast cancer: diagnosis of breast cancer cell growth before metastasis, stages 0, I II and IIIa
- Late/Advanced stage breast cancer: diagnosis of breast cancer cell growth after metastasis, stages IIIb and IV
- Prognosis: prediction on the course of disease and chances of recovery or survival
Survival: continuous living after breast cancer diagnosis and treatment

Experience: an event which affects a person or involves a person.

Woman: an adult Ghanaian female from 18 years up diagnosed of advanced breast cancer.
CHAPTER TWO

2.0. Literature Review

2.1. Introduction

The focus of this literature review is to explore issues relating to experiences of women with advanced breast cancer. The review is discussed under five headings; the impact of advanced breast cancer, culture, beliefs and breast cancer; physical effects (activities of daily living, lymphoedema and malignant wound), psychosocial experiences (pain, uncertainty, grief, fear of death; suicidal tendencies, anxiety and depression; coping with uncertainty and fear of death; support and coping), and effects of treatment in advanced breast cancer (physical and systemic effects). The literature search was conducted using the electronic databases: ‘CHINAL’, ‘EMBASE’ ‘HINARY’, ‘PUBMED’, ‘JSTOR,’ and ‘SCIENCEDIRECT’. The keywords ‘secondary’, ‘metastatic’, ‘advanced breast cancer’, ‘stage IV’ ‘breast cancer spread’ and ‘breast cancer’ were used together with ‘women experience’, ‘physical’, ‘pain’, ‘malignant wound’, ‘lymphoedema’, ‘psychosocial’, ‘psychological’, ‘social’, ‘support’, ‘coping’, ‘treatment’ and ‘qualitative’ either individually or in combination in order to identify relevant studies on the experiences of women diagnosed with advanced breast cancer.

The search identified many studies published on advanced breast cancer. Even though many studies have been done on this area, there is a paucity of studies focused exclusively on the experiences of women with advanced breast cancer. The majority of the studies identified focused on issues such as quality of life, clinical trials, informational needs, and unmet needs of...
women with advanced breast cancer. In the following section, the review will focus on the impact of advanced breast cancer, belief, culture and breast cancer, physical experience with advanced breast cancer, psychosocial experiences of breast cancer and treatment effects of advanced breast cancer.

2.2. The Impact of Advanced Breast Cancer

Reed, Simmonds, Haviland, and Corner (2011) observed that regardless of the advanced development in the early diagnosis and treatment of breast cancer, a significant number of women still develop metastatic disease. The actual number is unknown as this data is not collected. Globally, half a million deaths each year are attributed to metastatic breast cancer (Johnston, 2010). World statistics show that approximately one third of 1.3 million women still develop and subsequently, die from metastatic breast disease (Johnston & Swanton, 2006; Parkin, Bray, & Ferlay, 2002; Stewart & Kleihues, 2003; WHO, 2008). Although wide-ranging data on the incidence and mortality of breast cancer have been routinely collected for a number of years, there are gaps. In particular, data relating to diagnosis of metastatic breast cancer has not been collected. There seems to be no published evidence of any country globally that collects national data on the incidence of metastatic breast cancer (ACS, 2010; ACS, 2009; Mayer, 2010; Reed et al., 2011).

National and international attention is increasingly focused on the needs of patients with advanced breast cancer (Secondary Breast Cancer Taskforce [SBCT], 2008; Metastatic Breast Cancer Advocacy Working Group [BCAWG], 2008). Evidence suggests that the care for women with advanced breast cancer is inadequate, and the attention of clinical teams and breast care
nurse specialists has primarily been on supporting those with early stage breast cancer (Aranda et al., 2006; Aranda, Milne, & Osmond, 2002). As a result of development of effective and well tolerated therapies that can be used for a variety of patients sequentially, the prognosis of advanced breast cancer is improving and for many, it may become a long-term illness (Conlin & Seidman, 2008; Jones & Smith, 2006). It is reported that women with visceral metastases may have relatively short-life expectancy whereas those presenting with skeletal metastases and no other site of metastases have an average life expectancy of approximately 24 to 36 months. Conversely, women with slow progressive disease may live for many years; 10 to 15 years in some cases (DeVita, Hellman, & Rosenberg, 2001; Johnston & Swanton, 2006).

In view of the potential long-term nature of advanced breast cancer, women living with the disease are currently considered to be cancer survivors rather than at the end stage of life (Corner, 2008; Department Health, Macmillan Cancer Support [DHMCS], 2010). As the focus of palliative care is on end-of-life, the majority of women living with advanced breast cancer are not deemed to be in the end-of-life phase of illness; therefore, they often do not receive palliative care services if existent until the last weeks of life (Reed et al., 2011). Both the prevalence of metastatic breast cancer and the longer illness trajectory for many women have potential implications for health service provision and the cost of treatment and care (Reed et al., 2011).

Understanding the impact of metastatic breast cancer diagnosis is vital since the prognosis for such women is generally considered poor and women with metastatic disease live with the prospect of impending death (Price, 2004; Vilhauer, 2008). Furthermore, many present with a complex range of physical and psychosocial problems including pain, offensive malignant
wound, lymphoedema, fatigue, insomnia, suicidal tendencies, fear, anxiety, sadness, uncertainty about the future and changes in social and role functioning, which will later bring them into contact with palliative care services (Aranda et al, 2006; Kawn et al., 2010; Thomas-MacLean, Miedema, & Tatemichi, 2005; Price, 2004; Probst, Arber, & Faithfull, 2012; Sanson-Fisher et al., 2000; Vilhauer, 2008; Walker et al., 2008). In the following section, the literature review focuses on culture beliefs and breast cancer; physical experience with advanced breast cancer (pain, malignant wound, lymphoedema and changed body image), psychosocial experiences (uncertainty, grief, fear of death; anxiety and depression, support and coping), and effects of treatment in advanced breast cancer.

2.3. Culture, Beliefs and Breast Cancer

Breast cancer is influenced by traditions, cultural norms and beliefs (Goldblatt, Cohen, Azaiza, & Manassa, 2012). In Ghana very little is known about the influence of culture and traditions on breast cancer as few studies have been published on the disease. A number of studies examining the knowledge, beliefs and attitude among the Arab people in Israel regarding breast cancer showed dominance of fear, embarrassment, cultural barriers, social stigma and fatalistic beliefs regarding the cause and outcomes of cancer (Azaiza & Cohen, 2006; Azaiza & Cohen, 2008; Azaiza, Cohen, Awad, & Daoud, 2010; Baron-Epel, 2010; Baron-Epel, Granot, Badarna, & Avrami, 2004; Cohen & Azaiza, 2005; Cohen & Azaiza, 2010; Cohen, Mabjish, & Zidan, 2011; Soskolne, Marie, & Manor,2007). Cancer is mostly seen as God’s fate, punishment or as a test of one’s faith in God (Opoku, Benwell, & Yarney, 2012). This shares commonality with other studies (Azaiza et al., 2010; Azaiza & Cohen, 2008; Baron-Epel, 2010; Baron-Epel et al., 2004). Participants from these studies perceived cancer as death sentence and believed that people
isolate themselves socially from cancer patients due to the stigma attached to the disease, thus experiencing fear and shame.

Using a mixed method approach, Opoku et al. in 2012 carried out a study in two Ghanaian cities to examine the knowledge, attitudes, beliefs, and behaviour regarding breast cancer screening practices among 500 women. Women in the study expressed fear of the disease which was linked to death in most cases, denial and guilt as well as spiritual and supernatural attributes of the disease (Opoku et al., 2012). The majority of the participants also related treatment of the disease with death. This belief may be due to late presentation of the disease in Ghana. Studies done in Ghana show that about 57.6% of patients present for treatment with advanced staged disease and as such many patients die shortly after surgical intervention (Clegg-Lamptey & Hodasi, 2007; Opoku et al., 2012). The authors further reported women displaying a high level of reliance on God for protection from the disease, as well as on divine intervention and healing (Mona, 1997).

In the following section, the literature review focuses on physical experience with advanced breast cancer (pain, malignant wound, lymphoedema and changed body image), psychosocial experiences (uncertainty, grief, fear of death; anxiety and depression, support and coping), and effects of treatment in advanced breast cancer.

2.4. Physical Experience with Advanced Breast Cancer

In reviewing studies related to physical functioning and quality of life in women with advanced breast cancer, the key themes that emerged included “women perception of quality of life and the experience of physical symptoms”. In the majority of the findings, unrelieved physical symptoms especially pain, malignant wound, fatigue, mobility impairment, difficulty in breathing, reduced appetite, lymphoedema, change in body image, and practical service needs such as help with
daily living and housework were described (Alexander, 2010; Aranda et al., 2006; Baldwin, 2012; Louma & Hakamies-Blomqvist, 2004; Lund-Nielsen, Midtgaard, Rorth, Gottrup, & Adamsen, 2011; Maida, Ennis, Kuziemsky, & Trozzolo, 2009; Probst et al., 2012; Reed et al., 2011; Stromgren, Groenvold, Sorensen, & Andersen, 2001; Vilhauer, 2008; Wong et al., 2002).

2.4.1. Activities of Daily Living and Advanced Breast Cancer

Using a qualitative approach, Vilhauer (2008) explored the experiences of 14 Caucasian women living with metastatic breast cancer in the United States of America. Eligibility required women to be diagnosed with metastatic breast cancer, free of any concurrent chronic illness or mental condition that was likely to affect quality of life, have continuous access to computer, and be familiar with the use of electronic mail (e-mail). Findings from the study indicate that women with advanced breast cancer experience pain, fatigue, shortness of breath, decrease capacity for work and other leisure activities. These experiences may lead to the avoidance of physical activities such as driving and lifting things. Although the study provides rich information about the physical experiences of women with advanced breast cancer, the use of only Caucasian women makes it difficult for study findings to be generalized to other women with metastatic breast cancer from other geographical areas where cultural and ethnic diversity is high. Consequently, women who had no access to computer and internet were not eligible for the study further limiting the internal and external validity of the study (Vilhauer, 2008).

Using a diverse and a slightly larger sample as compared to Vilhauer (2008), Rosenzweig et al. (2009) employed mixed methods design to investigate the challenges of illness in 47 women with metastatic breast cancer from both White and African-American races perspective. Based on the findings of the study, the authors concluded that, low-income African American women
experienced greater physical distress and fatigue than the other delineated racial and economic groups such as high-income White American women. This compelled the women to enlist help from others in washing, cooking, bathing and grooming. Being dependant on others was also distressing to the women. They noted that women expressed the “not being able to... aspect of the physical experience as what bothers the most” (pg. 143-152). This study points to the fact that being of low income and of African American origin reportedly worsened women physical experience (Rosenzweig et al., 2009). The findings of this research illumine important perceptions that combined influences of race and economic status bring to the metastatic breast cancer experience.

A number of studies that examined the physical effects of women with advanced breast cancer employing both qualitative and quantitative approaches reported similar findings such as malignant wounds, lymphoedema, reduced physical activities, weakness and easy fatigability as some of the physical experiences of women. These negatively impacted on the women’s ability to engage in their daily activities such as cooking, going out for groceries, washing, and driving, making them dependent on others. Most women however depend on their family members for support. (Aranda et al., 2006; Cidon, Perea, & Lope-Lara, 2011; DeSanto-Madeya, Bauer-Wu, & Gross, 2007; Doumit, Huijer, & Kelley, 2007; Grocott, 2007; Kenne-Sarenmalm, Ohlen, Jonsson, & Gaston-Johansson, 2007; Lo et al., 2011; Lo et al., 2008; Louma & Hakamies-Blomqvist, 2004).

Kenne-Sarenmalm et al. (2007) studied 56 women with metastatic breast cancer. A quantitative approach was employed to measure the prevalence of distress symptoms, coping capacity,
coping effects and health related quality of life in women with recurrent breast cancer in the U.S.A. Women used in the study reported a wide range of symptoms such as lack of energy, difficulty sleeping, pain, dizziness, cough and loss of appetite. Sixty five percent (65%) of the women from the study reported experiencing multiple concurrent symptoms. These symptoms negatively impacted on the ability of the women to carry out their routine activities such as going to the market for groceries, church, social functions (Kenne-Sarenmalm et al., 2007). These findings were consistent with other studies in which women with advanced breast cancer reported multiple levels of physical symptoms, most commonly fatigue, weakness, insomnia and pain (DeSanto-Madeya et al., 2007; Thornton, Madlensky, & Flatt, 2005; Turner, Kelly, Swanson, Allison, & Wetzig, 2005; Aranda et al., 2006; Luoma & Hakamies-Blomqvist, 2004). Most of the above studies employed quantitative methodology in their investigation and this method did not permit participants to provide in-depth explanations of the symptoms experienced.

Aranda et al. (2006) studied the quality of life and unmet needs of urban women with metastatic breast cancer. The study was conducted at four large urban hospitals, three public and one private, in Australia. A sample of 172 women with metastatic breast cancer who were attending an outpatient oncology clinic was screened for the study. In an overall assessment of the health status of these women, more than half (63%) reported feeling fatigued and nearly a third (30%) reported pain. These findings broadly reflect previous research on quality of life issues for women with advanced breast cancer (Vilhauer, 2008; Stromgren, Groenvold, Sorensen, & Andersen, 2001). Aranda et al.’s (2006) study provides important information to nurses and other healthcare providers on the needs of women with advanced breast cancer (under researched
group). However, there were limitations. The sample was drawn from four large urban Australian hospitals, the needs of rural women and women who do not speak English are not represented in these findings and may well be different from those of urban, English speaking women.

DeSanto-Madeya et al. (2007) in a study detailing the daily activities of 84 women with advanced breast cancer also showed that although women were living full and active lives, they do experience a number of problems with physical functioning including engagement with work and leisure activities. Experience of physical symptoms is frequently associated with the site of metastasis (Burnet, 2000; Fulton, 1999; Kenne-Sarenmalm et al., 2007). The sites of metastasis that frequently caused women the most physical symptoms were bone, lung, liver, skin, lymph nodes and brain (Fulton, 1999; Burnet, 2000). Hanson-Frost, Suman, and Rummans (2000) for instance, examined the differences in the physical and social well-being of women during the various breast cancer states; in newly diagnosed, adjuvant therapy, stable disease and recurrent disease and observed that the recurrent group reported a greater impact on their physical function than any other group. They also noted that the increased difficulties with physical functioning were related to the sites of metastasis such as bone and lung, which resulted in more physical symptoms and physical limitations (Hanson-Frost et al., 2000).

2.4.2. Breast Cancer and Lymphoedema Experience

According to Baldwin (2012), lymphoedema is defined by the National Lymphoedema Network as “a chronic condition in which fluid accumulates in the interstitial tissue resulting in swelling, usually in the extremities” (Baldwin, 2012 p. 4). Lymphoedema related to breast cancer is more likely to develop in patients who have advanced breast cancer, and those treated with surgery,
radiation therapy or chemotherapy (Kawn et al., 2010; Thomas-MacLean et al., 2005; Quirion, 2010). Studies indicate that around one in five women treated for breast cancer develop lymphoedema (Clark, Sitzia, & Harlow, 2005; Todd et al., 2008). According to Williams (2011), a woman with lymphoedema may experience long term swelling of her arm, hand, breast, and/or upper body, due to the accumulation of fluid. It is reported that more women are at risk for physical and psychosocial sequelae as a result of lymphoedema (Baldwin, 2012). A number of studies have assessed the effect of lymphoedema on daily lives of women. Findings from these studies show numerous physical effects and these includes but not limited to arm swelling, heaviness of the hand, pain, tightness, fatigue, sleeping disturbances, deformity, mobility impairment, and recurrent infections (Chachaj et al., 2010; Hayes, Reul-Hirche, & Turner, 2009; Meikeljohn, 2011; Preston, Seers, & Mortimer, 2008; Ridner, 2009).

Greenslade and House (2006) found that activities of daily living in 48% of breast cancer patients with lymphoedema were impaired. Similarly, a report from Mei (2005) indicates a significant impact of the physical effect of lymphoedema on activities of daily living of women. These limit women’s ability to engage in daily activities such as gardening, leisure and other social activities that enhances psychological well being and recovery. Additionally, house hold chores such as cooking, cleaning, caring for children, and grocery shopping create a challenge for women with lymphoedema, requiring some of the women to sought for support from family and friends (Johansson et al., 2003; Paskett & Stark, 2000; Radina & Aimer, 2001; Thomas-Maclean et al., 2005). In a comparative study, it was observed that psychiatric morbidity and functional disability were greater in women with lymphoedema than in women with breast cancer only. Consequently, women with lymphoedema experience a greater decline in their
quality of life (Cidon, Perea, & Lopex-Lara, 2011). Baldwin (2012) and Ridner (2009) in their studies outlined significant psychosocial implications of lymphoedema as reported by their participants. These include frustration that the limb does not work like it used to, fear that something else will go wrong, performance and function concerns, psychological distress (anger, sadness and depressive symptoms), pain, altered body image, sexuality concerns, social anxiety and avoidance, and time management issues (Chachaj et al., 2010; McWayne & Heiney, 2005; Pyszel, Malyszczak, Pyszel, Andrzejak, & Szuba, 2006; Vassard et al., 2010). Arm protection, mobility impairment, sleep disturbance and altering of dressing due to size of affected arm and pain were reported by women in other studies (Barbasi, Hawes, Enden, & Addicoat, 2004; Collins, Nash, Round, & Newman, 2004; Johansson et al., 2003; Kärki, Simonen, Mälkiä, & Selfe, 2005; Ridner, 2005; Radina & Aimer, 2001).

According to Pyszel et al. (2006), although treatment of breast cancer can alter body image, the majority of patients with lymphoedema have difficulty adjusting to the visible swelling of secondary lymphoedema. The authors further indicated that women in their study reported that disfigurement resulting from breast cancer surgery is only visible in intimate situations and can be covered with cosmetic surgery and prosthetics (Pyszel et al., 2006). However, the disfigurement from upper extremity lymphoedema is always visible and thus can be a source of social anxieties (Greenslade & House, 2006; Pyszel et al., 2006). Using a qualitative approach, Thomas-Maclean et al. (2005) explored the experiences of 22 New Brunswick women with breast cancer related lymphoedema and its treatment. The researchers from their findings noted a variety of symptoms, such as numbness, tingling, aching, seepage, and burning. The women in Thomas-Maclean et al. (2005) study indicated that they were confronted with psychosocial
effects of breast cancer related lymphoedema. Thomas-Maclean and colleagues documented the severity of these effects on the women daily lives. These include women’s ability to engage in ordinary activities, including paid and unpaid labour, household chores, sports, and leisure activities, all of which seriously reduce their quality of life. The limitation of the study was that the sample did not include women with advanced disease and therefore the experience of women with advanced breast cancer with lymphoedema was missing in the study.

2.4.3. Malignant Wound Experience with Advanced Breast Cancer

A malignant wound is an infiltration of a cancer into the skin and the afferent blood and lymph vessels in the breast (Grocott & Cowley, 2001; Probst et al., 2012; Young, 2005). The fungation may spread outwards by local extension causing damage through a combination of loss of vascularity, proliferative growth and ulceration if the malignant cells are not controlled through early treatment with chemotherapy, radiotherapy or hormone-therapy (Grocott, 2000; Mortimer, 2003; Probst et al., 2012). According to Probst et al. (2012), women still present at initial diagnosis with a malignant wound. The women may delay seeking help and try to hide the reality of the cancer. This highlights the huge impact and shame associated with such a wound on an intimate part of the body, which is significant for sexuality and femininity (Boon et al., 2000; Probst et al., 2012).

Report indicates that the incidence of malignant wounds in cancer is 5% to 10% (Alexander, 2009; Lo et al., 2006; Probst et al., 2012) and it is shown to be 2- 5% in patients with breast cancer (Fairbairn, 1993; Haisfield-Wolfe & Rund, 1997, Grocott, 1999). According to Lo et al. patients diagnosed with metastatic cancer develop malignant wound during the last 6–12 months
of life. Studies that focused on the location of malignant wounds reported that around 49% to 62% originates from breast cancer (Dowsett, 2002; Naylor, 2002; Probst et al., 2009).

According to Probst and colleagues (2012), symptom management is one of the biggest problems identified in clinical reviews on malignant wounds. Studies report this area as challenging for patients, informal carers as well as for health care professionals (Grocott, 2007; Lo, et al., 2008; Probst, 2009; Probst, et al., 2012). Women in Probst et al. (2010) study reported wound odour, excessive exudates, pain, bleeding and itching as the most common experienced symptoms of malignant wounds (Grocott, 2007; Lo et al., 2008; Lund-Nielsen et al., 2011; Probst, et al., 2012). With the purpose of quantifying the prevalence of malignant wounds and wound symptoms at the point of referral among 67 participants, Maida and her colleagues in 2009 carried out a prospective sequential case series of palliative medicine consultations. The authors reported that 67.7% of the patients experienced one or more wound related symptoms. The most common reported symptom was pain (31.2%), followed by exudate (14.6%), odour (10.4%), itching (5.2%), bleeding (4.2%) and other symptoms like crusting. The authors however noted that 28.4% of the wounds were symptom free (Maida et al., 2009). The researchers employed quantitative methodology in their investigation and this method did not permit the participants to provide in-depth explanations of the wound symptoms experienced. Piggin and Jones (2007) explored the meaning of living with a malignant wound from the perspective of 5 women diagnosed with breast cancer in the UK. The women in the study expressed an overwhelming sense of vulnerability in living within a body that was continually changing and could not be trusted. The women further voiced that the visibility of the cancer wound was a source of immense distress which represented a huge new challenge and altered relationships with family and friends (Alexander, 2010).
The impact of a malignant wound upon day-to-day life and psychological health is revealed in Lo et al.’s (2008) research. Exploring the lived experiences of ten (10) Taiwan patients (six women and four men) with malignant wounds, five themes emerged from the data: ‘declining physical wellbeing’, ‘wound related stigma’, ‘need for expert help’, ‘strategies in wound management’ and ‘living positively with the wound’ (p. 2702). The findings show that patients experienced distress as a result of the wound-related symptoms as well as embarrassment due to symptoms like mal odour and leakage of exudates. The participants’ social behaviour and interaction were extremely affected by wound symptoms and resulted in a degree of social isolation (Lo et al., 2008). The participants in the study expressed that care from the wound care specialist helped them to be more comfortable; less distressed, and further reduced the experience of stigma and social isolation because the wound-related symptoms were managed. However, some of the participants’ reported that they used some management strategies that further injured their wound and exacerbated problems such as bleeding because of inadequate information and practical help from health professionals (Lo et al., 2008). Although the study provides some useful insights, it was a small, exploratory study and participant numbers were small with data collection limited to one study setting only. Further research in different clinical settings will add to the credibility of the findings reported in this study.

In a multi-centre study conducted by Lo et al. (2011), only 15% of the 70 participants with a wound are reported to have a specialist nurse involved in the care of their wound. Studies indicate that malignant wounds do not heal and are generally managed with palliatively to control both wound related symptoms and to manage pain, which is one of the most common symptoms identified by patients and by caregivers (Maida et al., 2009; Probst et al., 2012; Probst
et al., 2010; Schulz et al., 2002). Lawton (1998) observed how patients, who experienced the break down in the surface of their bodies from wounds and other problems exhibited a loss of self and social identity when their bodies became irreversibly unbounded. Although palliative care seeks to palliate the unbounded body and where possible, enable the bounding of the wound there is evidence from a number of studies that this group of patients with malignant wounds receive inadequate specialized professional help in relation to palliation of the malignant wound (Lo et al., 2008; Probst et al., 2010).

Using an interpretative phenomenological approach, Probst et al. (2012) explored the experiences of nine (9) women with a malignant breast wound living in Switzerland. Two main categories emerged from the data as ‘having to simply deal with the situation’ and ‘having this problem is very embarrassing’ (p. 3). Women in the study shared their experiences on the physical and social limitations imposed on them because of copious wound exudate, odour, pain, and bleeding. The researchers noted how the women described the stressful situation of living in a body that feels like ‘mouldy’ and ‘rotten’ (p. 4). The women in the study reported using self adopted strategies such as perfumes, guaze and essensial oil to control and disguise the odor. The researchers observed how stressful and embarrassing the women felt about wound leakage and bleeding which caused them to change their clothes and wound dressing at least six (6) times a day. The women in the study expressed that all these strategies took time and lead them to stay in the home where they felt safe from scrutiny and negative comments that damaged their identity. They also had to dispense with many of their daily activities such as going to the ‘sauna, work and other social gatherings’ (p. 4). In addition to management of mal odour and bleeding, the women in Prost, et al. (2012) reported wound-related pain as having a serious impact on their
quality of life. The women used the metaphor of a ‘knife of stabbing’ to characterize their wound pain (p. 5). The researchers observed that not only were the symptoms of the wound uncontrollable and unpredictable but also the speed of growth of the wound. The majority of the women in the study described how the wound was not only eating away the breast but spreading further and further, eroding and extending. For instance, ‘the cancer is eating away my chest’ (p. 5) was expressed by some participants and they described their loss of femininity due to their changing body image. The women identity as women and sexual being was challenged and they felt marginalized from the society in which they lived (Probst et al., 2012).

2.5. Psychosocial Experiences of Advanced Breast Cancer

According to Tunner (2005), a considerable number of psychosocial studies have been carried out on breast cancer. However, much of the studies to date have been skewed towards screening, primary diagnosis, and early treatment options. The emotional implications of women with disease recurrence and metastases are numerous but there is a paucity of studies illuminating the level and type of emotional morbidity experienced by these women as they negotiate the shift from potentially curable disease to an incurable disease (Tunner, 2005). Such information is of clinical importance to guide the provision of optimal psychosocial care for all women with breast cancer.

The emotional and psychological challenges of breast cancer have been described as traumatic, life altering and linked with high levels of uncertainty, fear, sadness, suffering, anxiety, pain, lost hope, and suicidal tendencies (Macmillian, 2006; Schneider & Shenassa, 2008; Warran, 2010 ). A number of studies suggest that, psychological problems can often be more traumatic and
challenging to some patients than the physical aspects of the disease, thus contributing significantly to the overall suffering and reduction in quality of life (Fawzy, Fawzy, & Armdt, 1995; Hopwood et al., 1991; Jenkins et al., 1991). Macmillian (2006) exploring the emotional impact of cancer of 1,751 people, noted that 45% people with cancer reported that the emotional aspects of the disease were most difficult to deal with, as compared to the physical effects. Other studies reports patients viewing their condition as hopeless and uncontrollable, resulting in a higher rate of psychological problems such as fear, sadness, anxiety, and depression (Kenne-Sarenmalm et al., 2007; Warren, 2010).

A study by Svensson, Brandberg, Einbeigi, and Ahlberg (2009) employed a qualitative approach to explore the psychological reactions and coping on disease progression after first-line chemotherapy among 20 women with metastatic breast cancer in Sweden. A range of psychological symptoms that were reported in this study include pain, sadness, disappointment, anxiety, and worry about the future which was the most emotional response and setback in view of disease progression. The authors further revealed that women who are most likely to be at risk of developing psychological problems are those with a history of psychological illness, lack of social support, isolation, pre-existing relationship problems, and low expectations of the treatment outcome. The women in this study enumerated a number of strategies that they used to cope with the situation. These included work, social support and attending church (Svensson et al, 2009). These findings concur with reports from other studies which examined the impact of social networks on psychological distress in breast cancer patients. It was reported that, being married or living with a partner appears to buffer women from mood disturbances after breast cancer treatment. Being unmarried or divorced was found as a predictor of depressive symptoms
(Christensen et al., 2009; Hoffman et al., 2009). Warren (2010) in a literature review identified common psychological problems experienced by women with advanced breast cancer such as living with uncertainty, anxiety, depression, lack of control, and emotional functioning.

2.5.1. Pain Experience with Advanced Breast Cancer

Pain is a major symptom reported by women with breast cancer. It is estimated that 17–57% of patients in active treatment and 23–100% of patients with advanced or terminal disease suffer from pain of the disease (Miaskowski, Clearly, & Burney, 2005; Patrick et al., 2004). Evidence from one of the earliest studies commonly cited on advanced breast cancer maintains that women diagnosed with the disease experience significant pain (Daut & Cleeland, 1982). Cancer pain has an intense impact on every aspect of life and is thus the leading cause of total distress in cancer patients (Kuuppelomaki & Lauri, 1998; Wells, Murphy, Wujcik, & Johnson, 2003) and a significant number of patients continue to experience pain despite pharmacological interventions (Lynn et al., 2009; Zeppetella, O’Doherty, & Collins, 2000).

In a study conducted by Doumit, Huijer, and Kelley (2007), the lived experiences of 10 Lebanese oncology patients (6 women and 4 men) receiving palliative care were explored. The respondent’s primary diagnoses varied among breast, colon, lung and bone cancer with metastasis and their treatment at the time of the study differed between palliative chemotherapy and symptomatic treatment. Using a qualitative approach, the authors reported that the main concern of the respondents focused on the “pain” they experience, particularly the fear of becoming dependent on others and with the feeling of being pitied. Doumit et al. (2007) noted that, the women’s expression about pain and death is in accordance with Henry Fielding (1707–
1754), who wrote, ‘it is not death, but dying, that is terrible’ (p. 317). Respondents maintained that the worst part of their disease was mainly “pain” and craved relief by any means even if it is killing the cancer itself. As a limitation, the study could have used a multi method design to explore further and compare the pain experience between men and women to illuminate any such differences.

Several studies have also reported feelings of fear of pain and loss of control by women with breast cancer in their findings (Doumit, Saghir, Huijer, Kelley, & Nassar, 2010; Vilhauer, 2008). Women used in these studies expressed living with frustration due to fear of disease progression and pain. The majority of women as reported in these studies particularly mentioned that, they are less active because of the pain they suffer from their cancer. The severity of the pain prevents them from engaging in daily activities such as lifting and dragging of loads. These findings are also similar to other studies about cancer and other chronic diseases (Bottorf et al., 2007; Browall, Gaston-Johansson, & Danielson, 2006; Ganz et al., 1996).

Bender et al. (2008) explored the meaning of pain to 18 women receiving treatment for breast cancer in a large teaching hospital in Canada. The authors noted that all women seemed to find it difficult to describe their pain adequately and often begin by saying ‘It is hard to describe…’ (p. 185), and resorted to analogy or metaphor in their description. Some of the women explicitly expressed that they would like to learn how to describe their pain to health professionals. The majority of women described themselves as living with the cancer for six or more years and had evidence of metastasis. A predominant concern of all these women was a desire to know the cause of their pain; whether their pain was caused by or related to their cancer. They feared that
new or an intense pain meant that the cancer was getting worse or spreading or a new form of
cancer was developing. These findings are also supported by a number of studies on patients’
experience with pain (Doumit et al., 2010; Doumi et al., 2007). The study explored the meaning
of pain from women with breast cancer at various stage of the disease. Maximum variation
sample of women with diverse characteristics (disease status and treatment profile) was obtained
to capture the core experiences and central themes that cut across a variety of patient
perspectives.

A report from a ten year prospective study on pain relief concluded that effective management of
pain in women with advanced breast cancer is a significant quality of life concern (Aranda et al.,
2006; Kenne-Sarenalm et al., 2007; Thornton et al., 2005; Zech, Grond, Lynch, Hertel, &
Lehmann, 1995). It is however rare to have a complete pain relief system. For the last 20 years
the use of analgesics for pain management in cancer patients have been based on the World
Health Organization’s (WHO’s) analgesic ladder; in the best hands, this can result in about 75%
of patients achieving good pain control. However, poor cancer pain management has been
identified by WHO as a global health problem of the highest priority (Li et al., 2012; Zhao, Zhou
& Song, 2007). Growing bodies of evidence continues to show that the majority of patients with
various malignancies experience moderate to severe pain (Bennet, 2008; Cohen, 2008; Nessa,
2004). Li et al. (2012) noted that inadequate pain control can significantly affect the patient’s
quality of life and may in turn affect the patient’s will to live or comply with treatment
recommendations. Unrelieved pain increases the risk for mood disturbance, and can inhibit
immune function, facilitating the progression of advanced disease (Li et al., 2012; Zaza & Baine,
2002).
There are different ways to cope with pain as noted by Ostermann, Neugebauer, and Heusser, (2010). Studies indicate that patients who are often in pain resort to their spouses or intimate partners for physical and emotional support, and this serves as an important coping resource (Badr, Carmack, Kashy, Cristofanilli, & Revenson, 2010; Giese-Davis, Hermanson, Koopman, Weibel, & Spiegel, 2000; Keefe, Abernethy, & Campbell, 2005; Keefe et al., 2003). Patients with cancer pain have a strong reliance on external sources respectively Trust in God's Help (Büssing & Ostermann, 2008; Büssing, Ostermann, & Matthiessen, 2007).

### 2.5.2. Lack of certainty, grieving in advanced breast cancer and fear of death

Lack of certainty in advanced breast cancer has many facets (Warran, 2010). Living with a range of changing emotions is seen as a dominant aspect of uncertainty in a number of studies (Aranda et al., 2006; Burnet & Robinson, 2000; Davies & Sque, 2002; Svensson et al., 2009; Turner et al., 2005). In these studies, the authors found among women with breast cancer that uncertainty about the future and learning to be in control was critical. In contrast to patients with early staged breast cancer who generally viewed their treatment as being potentially curative, patients with advanced breast cancer recognised the incurable nature of their disease and as a result, experienced greater uncertainty (Burnet & Robinson, 2000). In the literature, Nelson (1996) was one of the most cited studies on breast cancer and uncertainty. The author carried out a qualitative research to examine certainty about the future of nine (9) women living with breast cancer at different stages of the disease trajectory. Women in Nelson’s (1996) study spoke of anxiety throughout their uncertainty experience which was linked to their awareness of the unpredictable nature of the disease.
Advanced breast cancer patients also experienced ‘grief’ associated with real and imagined losses (Turner et al., 2005; Vilhauer, 2008). Real losses focused on an inability to plan or control important areas of their life due to disease progression and side effects of treatments while potential losses include the possibility that women would miss out on significant life events such as the marriage of children or grandchildren if their lives were foreshortened (Nelson, 1996). Vilhauer (2008) observed that the stress that worries breast cancer women comes from uncertainty, fear of dying, fear of disease progression, debilitation and the loss of their future.

It has been observed that report from the media transmits a negative sense of fear and uncertainty on women’s future. Women are frightened by what media said concerning new and emerging treatments that offered no certainty of ‘cure’ (Davies & Sque, 2002, p. 583-588). These stories frequently resulted in an unpredictable change of emotions as patients alternated between hope and hopelessness as a result of these reports (Dunn & Steginga, 2000; Marks, 2000; Saywell, Beattie, & Henderson, 2000). Turner et al. (2005) indicated that one-third (32.8%) of the 66 participants viewed lack of certainty as being one of the difficult things to come to terms with in advanced breast cancer. Some participants linked the lack of certainty to living with a ‘time bomb ticking’ (p. 402), and this corresponds with what was reported in Davies and Sque’s (2002) study, that having an advanced breast cancer is like waiting for a ‘time bomb’ to explode (p. 589). These authors theorised these experiences as ‘living on the outside looking in’ (p. 586), to describe and explain the disembodied experience of living with the uncertainty of advanced breast cancer. Turner et al. (2005) noted that treatment effectiveness, whether positive or negative, influenced women’s lack of certainty and their ability to have control over their lives.
The ways in which women tried to gain power and control over this lack of certainty was to keep busy, either through their working lives or other activities in order to avoid thinking about what might happen in the future. Access to information was also very important in helping women deal with lack of certainty. In general, women with advanced breast cancer use information and varied support modalities to learn about their diagnosis, treatment and their side effects (Nelson, 1996; Svensson et al., 2009). These studies revealed a trend towards a relationship between the benefits of information and support on particular areas of need. Further research is needed to explore the relationship between these variables to provide a deeper understanding of their impact on the needs of women with advanced breast cancer.

Being well-informed and understanding the illness and its treatment also helped women to gain control over their lives (Leadbeater, 2006). Given the prognostic uncertainty surrounding a diagnosis of advanced breast cancer, it is necessary that nurses and other health professionals discuss issues on treatment and prognosis fully so that patients do not think that important information or details about their prognosis have been deliberately kept from them (Leadbeater, 2006; Mahon, Cella, & Donovan, 1990; Mayer & Grober, 2005). Simply talking about their lack of certainty with another person contributed to women feeling better supported, even if this did not change the outcome (Koopman, Hermanson, & Diamond, 1998; Mayer & Grober, 2005; Nelson, 1996; Svensson et al., 2009).

A number of studies also reported that fear of death was a psychological distress among breast cancer patients (Chekryn, 1984; Ganz, 2008; Landmark & Wahl, 2002; Mahon et al., 1990). When Chekryn (1984) questioned respondents if cancer recurrence posed specific problems,
83% of the women expressed concerns about the likelihood of death. Mahon et al. in 1990 confirmed this in a study of 40 patients diagnosed with recurrent cancer, where every patient expressed concerns about death and death-related issues. Similarly, in Vilhauer’s (2008) qualitative study, most of the women mentioned an episodic preoccupation with fear of death. For many women with recurrent breast cancer, the threat of death is much more real than it is in the initial stage of the disease, given that fear of dying generally regresses in women with curable disease over time (Mahon et al., 1990). Women’s fear of death could come back at any time, particularly when their disease start to progress or when they become aware of the death of others with the same disease. Additionally, fear about their death was powerfully evoked when women saw reflections of themselves in other sick patients (Nelson, 1996; Turner et al., 2005; Vilhauer, 2008). It is vital for women to understand the lack of certainty of their advanced breast disease, while putting it into a broader life perspective that is meaningful to them (Leadbeater, 2006; Nelson, 1996).

2.5.3. Anxiety and depression in advanced breast cancer

A previous study on breast cancer maintained that, the psychological impact of initial diagnosis of cancer tends to decrease with time among newly diagnosed patients and most patients adjust to their disease (Cassileth et al., 1985). However, problems like depression and anxiety tend to persist for longer periods after diagnosis (Dow & Lafferty, 2000; Irvine, Brown, Crooks, Roberts, & Browne, 1991; Omne-Ponten et al., 1994). As compared with early stage cancer, the diagnosis of late-stage cancer reflects a failure of early detection and this poses a greater threat to the life of the patient because of the spread of the disease (Greene et al., 2002). Metastasis of a primary cancer therefore, is more likely to cause elevated levels of psychosocial distress such as
anxiety and depression than the non-metastatic disease (Siddiqi, Given, Given, & Sikorskii, 2009). Studies have pointed out that among patients with chronic disease, those with depression normally respond differently to treatment, suffer higher mortality rate and their functional limitations are not always explained by their physical capabilities as compared with non-depressed patients with the same disease (Angelino & Treisman, 2001; Bush et al., 2001; Hahm et al., 2008; Murr et al., 2000; Spiegel & Giese-Davis, 2003). Furthermore, it has been reported that cancer patients with metastasis are more depressed and experience worse quality of life than patients with primary disease (Bull et al., 1999; Simon, Thompson, Flashman, & Wardle, 2008).

Employing a quantitative method, Grabasch et al. (2006) studied 227 women with metastatic breast cancer in Australia to determine the frequency of psychiatric morbidity and to assess quality of life. The authors reported that, 42% of the women had depression or anxiety, or both. Grabash and colleagues concluded that, women with advanced breast cancer experienced high rates of psychiatric and psychological disturbance which substantially affected their quality of life. A significant limitation of the study was the exclusion of women with geographical inaccessibility and women with minimal command of spoken English. This cast a strain on internal validity and generalization of the study findings (Grabasch et al., 2006). However, the study illuminates the need for clinicians to be vigilant in monitoring psychological adjustment as part of a comprehensive biopsychological approach when caring for women with advanced breast cancer. These findings were similar to those in a study by Turner et al. (2005), where women newly diagnosed of advanced breast cancer reported feelings of anger, anxiety, and depression.
Fulton (1999) studied the physical, psychological, and rehabilitation needs of metastatic breast cancer diagnosis in 80 women in the UK. It was found that, there was a strong association between physical function and mood; women reported that their physical symptoms had an effect on their mood. This is consistent with Kenne-Sarenmalm et al.’s (2007) findings, where most of the 56 women completing questionnaires looking at physical symptoms, anxiety and depression reported that the three were more likely to occur in cycle. Using a qualitative approach to study 25 women with breast cancer, the majority of women in Luoma and Hakamies-Blomqvist’s (2004) study spoke of feeling bad-tempered, feeling down, depressed and being less tolerant than they had previously been. The respondents voiced about having good emotional functioning in the absent of physical symptoms such as pain, fatigue and insomnia, and decreased emotional functioning when physical symptoms were not controlled.

2.5.4. Suicidal Tendencies

In a study conducted by Oh in 2005, a spouse shared his experience on how his wife committed suicide one year after been diagnosed with terminal cervical cancer. The spouse narrated that due to the severe pain his wife experienced, she was unable to maintain her daily life activities and consequently suffered from depression and helplessness which in turn caused her to commit suicide (Oh, 2005). Shime and Hahm (2011) noted that cancer diagnosis and treatment impose significant physical and psychosocial burden such as pain, weakness, suffering, anxiety and lost hopes on sufferers. To exemplify, the risk of suicidal ideation in cancer patients was higher compared with general population and the incidence of suicide in cancer patients was nearly twice that of the general population (Misono, Weiss, Fann, Redman, & Yueh, 2008; Rasic, Belik, Bolton, Chochinov, & Sareen, 2008; Walker et al., 2008). For instance, in Walker et al’s
(2008) study, three times higher risk of suicidal thoughts among patients diagnosed with cancer was noted. The authors further reported that 7.8% of these patients had thoughts of suicide or self-harm (Walker et al., 2008). This was supported by other researchers who reported a suicidal ideation prevalence of 17.7% in a population based sample of cancer patients (Schneider & Shenassa, 2008). Studies estimate that 8.5–26% of terminal patients have high levels of desire for hastened death (Jones, Huggins, Rydall, & Rodin, 2003; Mystakidou, Parpa, Katsouda, Galanos, & Vlahos, 2006; Shime & Hahm, 2011).

A number of factors are known to be associated with the desire to commit suicide among cancer patients (Jones et al., 2003; Mystakidou et al., 2006). Among these are socio-demographic factors such as advanced age, high level education, and single status (Mystakidou et al., 2006; O’Mahony et al., 2005). Among physical and illness-related factors, physical functioning and pain have been consistently related with the desire for hastened death (Mystakidou et al., 2006; O’Mahony et al., 2005; Rodin et al., 2007; Shime & Hahm, 2011). Cancer sites such as breast, cervix, head and neck, and lung were also associated with high suicide risk (Kendal, 2007; Oh, 2005; Zeller, 2006). However, a number of studies have consistently revealed that psychosocial factors such as depression, anxiety and spiritual well-being have a huge impact on the desire to hastened death (Breitbart et al., 2000; Rodin et al., 2007; Shime & Hahm, 2011). For instance, in Rodin et al. (2007) study with ambulatory metastatic cancer patients, greater association of hopelessness and depression was observed with desire for hastened death.

In an attempt to examine ‘the will to live’ in 168 advanced cancer patients, Chochinov and colleagues reported that depression, anxiety and reduced sense of well-being were major
predictors of ‘the will to live’ (Chochinov, Tataryn, Clinch, & Dudgeon, 1999). Beside these major predictors, dependency, sense of burdening others, spiritual well-being, meaninglessness, and quality of life were also reported to be associated with suicidal tendencies among cancer patients (Breitbart et al., 2000; Morita, Sakaguchi, Hirai, Tsuneto, & Shima, 2004; Shime & Hahm, 2011). According to Shime and Hahm (2011), systematic understanding of the factors underlying desire for hastened death and the relative importance of each will help to identify the direction and priority of the intervention.

2.5.5. Lost hopes and Breast Cancer

In an exploratory study on the impact of breast cancer on the duties of young women as mothers, Colleen and Moira (2011) observe that women experience a major disruption to their gender identity and ascribed roles. The chronic effects of breast cancer make women lose their roles as mothers. Women feel they are not recognized as mothers but just as patients, and their responsibilities for the well-being of children and the stability of family life are discounted (Colleen & Moira 2012). Consistent with the above findings, Campbell-Enns and Woodgate (2012) note that mothers with breast cancer describe having lost control of their bodies because of the physical changes related to breast cancer and breast reconstructive surgery. They described these changes as not only mitigating negative feeling about their bodies, but also affecting the bond that exist between them and their young children. The findings of Vallido, Wilkes, Carter and Jackson (2010) emphasize the loss of mothering role as a significant concern of mothers with breast cancer. According to them, loss of mothering role and feminine identity is a major concern of women with debilitating breast cancer. In a report of literature review on the title; “mothering disrupted by illness”, Vallido et al. 2010 indicate that women with breast cancer
were distressed by the times when their illness, hospitalization, fatigue or disability prevent them from caring for their children as they normally would. Mothering could be disrupted even when women were physically present with their children (Backman, Smith, Smith, Montie, & Suto, 2007).

2.5.6. Support and Coping with Advanced Breast Cancer

The diagnosis and treatment of breast cancer affects numerous dimensions of a woman’s life, including the physical, psychological, social, financial and spiritual (Cebeci, Balc, Yangin, Tekel, 2011). Common stressors reported by women diagnosed with breast cancer include distracted work life, future uncertainties, fear of death, physical distress especially, pain, and financial burden (Aranda et al., 2006; Cebeci et al., 2011; Hocaoglu, Kandemir, Civil, 2007; Julkunen et al., 2009; Price, 2004; Sanson-Fisher et al., 2000; Vilhauer, 2008). Reports from a number of studies indicate that the name ‘cancer’ is seen as a major source of stress. This is because it symbolizes death and intensive treatment processes, both of which are difficult for patients and their families to accept (Doumit et al., 2010; Gurm et al., 2008; Hocaoglu et al., 2007; Remmers, Holtgräwe, Pinkert, 2010; Vargens & Berterö, 2007). Studies reported the importance of receiving support by women diagnosed with breast cancer from various sources such as family, spouse, friends, religious bodies and health care professionals (Aziato, 2009; Berterö & Wilmoth, 2007; Cebeci et al., 2011; Erci & Karabulut, 2007; Howard, Balneaves, Bottorff, 2007; Raupach & Hiller, 2002; Vilhauer, 2008; Westman, Bergenmar, & Andersson, 2005).
According to Sarpong (1975), family network and support of family members is very important in Ghana especially in situations such as birth, education, marriage, ill health and death. Emotional support provided by families and friends to women diagnosed with breast cancer buffers the effects of the stresses faced by the women and improves their psychosocial well being (Bloom, Stewarts, Johnston, Banks, & Fobair, 2001). In Turkish society, it is reported by numerous studies that it is a cultural expectations and obligations for family members to play a major role in the treatment of cancer patients. Family and friends, especially women, tend to strongly support women with breast cancer. (Berterö & Wilmoth, 2007; Cebeci et al., 2011; Erci & Karabulut, 2007; Howard et al., 2007; Raupach & Hiller, 2002; Westman et al., 2005). The authors further noted the importance of family support, especially spouse support, as vital for cancer patients to best cope with their disease and treatment process. In a study by Cebeci et al. (2011) the participants emphasized the importance of family support in the process of breast cancer diagnosis and treatment and reported that they were physically, emotionally, financially and socially supported by their family members.

Gurm et al. (2008) illustrated that the social support and assistance received by women with breast cancer improved their coping behaviours, strengthened them, and decreased their distress, thus increasing their quality of life. Psychosocial interventions that provided social support and helped women to develop coping behaviours were also shown to reduce distress and improve the quality of life of women with breast cancer (Aranda et al., 2005; Cebeci et al., 2011). In Cebeci et al. (2011) study, it was noted that the relationship between the majority of women diagnosed with cancer and their spouses gradually improved after receiving a cancer diagnosis and during the treatment process. The authors further observed that the relationships of couples who already
had problems prior to diagnosis of the disease gradually worsened during the course of the disease and treatment. This was supported by a study by Hocaoglu et al. (2007) in which the authors revealed that marriages that were already strong before the cancer diagnosis improved over the course of coping with the disease, whereas marriages that were weak before the diagnosis were more likely to be negatively affected. Moreover, Wimberly, Carver, Laurenceau, Haris, and Antoni (2005) showed that a good marital relationship was very important for coping emotionally with the disease and its effects.

A report from Westman et al. (2005) indicate that some patients in their studies wished for an existential support from nurses, while others received the support that they needed from family and friends. However, in the study of Cebeci et al. (2011) women expressed that they did not receive psychosocial support from health personnel; they reported receiving only informational support from nurses during chemotherapy. The study of Raupach and Hiller (2002) concluded that women require more support and information on various problems they encounter following breast cancer treatment. Therefore, it is important that healthcare personnel especially, doctors and nurses understand and effectively provide individual support and information to patients and families in order to help them cope with the disease and the treatment processes. This can go a large extent to reduce anxiety and fear (Beaver & Witham, 2007; Gysels, Richardson, Higginson, 2004; Raupach & Hiller, 2002).

In high income countries, the peak age for breast cancer is 50 years (Cancerhelp, 2006); however, in Ghana it is 40 to 45 years (Asumanu, et al., 2000; Baako, 1999). This age range is a productive period and this is when the disease strikes women down. It is reported that the
majority of women diagnosed with breast cancer are in working age (Nilsson, Olsson, Wennman-Larsen, Petersson, & Alexanderson, 2011). For instance, 54% of all women diagnosed with breast cancer in Sweden are below 65 years of age (National Board of Health and Welfare, 2007). In Ghana between 29 to 32% of women diagnosed with breast cancer are below the age of 50 years (Anim, 1979; Ohene-Yeboah & Adjei, 2012). Gainful employment is noted as an important factor in the live of man providing not only financial security but also improving health, social interactions and a sense of contributing (Friesen, Yassi, & Cooper, 2001; Holland-Elliot, 2004; Nilsson et al., 2011). Additionally, work has been shown to have a significant impact on quality of life and most women diagnosed with cancer describe work as a normalizing factor (Kennedy, Haslam, Munir, & Pryce, 2007; Rasmussen & Elverdam, 2008; Frazier et al., 2009; Johnsson, Fornander, Rutqvist, & Olsson, 2010). In Europe and America, reports from a number of studies indicate that poor health may impede on cancer patients’ ability to work. Additionally, poor health can also lead patients to experience limitations and a range of difficulties relating to work (Bednarek & Bradley, 2005; Bouknight, Bradley, & Luo, 2006; Bradley, Given, & Roberts, 2002; Bradley, Neumark, Luo, Bednarek, & Schenk, 2005; Bradley, Oberst, & Schenk, 2006; Bradley, Neumark, Lou, & Schenk, 2007; Farley Short, Vasey, & Tuncelli, 2005; Farley Short, Vasey, & BeLue, 2008; Gudbergsson, Fossa, Borgeraas, & Dahl, 2006; Hewitt, Rowland, & Yancik, 2003; Schulz, Triska, & Tonkin, 2002). Also, reports from other studies reveal that cancer and its treatment poses difficulties in the work life of sufferers. These include Physical limitations, fatigue, emotional problems, and difficulties with concentration and memory; this may lead to a decreased ability to work (Bower, Ganz, Desmond, 2006; Hansen, Feuerstein, Calvio, Olsen, 2008; Sesto & Simmonds, 2009). Furthermore, challenges may arise because of ‘supervisors and co-workers’, lack of support from
colleagues and managers, the physical and cognitive demands of the work (Hoffman, 2005; Taskila & Lindbohm, 2007). Positive workplace support from managers and colleagues and its importance have been noted in other studies. These support was perceived as very useful as it helped women financially and socially (Main et al., 2005; Bouknight et al., 2006; Kennedy et al., 2007; Nachreiner et al., 2007; Johnsson et al., 2010). A study done in Sweden found that patients diagnosed with cancer treasured the support received from supervisors and colleagues from work expressing it as “brilliant and fantastic” (Amir, Neary, & Luker, 2008, p. 194). Participants in this study expressed that the support they received from workplace positively impacted their lives financially, socially, and emotionally (Amir et al., 2008).

According to Aziato (2009), diagnosis and treatment of breast cancer financially burdens women. In her study which explored the post mastectomy experiences of Ghanaian women diagnosed with breast cancer, it was noted that all the participants spoke about the high cost of treatment especially chemotherapy and radiotherapy (Aziato, 2009). However, it was reported that, the participants were financially supported during treatment. The financial support received by participants in Aziato’s (2009) study came from family, spouse, friends, supporting groups, religious leaders and research organization.

Coping strategies of women with breast cancer have been explored and these include faith in God, acceptance, will power, seeking for information, and social support (Aranda et al., 2005; Cebeci et al., 2011; Doumit et al., 2010; Doumit et al., 2007; Svensson et al., 2009; Vilhauer, 2008). All the eight (8) women in Cebeci et al. (2011) study believed that their disease was created by God; thus, their ‘faith in God’ (p. 4) increased after their breast cancer diagnosis.
Furthermore, all the women engaged in the act of worship to reduce their fears and stress. A number of studies have indicated that the religious beliefs of patients can increase after a diagnosis of cancer, and this is measured by increase in prayer and religious study (Bussing, Abu-Hassan, Matthiessen, Ostermann, 2007; Choumanova, Wanat, Barrett, Koopman, 2006; Harandy et al., 2010; Howard et al., 2007; Tam Ashing, Padilla, Tejero, Kagawa-Singer, 2003; Tokgöz et al., 2008). Moreover, spirituality can prevent cancer patients from falling into desperation (McClain, Rosenfeld, & Breitbart, 2003). Linley and Joseph (2004) observed that religious activities and intrinsic religiosity were both positively associated with growth. Specifically, numerous researchers have showed that spirituality and religious practice are associated with better coping and psychological well-being among breast cancer patients (Bussing, et al., 2007; Choumanova et al., 2006; Harandy et al., 2010; Howard, Balneaves, & Bottieff, 2007; Tam Ashing et al., 2003; Tokgöz et al., 2008). In the study by Doumit et al. (2007), a belief in God and religion were important factors for coping with the diagnosis of cancer.

2.6. Treatment effects of advanced breast cancer

Breast cancer is defined as incurable at the point of metastasis, and the aim of treatment changes to keeping the patient ‘as well as possible for as long as possible’ (Booth & Earl, 2006, p.1). This implies that, long life and comfort are important despite the impossibility of cure. The authors further maintained that, attention to quality of life and side effects of treatment play an important role (Booth & Earl, 2006). A number of studies on treatment of breast cancer maintain that the main problems for patients are the cancer and cancer treatment-related symptoms such as altered body image, anaemia, anorexia, nausea, vomiting, fatigue and pain, whilst many feel impaired in
their daily and social activities and have to deal with weight gain and a changed body image (Aziato, 2009; Bokemeyer & Foubert, 2004; Curt et al., 2000; Foubert, 2006; Hoybye et al., 2008; Northouse et al., 2002; Ribi et al., 2007; Vilhauer, 2008). The reality of lengthening survival means that women living with advanced breast cancer experience increasing needs that are clearly quite different from those of women with early breast cancer (Aranda et al., 2006; Burnet, 2000; Johnston & Swanton, 2006; Kissane et al., 2004; Mayer, 2010).

Studies on breast cancer conclude that, longer life for women with advanced breast cancer can only be obtained through continuous treatments, each of which is bound to fail sooner or later (Burnet, 2000; Johnston & Swanton, 2006). As a result of these treatments, women typically experience cumulative side effects and toxicities over time, for which they must receive additional therapies (Mayer, 2010). Several studies argue that with advanced breast cancer, treatment no longer centres on a cure, as it might have done at the time of a primary breast cancer diagnosis. The goal of treatment is on promoting and maintaining quality of life, relieving symptoms and extending life expectancy (Booth & Earl, 2006; Colozza et al., 2007; Davis & Sque, 2002; Dodwell, Wardley, & Johnston, 2006; Mayer, 2010; Smith, 2006; Von Minckwitz, 2006). Additionally, patients with advanced breast cancer must cope with ongoing symptoms of the disease as it progresses, necessitating further supportive care for physical and other debilitating symptoms (Aranda et al., 2005; Kissane et al., 2004; Vilhauer, 2008). A number of studies maintain that treatment of breast cancer is stressful to patients with the disease and may present a wide range of physical, psychological, social and economic effects that may influence the patient's needs (Arman, Rehnsfeldt, Lindholm, & Hamrin, 2002; Aziato, 2009; Boehmke &
Dickerson, 2006; Cebeci et al., 2011; McPhail & Smith, 2000; McPhail & Wilson, 2000; Schmid-Büchi, Dassen, & Halfens, 2005).

2.6.1. Physical effects of cancer treatment: Change in Body image

Cebeci et al. (2011) employed a qualitative approach to study the life experiences of 8 women diagnosed with breast cancer on chemotherapy in South Western Turkey. Eligibility for inclusion required women to be diagnosed of breast cancer for at least one year with no metastasis, married with no psychiatric disease, and ability to speak Turkish. Findings from the study indicate that women reported the loss of hair and breast as the most significant losses during breast cancer treatment. Most women in Cebeci et al. (2011) described the breast as very important and one of the most essential features of being a woman. Loss of the breast was therefore viewed as a loss of femininity. The women further expressed that ‘the most demoralizing and devastating loss was the mastectomy’ (p. 4). Thus, the loss of breast was seen as the most distressing and destructive loss for women. The use of qualitative approach in this study was appropriate in gaining deeper understanding and more substantial narrative data on the life experiences of breast cancer women on chemotherapy. However, this study has several limitations. First, the data was gathered from only Turkish speaking women thus, ignoring the experiences of non-Turkish patients. Therefore, the results may not be useful to a larger population with different ethnic background. Future studies could focus on a larger group of patients with diverse ethnic background. Secondly, the study included only primary breast cancer patients ignoring the experiences of patients with advanced disease. Despite these limitations, the results from the study would contribute to the ongoing effort to fill the gap in literature on breast cancer. Additionally, it will help nurses and other health professionals to understand the
experience of women living with breast cancer during therapy, and subsequently plan appropriate care in meeting the needs of the patients.

A number of studies examining the treatment effects on women with breast cancer which employs a qualitative approach also reported similar findings (Aziato, 2009; Doumit et al., 2010; Howard et al., 2007; Özkan & Açlalar, 2009). Women in these studies voiced that the breast and hair are seen as symbol of femininity and sexuality in their society. Thus, the loss of breast and hair was a traumatic life experience for many of the women, damaging their sense of attraction and sexuality. In contrast to Cebeci et al. (2011), women in Doumit et al. (2010) reported hair loss as the most ‘demoralizing and devastating loss’ (p. 45). The authors further noted that though the hair loss was expected by most of the women, they all described it as shocking, distressing and upsetting (Doumit et al., 2010). Findings from a study conducted by Vilhauer (2008) indicate that women with advanced breast cancer experience treatment related hair loss, loss of breast, weight loss/gain, and decrease capacity for leisure activities. These feelings may lead to developing a negative body image and reframing from attending social gatherings and having sexual intercourse. Physical changes leading to changes in body image appear to be very critical to women and are often affected both by breast cancer and its treatment. Vilhauer (2008) reports that women feel embarrassed and rejected due to the disfiguring outcome associated with mastectomy, weight change and the hair loss from chemotherapy and radiation therapy.

Using a cross sectional mail survey design, Schmid-Büchi, Halfen, Dassen, and Borne (2011) examined the psychosocial problems and needs of 72 patients with breast cancer and their relatives after treatment in Switzerland. Participants were within 1–24 months after completion
of cancer treatments such as surgery, chemotherapy and/or radiotherapy at the time of the study. The authors indicated that the majority of the participants reported a feeling of impairment in their physical and social activities. The participants were also concern about their body image, and further reported of feeling less feminine and attractive, complained of weight gain, changes of body perception, and appearance (Schmid-Büchi et al., 2011).

These findings are confirmed by other studies (Curt et al., 2000; Foubert, 2006; Hoybye et al., 2008; Northouse et al., 2002; Ribi et al., 2007; Vilhauer, 2008). These studies also reported loss of hair, changed body image and limitations in physical and social activities as a result of treatment with chemotherapy and/or radiation therapy. Participants in these studies indicated that, change in their physical appearance negatively impacted on their social lives. They consciously blocked social contacts and interactions to avoid gossiping. Although the study reveals opportunities for providing comprehensive care for patients, it has some limitations. The sample did not include patients with advanced breast cancer. Consequently, the small sample of 72 pairs, the use of language and access to electronic mail as inclusion criteria, cast a strain on the internal and external validity of the study. Furthermore, the study could have explored further and compare the effect of treatment between short and long period post treatment to illuminate any of such differences.

Skin reaction is one of the most common side effects of chemotherapy and radiotherapy (Ryan et al., 2007). The route of administering chemotherapy and radiotherapy is through the skin (Ryan et al., 2007). Evidence from a number of studies indicate that emitting ionizing radiations from radiotherapy and the toxic agents from chemotherapy are the main causes of skin reactions
experienced by cancer patients during treatment (Eide & Weinstock, 2005; Lopez et al., 2005; Ryan et al., 2007). According to Alley et al. (2002), alopecia, hyperpigmentation, hypopigmentation, erythema, moist desquamation, necrosis, and atrophy are the frequent dermatological manifestations reported by cancer patient receiving chemotherapy and radiotherapy.

2.6.2. Systemic Effects

Chemotherapy and radiotherapy are important treatments in cancer care. However, it is noted to be associated with debilitating side effects such as bone marrow suppression, and with increased susceptibility to infection, anorexia, diarrhoea, nausea and vomiting (Vincent, DeVita, Hellman, & Rosenberg, 2001). According to Ryan et al. (2007), cancer patients continue to experience a range of side effects despite advances in medical technology. In Schmid-Büchi et al. (2011) study, it was reported that participants who received chemotherapy and/or radiotherapy experienced gastro-intestinal symptoms such as nausea/vomiting (23.9%), changes in perception of taste when eating (25.4%), and diarrhoea which was the least common symptom (11.6%). These findings appears congruent with the reports of other studies (Aziato, 2009; Curt et al., 2000; Foubert, 2006; Hoybye et al., 2008; Northouse et al., 2002; Ribi et al., 2007; Vilhauer, 2008). Participants in these studies also reported loss of appetite, nausea, vomiting, anaemia, and limitations in physical activities as a result of treatment with chemotherapy and/or radiation therapy.

According to Rhodes and McDaniel (2001), nausea and vomiting are among the most distressing side effects of chemotherapy. In the literature, it is noted that, chemotherapy-induced nausea and
vomiting can negatively affect patients’ quality of life impacting physical, psychosocial, cognitive and role functioning (Bosnjak, Radulovic, Neskovic-Konstantinovic, & Mitrovic, 2000; Martin, Rubenstein, Elting, Kim, & Osoba, 2003).

With the aim of acquiring a deeper understanding of cancer patients’ symptom experiences with nausea and vomiting, and their consequences on daily life, Bergkvista and Wengströmb (2006) studied nine women receiving chemotherapy in Sweden using qualitative approach. All the women in Bergkvista and Wengströmb (2006) study expressed that nausea and vomiting was one of the distressing symptoms they experienced during chemotherapy. This had a significant effect on their daily lives as it negatively affected their food intake, weight and sleeping pattern. Additionally, the authors noted that, the respondents’ social lives were negatively affected by severe nausea and vomiting. Women in Bergkvista and Wengströmb (2006) study also reported experience of weakness from untreated and long standing nausea and vomiting days after treatment. This lengthened recovery periods between treatment cycles and subsequently delayed normal treatment cycles.

In their study, Maroun and the Canadian Working Group on Chemotherapy-Induced Diarrhoea reported diarrhoea as a common side effect of chemotherapy. The authors further noted that, the incidence of all grades of diarrhoea during chemotherapy has been reported to be as high as 82% (Maroun et al., 2007). Similarly, a number of studies have also reported diarrhoea as the most common and distressing symptom of chemotherapy and radiotherapy (Arnold et al., 2005; Benson, Ajani, & Catalano, 2004; Rothenberg, Meropol, Poplin, Van Cutsem, Wadler, 2001; Sharma, Tobin, Clarke, 2005). In these studies, the effects of severe and persistent diarrhoea reported were fluid and electrolyte losses. This can cause potentially life-threatening
dehydration, electrolyte imbalances, and renal impairment. In a retrospective analysis of 100 consecutively treated colorectal cancer patients with diarrhoea, Arbuckle, Huber, and Zacker (2000) reported that 45% of the 673 chemotherapy cycles were associated with chemotherapy induced diarrhoea. Totally, 52 (52%) of the 100 patients experienced severe diarrhoea (grade 3 or 4). The authors further reported that 56% of the patients required a modification in chemotherapeutic regimen thus dose reduction, delay in therapy, or discontinuation (Arbuckle et al., 2000). Similarly, Dranitsaris, Maroun and Shah (2005) conducted a retrospective analysis of 63 colorectal cancer patients after receiving a variety of chemotherapy regimens with or without concurrent radiotherapy in Canada. The authors found that 58% of the patient developed severe diarrhoea after the first cycle of chemotherapy. Also, it was noted that 59.6% of the patient required a reduction of, change in, or discontinuation of their chemotherapy regimen (Dranitsaris et al., 2005).

Hopkinson, Wright, McDonald, and Corner (2006) maintained that the majority of patients diagnosed with advanced breast cancer experience alteration in eating habit. The prevalence of loss of appetite among cancer patients is reported to range from 30% to 80% (Poole & Froggatt, 2002). A number of studies have reported loss of appetite as one of the adverse effects of chemotherapy and radiotherapy (Aziato, 2009; Kubrak et al., 2010; Poole & Froggatt, 2002). Bernhardson, Olson, Baracos, and Wismer, (2012) examined eating habits during chemotherapy in 12 cancer patients with chemosensory alterations in Canada. Using qualitative approach, the authors reported that all the participants experienced taste alterations following chemotherapy cycles with alterations most noticed immediately after chemotherapy and lasting after two or three weeks.
One of the frequent occurring problems noted in cancer patients is anaemia (Ludwig et al., 2004; Smyth & Zumbrink, 2005). Red blood cells are prone to the cytotoxic effects of chemotherapy and radiotherapy (Cutsema & Arends, 2005). According to Bokemeyer and Foubert (2004), the causes of anaemia in patients with cancer are generally multifactorial, and may be related to the cancer and/or the myelosuppressive effects of chemotherapy and radiation therapy (Foubert, 2006). Foubert (2006) noted that anaemia may influence treatment outcomes. Perhaps of equal concern to healthcare professionals is the reduced success of treatment and decreased survival rates associated with anaemia (Smyth & Zumbrink, 2005). Research indicates that chemotherapy dose reductions or delays used to allow erythropoietic recovery reduce the overall chemotherapy dose intensity and may compromise therapeutic efficacy. Furthermore, evidence suggests that anaemia may be detrimental to disease control and survival in patients with cancer (Obermair et al., 2000; Obermair et al., 2001). Because of the unfavorable effects of anaemia on quality of life and prognosis of cancer patients, the treatment of anaemia would be expected to improve outcomes (Smyth & Zumbrink, 2005). For patients on treatment, blood transfusion remains an option if immediate correction of anaemia is required to raise the level of haemoglobin (Hb) (Smyth & Zumbrink, 2005). Blood transfusions remain a rapid, transient and reliable method of correcting anaemia, especially in life-threatening situations. However, potential risks of transfusion reported include transmission of infectious agents, allergic/febrile reactions, iron and circulatory overload, and possibly an unfavourable effect on cancer outcome (Smyth & Zumbrink, 2005). Blood transfusions are also depended on a limited resource (based on volunteer donations) and are typically reserved for patients with severe anaemia (Bokemeyer & Foubert, 2004; Rizzo et al., 2002).
2.7. Reflections on the Literature Review

The literatures reviewed so far indicate that advanced breast cancer and its treatment have physical and psychosocial consequences on patients. These findings are basically base on studies from high income countries. There is a wide gap in existing knowledge about advanced breast cancer in the Ghanaian context. In this study, information about the experiences of women diagnosed with advanced breast cancer will be provided. Challenges faced by Ghanaian women diagnosed and treated of advanced breast cancer will be explored and described. It is hoped that the study findings will aid in developing interventions that will address the needs of women with advanced disease. In the ensuing chapter, detailed descriptions of the methodology employed in the study are presented.
CHAPTER THREE

3.0. Methodology

3.1. Introduction

This chapter describes the research design, setting, target population; sampling, data collection and data analysis. In addition, trustworthiness (methodological rigour) and ethical considerations are discussed.

3.2. Research Design

The study employed a qualitative exploratory descriptive design. This design was used to explore, understand and describe the experiences of women diagnosed with advanced breast cancer (Mayan, 2009; Mayan, 2001). The design was also useful since little is known in the area of study: experiences of women with advanced breast cancer in Ghana (Larrabee, 2009). According to Larrabee (2009) and Mayan (2009), the purpose of qualitative research is to study human phenomena in their naturally occurring states using holistic methodologies rather than manipulation and controlling. Several studies that focused on experiences of patients with breast cancer in different settings employed qualitative methods. This study draws from such studies (Doumit et al., 2007; Doumit et al., 2010; Vilhauer, 2008; Rosenzweig et al., 2009).

3.3. Research Setting

Kumasi, Ghana’s second biggest city is 300km from the National Capital, Accra. The city is 150sq km in size. Politically, Kumasi is divided into ten sub metropolitan areas: Manhyia, Tafo, Suame, Asokwa, Oforikrom, Asawase, Bantama, Kwadaso, Nhyiaeso, and Subin. There are 209 communities in Kumasi. In terms of population, it is the largest of the 27 districts in the Ashanti
Region with an estimated population of 1,690,488 and an annual growth rate of 3.4% (Ghana Statistical Service, 2011). The indigenous people are Ashantis and their primary occupation includes trading and farming. The local dialect of the Ashantis’ is ‘Twi’ (Ghanaian local language). Kumasi is cosmopolitan in nature and has drawn migrants from all over the country and from abroad. There is mixed culture in Kumasi because, apart from the Ashantis, other ethnic groups have also settled in the city. These include Fantes, Dangomba, Frafra, Hausa, Ewe, Ga Adangbe and Krobo.

There are many public and private schools in the metropolis and contains one of the nation’s universities (Kwame Nkrumah University of Science and Technology). The Metropolitan health services are organized around both private and public hospitals and include:

- 1 Teaching Hospital (Komfo Anokye Hospital).
- 5 District Hospitals (with one designated as the Regional Hospital).
- 4 Quasi-governments Hospitals.
- 2 Children Hospitals.
- 7 Health Centres.
- 3 Christian Health Associations of Ghana (CHAG) Institutions.
- 13 Industrial Clinics.
- 113 Private Hospitals/Clinics.
- 55 Maternity Homes.
- 15 Private Laboratories.
- 672 Pharmacies.
- 510 Chemical Shops.
The Oncology unit of the Komfo Anokye Teaching Hospital was the outlet for the recruitment of the participants. The unit is the only national radiotherapy centre in the Kumasi Metropolis that sees and treats cancer patients. The Komfo Anokye Teaching Hospital (KATH) in Bantama was built in 1940 and became a Teaching Hospital in 1975. The geographical location of the 1000 – bed Komfo Anokye Teaching Hospital, the road network of the country and commercial nature of Kumasi make the hospital accessible to all the areas that share boundaries with Ashanti Region and others that are further away. Referrals are received from the three Northern Regions namely, Northern, Upper East, and Upper West Region; Brong Ahafo, Central, Western, Eastern and some parts of the Volta Region.

The hospital’s Radiotherapy and Nuclear Medicine (Oncology Unit) was commissioned in 2004 by the then president of Ghana, His Excellency, Mr. John Agyekum Kufuor and has been operating till date. Cancer treatment services are given to clients with malignant tumours and haematological cancers. The centre sees and treats about 575 newly diagnosed patients annually. The highest treated cases at the centre are cervical cancers followed by breast cancers. The treatment modalities available at the unit are chemotherapy, radiotherapy and brachytherapy. The centre also sees to referred cases from the neighbouring countries such as Cote d’lvoire, Togo, Nigeria and other African countries.

3.4. Target Population

The target population for this study was Ghanaian women living in the Kumasi metropolis who have been diagnosed with advanced breast cancer.
3.4.1. Inclusion Criteria

Criteria for inclusion for the study were women who: (a) were diagnosed with advanced breast cancer, (b) could express themselves in ‘Twi’ (local dialect) or English (these were the languages the researcher could speak fluently), (d) gave consent to take part in the study.

3.4.2. Exclusion Criteria

The following women were excluded from the study: women diagnosed with early breast cancer. Also, women who could not express themselves in ‘Twi’ (local dialect) or English language and women at the terminal stages who found it difficult to communicate. Women with obvious psychiatric disorder were also excluded from the study. Obvious psychiatric disorder was identified from the behaviour of potential participants such as mannerisms and inappropriate answers, history from the family and the healthcare team’s records documented in the women medical folder. This was part of the recruitment screening by the researcher.

3.5. Sample Size and Sampling Technique

The sample size of the study was 10. This was determined after the 10th participant was interviewed. The data reached saturation by the 10th interview as successive participants gave similar responses and no new themes or subthemes were generated. The study employed purposive sampling technique; this allowed sufficient recruitment of participants who met the inclusion criteria for the study. Thus, the researcher purposively recruited participants she believed could provide more in-depth information on lived experiences of advanced breast cancer (Larrabee, 2009; Mayan, 2009; Polit & Beck, 2008). The Oncology unit of the Komfo Anokye Teaching Hospital was the outlet of recruitment. Women diagnosed with advanced
breast cancer that came for review at the Oncology unit or were referred to the unit and met the inclusion criteria were recruited.

The researcher sought formal permission with an introductory letter from the school of Nursing, University of Ghana, stating the purpose of the study and gave a copy of the ethical approval to the head of the Oncology Unit. Two of the researcher’s nursing colleagues at the Oncology unit and the nurse manager of the unit helped to recruit the participants (recruitment links). The “link nurses” were asked by the researcher to give the study’s information sheets to the potential participants. In cases where potential participants could not read and understand the information sheet, the link nurses read and explained the content of the information sheet to them. The researcher had a pre-interview interaction with the linking nurses to specify the purpose of the study, the inclusion and exclusion criteria. They were provided with a reminder sheet which spelt out the purpose of the study, inclusion and exclusion criteria as well as an information sheet (recruitment tool) to give them full information about the study. This helped the nurses to assist in recruiting appropriate participants. The researcher’s contact number was made available to the nurses and they alerted the researcher when potential participant was identified. The researcher subsequently screened potential participants to confirm their suitability for the study while maintaining confidentiality. The researcher, being a nurse at the Oncology unit also employed purposive sampling to recruit participants during breast clinic on Mondays.

3.6. Data Collection Tool and Procedure

In-depth interview of each participant was conducted face-to-face by the researcher using a semi-structured interview guide. This created an opportunity for participants to express their feelings,
thoughts and views in their own words with the purpose of gathering rich data (Mayan, 2009; Mayan, 2001). The interview guide contained a few (7) open-ended questions which were developed based on the research questions, the objectives of the study and on the literature review (Appendix B). The interview language was one in which the participants and the researcher could speak fluently. Six (6) of the interviews were conducted in participant’s home and four (4) in an office assigned to the researcher at the Oncology unit. All the interviews were conducted in Twi (local dialect). Pre-interview demographic information was collected before the main interview. The interview guide was translated into Twi (local dialect) during the interview as the researcher does not write this language. The researcher ensured translation of the interview guide by another person who spoke and wrote this language to ensure accuracy of translation.

The interviews lasted approximately 45 to 90 minutes per session and were tape-recorded with the participants’ permission. First, the researcher informed the participants that, they have the choice not to answer questions they consider private and this would not affect the care they received. Then, the researcher started the interview with a general question; this helped the participants to relax. The researcher used flexible open ended and descriptive questions as well as intentional silence during the interview to allow participants express their thoughts. Each interviewee was asked to reflect on her experiences with advanced breast cancer. Other questions which inquired about the physical and psychosocial experiences as well as the effects of treatment with advanced breast cancer were asked. Participants were encouraged to freely express themselves. Responses were probed or redirected where necessary during the interview and this enabled interviewees to respond within the study objectives.
Some of the women with breast wound and lymphoedema at a point in the interview, wept for sometime during which the tape was put off until they regained control of themselves. Other participants also shed tears sharing their experiences with advanced breast cancer. The women looked cheerful after sharing their stories and hence were not referred for counselling. The researcher kept detailed field notes. This included information about the environment, gestures, interruptions, and other relevant events that occurred during the data collection. In addition, the researcher’s impact on the setting through her presence was recorded in the field notes. The researcher’s thoughts, feelings, ideas, moments of confusion, biases, and interpretations (researcher’s reflexions) about what was observed during the interview were written in the field notes. The field notes helped the researcher to make sense of the data. Furthermore, it was used during the data analysis to add context and depth to the findings (Mayan, 2001). A journal was kept to record the researcher’s personal reflections, emotions, mistakes and successes. This also provided context and background for the analysis. During the interview, the researcher asked for clarifications and explanations thus, there was no need for a second interview. Every interview was summarized and the participants thanked for participation.

3.7. Pilot Study

The questions set to conduct the interview for the study were pre-tested using two women diagnosed with advanced breast cancer at “Peace and Love Clinic”, to ensure that the guiding questions (see Appendix B) were clear. The institution is the only private cancer clinic in Kumasi and had similar characteristics of the study population used for the main study. The results of the pre-testing helped the researcher to make the relevant and necessary amendments in the original interview guide. Some of the questions were restructured based on the information collected
during the pre-testing. Through the pilot interviews the researcher practised and improved her own interviewing skills.

3.8. Data Management

The importance of data management is to accurately store the data for easy access or retrieval in future (Bell, 2010). This will promote the progress of the research. The data generated from the study was manually managed by the researcher. Each participant was assigned a number (001 through 010) in order of recruitment into the study. The interviews were transcribed from “Twi” (local dialect) to English language based on the meaning of the respondents’ comments. The researcher discussed the transcription with a person competent in “Twi” (local dialect) and English language to ensure translation whiles maintaining confidentiality. This was to confirm translations and to ensure accuracy. The researcher explained the need to maintain confidentiality to the translator. Later, pseudo names were used to replace the numbers. A seven centimetre margin was created to provide space for writing codes. Participants’ validation was done at the end of each interview through summary of key elements to ensure participants’ meanings were not altered. Hard copies of each of the interviews were kept in a locked cabinet for safe keeping. This was separated from the demographic information sheets which were identifiable information. Each interview was typed with different colour fonts and saved with a different file name. The interviews were also saved and stored on an external drive to prevent the loss of data. Measures that were employed to store and protect the raw data for at least 5 years are indicated under ethical considerations (p. 73-74). Future use of the raw data will be done with ethical approval from the appropriate body. Additionally, measures ensuring anonymity and
confidentiality were explained to the participants as indicated under ethical considerations (page 73-74).

**3.9. Data Analysis**

In a qualitative study, analysis of the data begins from the first participant and is an iterative process (Larrabee, 2009; Mayan, 2001). Data was analyzed concurrently with data collection using content analysis. This was done to describe the findings. Content analysis is the process of organizing and integrating narratives, according to emerging themes and concepts. Classically, it is a procedure for analyzing written or verbal communication in a systematic and objective fashion (Punch, 2005). Voluminous data was generated and techniques described by Miles and Huberman were employed to analyse the data. These included data reduction; data display and drawing conclusion and verification (Miles & Huberman, 1994; Punch, 2005). Each transcript was read, reread many times to gain a sense of the whole and to be familiarised with the content of the transcript. The researcher searched for similar ideas, thoughts and words within the data as she read and this made up the codes. Similar codes were grouped to form themes, and related themes were clustered to form categories.

All the identified categories were coded with descriptive subheadings in a file. Each transcript was handled in this same manner, and new theme or category that emerged during the process was added to the file until all the scripts were scrutinized. During the analysis, relationships between the themes and the categories were further analyzed and grouped into major categories. Identified codes were written in the margin created against the line of the transcripts where the themes or codes were found. This process of summarizing, coding and categorization of the
transcribed data is called data reduction (Miles & Huberman, 1994). After the data reduction process, the researcher gained understanding to draw inferences and pattern of relationships in the data. This is known as data display (Miles & Huberman, 1994).

Different files were created for all the major themes. Employing the techniques of cut and paste, the researcher managed the process by cutting and pasting data from one interview after the other using different colour fonts. The final step in content analysis is drawing of conclusion and verification (Miles & Huberman, 1994). During the interview, the researcher asked for clarifications and further confirmed individual responses by summarizing the participants’ stories at the end of each interview. Tentative conclusions were drawn and comparisons of individual responses were made in relation to respondents’ experiences with advanced breast cancer. The researcher reached consensus with her supervisors during the coding process. The initial content of each file were reviewed by researcher’s supervisors and some codes were moved to appropriate files.

3.10. Methodological Rigour

Rigour in qualitative study has to do with the ability to determine if the conclusions drawn by the researcher accurately represents the participants’ experiences and are to be trusted. Credibility, dependability, confirmability, transferability and authenticity have been promoted as the major criteria for establishing trustworthiness in qualitative research (Guba & Lincoln, 1981; Guba & Lincoln, 1989; Larrabee, 2009; Shenton, 2004). According to Mayan (2001), other strategies that can be used during the research to contribute to rigour include prolonged engagement, participant/member checks, journal writing, peer review, and audit trail. The researcher ensured
trustworthiness using the above criteria: credibility, dependability, confirmability, transferability, and authenticity.

Credibility is achieved when the findings from the data reflects reality (Larrabee, 2009; Guba & Lincoln, 1981). In order to ensure this, the researcher purposefully recruited participants who met the inclusion criteria and could provide in-depth information on their experiences with advanced breast cancer. Additionally, the researcher conducted member checks to verify responses and interpretations with the participants at the end of each interview before drawing final conclusions from the data. This process of summarizing and obtaining feedback from the participants ensured that stories of the participants were correctly and clearly presented. Each interview was also transcribed and analyzed (coded) before the subsequent interview was conducted. The researcher’s supervisor further coded some of the interviews independently. This was compared to the coding done by the researcher and any disparities were discussed. This was done to ensure true representation of participants’ reality.

Transferability is the extent to which the findings of the study can be applicable in other settings (Guba & Lincoln, 1981; Larrabee, 2009). The researcher ensured this through a detailed description of the research setting, methodology and background of the samples used in the study. Additionally, analysis of documents and the transcribed data were kept for reference purposes. This is known as “inquiry’s paper trail” (Larrabee, 2009 p. 37). This will provide the means for other researchers to transfer the conclusions of this study to other similar cases or to repeat, as closely as possible, the procedure of this research.
Dependability pertains to whether or not the study could be replicated by another researcher (Guba & Lincoln, 1981; Larrabee, 2009). In order to meet this criterion, the researcher worked closely with her supervisors from the start of the study to finish. The researcher in her report provided detailed description of the research design and the procedures used in collecting and analysing the data in the final report. Additionally, detailed description of the research methodology as it was implemented was also provided. The full background of participants was also provided.

In order to establish confirmability and authenticity, the researcher ensured that the findings reflected the participants’ experiences and not the researcher’s. Observations made by the researcher during the interview were detailed in the field notes. A journal was kept by the researcher to provide context and background for the analysis as indicated under data collection tool and procedure (p. 66-67). In ensuring authenticity, the researcher strived to understand the women’s realities and presented it in a manner that made readers sensitive to the issues described relating to the experiences of women with advanced breast cancer (Guba & Lincoln, 1981).

3.11. Ethical Considerations

The ethical approval was obtained from the Institutional Review Board at the Noguchi Memorial Institute for Medical Research, University of Ghana for ethical approval. Ethical approval was granted (Appendix I). Permission was sought from the Oncology unit of the Komfo Anokye Teaching Hospital, Kumasi with an introductory letter from the School of Nursing, University of Ghana and a copy of the ethical approval. The purpose, objectives and any potential benefits and risks were explained to participants in the language of their choice (Twi) a week before data
collection. This allowed participants enough time to consider their participation. Respondents who met the inclusion criteria and understood and agreed to be part of the study were asked to give their consent by signing or thump printing a consent form. Respondents were informed that they could decline to take part of the study or withdraw from the study even after they had signed the consent form without any consequences. Additionally, they were informed that the raw data will be used only for the purposes for which it was collected. Only the researcher, her supervisors, and a translator had access to the raw data.

Anonymity was ensured by assigning numbers (001 to 010) to each participant during recruitment. Pseudonyms were used later to replace the numbers when quoting verbatim expressions of the participants in the findings chapter. The participants were informed that, the data and other study documents such as consent forms, audiotapes and transcripts would be kept in a cabinet under lock and key in the researcher’s office for at least five years after the study. The sheet containing the demographic data and other identifiable information were also kept under lock and key separately from the interview data in a cabinet in the researcher’s office. The participants were informed that appropriate ethical clearance would be sought if necessary to use the data in the future for any other purpose. The researcher arranged with the hospital counsellor to assist the participants who may need counselling after expressing their experiences of living with advanced breast cancer at no cost to them. No participant was referred to the counsellor because the participants regained control over their emotions after sharing their experiences. The participants were assured of anonymity during publications of aspects of this study.
CHAPTER FOUR

4.0. Findings

4.1. Introduction

This chapter describes the findings of data generated from the respondents on their experiences of advanced breast cancer. Experiences that were common to all the respondents as well as distinctive experiences of individual respondents are also presented. Using content analysis, eight (8) themes that emerged from the data were; impaired activities of daily living, malignant wound, body image, physiological effects, emotional reactions, support, lost hopes, and coping. These main themes and their sub themes (categories) are presented with anonymised verbatim quotations from the respondents using pseudonyms. A background description of respondents of the study is also provided.

4.2. Description of Study Population

The study population was ten women aged between 32 and 65 years. One (1) was in her early thirties; two (2) in their mid forties, two (2) in their early fifties, three (3) in their late fifties and two (2) in their mid sixties. Their educational backgrounds were primary education (3), middle (1), tertiary (3) and no formal education (3). Two (2) of the participants were divorced and the rest were married. One of the participants was a Muslim and the rest were Christians. Four (4) of the women were initially diagnosed with primary breast cancer and later developed advanced breast cancer while the rest reported with advanced breast cancer. Participants’ current treatments differed between chemotherapy or radiotherapy or both (8), and symptomatic treatment (2). Participants’ life experience with advanced breast cancer ranged between 1 and 3 years. Four (4) of the women had family histories of breast cancer. One (1) respondent in her
early thirties had no child while the others had children. For those with children, the number ranged from 1 to 12. At the time of the interview all participants were not working. However, before the diagnosis, their occupations included trading (4), farming (2), nursing (1), teaching (1) and cleaning (2). The women could spoke several languages such as English, Twi, Dagaari, Buem, Krakyei, Hausa, and Fante. All the participants could speak Twi aside their native languages. The residential location of participant varied between urban (8) and rural (2) settlement in and around the Kumasi metropolis.

In the quest to answer the first research question; “What are the physical effects of advanced breast cancer on women?” the study identified two major themes; “impaired activities of daily living and malignant wound”. These are presented in the following paragraphs.

4.3. Impaired Activities of Daily Living

All the women in the study expressed their inability to carry out activities of daily living. The sub-themes identified are; washing (laundry problems), difficulty in bathing and grooming, cooking and eating constraints, mobility impairment, and lymphoedema (painful arm swelling). It was realized that the women sought support from spouses, family, and friends to wash their clothes.

4.3.1. Washing (Laundry problems)

All the women indicated their inability to wash their dirty clothes when. As a result, most of the women avoided wearing many dresses in order to reduce the bulk of clothes for laundry. This was because they depended on external support for washing. As a 38 year old Afiba narrated:
“As for washing my dirty clothes, sometimes I call some of the ladies I am free with in my neighbourhood to help me. I don’t wear a lot of clothing, so it takes about two weeks or a month before I find somebody to come and wash”.

She continued to say;

“When my husband comes to visit, he sometimes washes my panties. He does really well in this regard. Any number I pack, he washes and irons all for me”.

Aku also could not wash her things and depended on her sister in law for washing. She echoed;

“No, if my clothes are dirty, my sister in-law washes for me. She asks for my dirty clothes when she is laundering. What I do is that, I don’t wear a lot of clothes. I wear only this dress everyday; if I should put on a lot of cloths, I can’t wash them when dirty”.

However, some of the women felt embarrassed that their clothes had to be washed by others due to the odour and stains from their wounds. For instance, Dzifa lamented;

“As for my laundry, my niece does it for me. Even though she is a relative, I at times become embarrassed because of the scent and blood stains from the wounds but what can I do? She uses parazone to wash them for me”.

Asaaba was also concerned about her sister’s house helps washing her clothes. She said;

“For that, she makes her house help wash them and I really think about that because I wish I could do it myself. The children are not mine, they live with my sister. When they are asked to clean my wet, stained and smelly clothes, it bothers me that they are being bothered. My sister expects me to ask the house help to wash my clothing anytime I need help, and says I shouldn’t be bothered, but I am”.

4.3.2. Difficulty Bathing and Grooming

All the women in this study bemoaned their inability to bath and groom themselves because of weakness, pain and swollen arms from the progressive disease and therefore needed assistance in
bathing and grooming. Most of the women stated that they were bathed by their daughters. Nyamekye had lymphoedema so her daughter bathes her. She shared her experience as follows;

“I cannot do anything. My hand has become very heavy. My hand was not like this initially. Now I don’t do anything at home, I cannot bath; I can’t put on my clothes and I can’t tie my hair scarf unless someone helps me. I have been lying at one place; my daughters do everything for me”.

Forty year old Maama could not lift her hands because of lymphoedema and back pain. She sought for support in everything. She also had this to share;

“Everything needs to be done for me, even with bathing and dressing because my back, sometimes even if I just lift my hands, I feel pain all over my back”.

However, Aku and Dzifa had no one to assist them in bathing and grooming and therefore tried to bath and groom themselves even when in pain. Aku said;

“I can’t take a complete bath. When I go to the bathroom, I bath my feet and then pour water on myself. I can’t bath my back; I have not bathed my back and left hand for some time. I have no one to assist me. I have to manage with bathing even in pain. It is very difficult for those of us who have nobody to care for us so I try myself”.

Dzifa baths with only one hand. She shared her experience;

“I bath like when you are bathing in bed. Using only one hand, I bath with soapy sponge and wipe with a wet towel. I manage to do it even though it takes a longer time. I use only one hand and it pains so I will not be fast like using two hands”.

4.3.3. Cooking and Eating Constraints

It was realized that all respondents expressed worry and sadness, and most of them cried when they could not cook because of weakness and swollen arms from advanced cancer. The majority of the respondents lived with hunger which sometimes led to dizziness at night, sweating, and difficulty in sleeping. These symptoms can be possible indications of hypoglycemia.
Aku for instance, was not able to cook and she experienced symptoms indicative of hypoglycemia at night due to hunger. She narrated;

“At night I feel hungry; my heart beat so fast and I experience dizziness. Three (3) days ago someone brought me bananas and I was able to eat eight (8) of them, I was dying that night; I ate eight (8) and drank water before I could sleep. The next day I felt the same thing in the night”.

She continued to say;

“No visitor enquires about my eating. I can’t use my hand for anything and I don’t also have any one to cook for me. I do not like food from restaurants. I can get very hungry”.

Likewise, Afiba was not able to cook like she used to and expressed her sadness through crying when she is hungry. She said;

“Sometimes when I cast my mind back to the things I used to do especially cooking when hungry, I become sad and cry. I buy foodstuff in bulk but I cannot cook and I have no one to cook for me. It mostly go bad and I most of the time stay with hunger”.

Asaaba reported that her husband cooked for the whole family. She echoed;

“I cannot cook. My husband does the family cooking. He cooks for me and the children. He is very supportive”.

4.3.4. Mobility Impairment

The majority of the women reported weakness and reduced strength because of advanced cancer and side effect of chemotherapy. The women stated that they could not go about their routine activities such as going to the market, grocery shops and church.

Dzifa, whose disease has metastasized to the bone and is immobile, reported;
“Sister, this disease is very difficult, as I talk to you now all my back is sore because I am immobilized. The doctor now says the cancer has metastasized into my bones so I can neither walk nor stand. I am always indoors lying down. I cannot go to work nor do anything. I need to be carried to a car to the hospital so it is very difficult”.

Afiba couldn’t go to the market and sought help for her food items to be bought in bulk. She said;

“Because I do not have the strength to go to the market, I make her (work colleague) buy the food items in bulk. I do not even have the strength to get up and put the items in to the fridge when they are brought. Most of the items go bad”.

Aku could not walk by herself and needed support to board a car. She echoed;

“I cannot go anywhere, to the market, church or anyplace I used to go. Walking is very difficult for me now. I feel tired and weak and my hand prevents me from getting up. My hand and back need to be supported when I am getting up, even when getting into a chartered taxi to the hospital; a lot of people need to support me into the taxi. I am now confined to only this place because of this disease”.

4.3.5. Lymphoedema (Painful swollen arm)

Six of the women had lymphoedema at the time of the study. As stated on (page 78) under the sub-theme ‘difficulty bathing and grooming’, the women stated that they could not use the swollen arm to do anything including bathing and grooming. They felt pain and the swollen arm also caused them to slant to the opposite side of the affected arm. Dzifa felt heaviness of the affected arm and could not walk with the arm by her side. She shared her experience as follows;

“It has become heavy like a bag of cement. I cannot walk with it by my side unless I support it with my other hand. I ask for help to board a car. I cannot bring my hand down and it has caused me to slant to the opposite of the affected arm”.
Aku could not lift her swollen arm; she could not pick anything from the floor. She commented;

“All my back is swollen and is very hard. I can’t even lift my hand up; I can’t do anything with it; I can’t use it to pick anything from the floor, it is just lying beside me’’.

Nyamekye compared her heavy swollen arm to a bag of ‘cement’. She said;

“I am not balanced because my arm is heavy and it pulls me. When I sleep and rest it on me, my body becomes tired. It has become very heavy; have you lifted a bag of cement before? That’s how it feels’’.

Additionally, Nyamekye noticed a change in her posture and does not see herself as a human being due to the effect of advanced breast cancer. She echoed;

“I mostly stand in front of my mirror to look at myself. I wasn’t like this initially; now I have slanted to the opposite of the affected arm. My photo is hanged in front of my bed so when I look at the photo and then at myself, it is like today I don’t resemble a human being at all but what can I do? It is the sickness that has caused these changes in my physique because I looked very different in the past’’.

4.4. Malignant Wound

This major theme considers experiences of women with breast wound. It describes sub-themes such as nature of wound and odour. Five (5) of the respondents had offensive breast wounds at the time of the study. The respondents stated that they see the breast as representing womanhood and feminism and therefore the breast wound was a source of stress to them.

4.4.1. Nature of Wound

Five (5) of the women had malignant wounds. The women stated that their breasts were rotten with maggots and discharges. The researcher observed the breast of two respondents that were
filled with maggots and the breast tissue was almost destroyed; one had a big hole in the breast with yellowish slough and two women had their breast wounds bleeding on contact. In this regard, Dzifa had her breast destroyed by cancer. There was discharge from her wound; she felt pain and the wound bled on contact. She expressed her grief as follows;

“The breast has become a very big wound with a hole in it; the cancer has eaten the breast away. My normal breast was big but now my chest is flat, I have not done any surgery. The wound smells with discharges. Now if I wear a dress, it gets stuck into it so when I am undressing, it pains me and bleeds too”.

Ama’s wound was filled with maggots. She was concerned about her beauty and could not expose her breast to her husband. She described her thoughts as follows;

“As a woman, my beauty is symbolized by my breast and my breast is destroyed with cancer. How can a woman’s beauty become a wound like this with all these maggots? It always secretes fluid and is very painful. Sister, I am really suffering. Now I feel shy to expose my chest to my husband. The worms eat the breast and that is very painful”.

Forty two year old Asaaba was concerned about the embarrassment she experienced because of excessive wound discharge that wet her dress. She narrated;

“My wound is filled with worms. The worms feed on my breast and that causes a great deal of pain. The wound discharge is copious and no amount of absorbents can keep it dry. My dress always gets wet and that is very embarrassing. I am very worried about it and the doctors said it will not heal. So can I live with this till I die?”.

4.4.2. Odour

Odour from breast wound was a major source of worry and sadness for women with advanced breast cancer in this study. The odour caused the women to isolate themselves from people and also prevented them from attending social gathering to avoid embarrassment and gossip. The
women expressed concerns about the odour from their wound. Asaaba could not mingle with people because of odour from her wound. She felt stigmatized and isolated. She lamented;

“I fear to mingle with other people and to even sit near people. People become disturbed when I move close to them. I smell very bad and pollute the whole environment. People get up and some also spit. This is all because of the wound odour. The smell does not go down even when I spray with perfume. I feel stigmatized and isolated. This is one of the biggest embarrassments I experience”.

Dzifa was worried about comments from people and drivers and she wished to die than to go through disgrace. She expressed her desolation as follows;

“Sometimes, going out to do my labs becomes a very big burden for me. This is because I may meet people in the vehicle and at the laboratory. Sometimes in a vehicle, the conductor or passengers make comments about a bad smell in the car; knowing that the smell comes from me worries me. People spit through the windows and push away from me. I always cry in my closet and I wish God to kill me than to go through this disgrace and stigma (tearing up)”.

Yaa felt shy to go for social gathering. In an attempt to control the wound odour, she used air refreshners. She shared her experience as follows;

“My wound smells very bad, I use air refreshner but it does not control it. I feel shy to go to the laboratory, church or other social gatherings. My presence is always noticed because of my odour. Even at home, people don’t like coming into my room because of the odour. It is embarrassing”.

In answering the second research; “What are the effects of cancer treatment on women with advanced breast cancer”? Two main themes were identified: body image and physiological effects. These are presented in the following paragraphs.

4.5. Body Image

Altered body image was reported by women as one of the adverse effects of cancer treatment, specifically, the effects of chemotherapy and radiotherapy. These include hair loss, change of
skin colour (complexion) and weight loss. Some of the women also developed lymphoedema after receiving chemotherapy and radiotherapy. It was observed that women lost their hair after cycles of chemotherapy. In addition, most of the women’s skin became very dark as a result of chemotherapy and burns from radiotherapy. Advanced breast cancer and some effects of treatment induced loss of appetite that caused participants to lose weight extremely. All the women perceived these changes in appearance to be disfiguring. The women emphasized that, signs of severe illness; hair loss, change in skin colour, and extreme weight loss made them uncomfortable and prevented them from attending social gatherings such as church to avoid gossiping. It also led to their feeling of alienation. The sub-themes identified are presented below.

4.5.1. Hair Loss

In describing their current experience with advanced breast cancer, all the women talked about hair loss as a result of chemotherapy. Respondents reported that the most demoralizing and devastating loss was hair loss. Though hair loss was expected by most of them, they all described it as shocking, distressing and upsetting. Nyamekye was pre informed about her hair loss but she did not imagine it to be very sudden. She described her experience as follows;

“The nurses told me before the chemotherapy that, I may experience hair loss but I never imagined it to be that sudden. My hair started falling off after just the first cycle when my daughter was bathing me in the evening. We were shocked and we cried. It was devastating, now I am bald; I have no hair on my head. The treatment is not easy”.

Afiba covered her hair loss with wig and scarves. She could not attend social functions because of her changed appearance. She wailed;
“All my hair is gone because of the injections. I see hair on the floor, my bed and pillow; my hair was just falling off. Now I use weave-on and scarf to cover my head. In fact, this has caused me to change and I don’t even attend social functions because of the changes”.

Ama lost all her hair after three cycles of chemotherapy. She hid herself from people and stopped all friends from visiting her at home. She narrated;

“After taking three cycles of the injection, all my hair is gone and this has further destroyed the way I look. I feel shy to go for a public function and I don’t even use public transportation anymore. I don’t go to church and I have stopped all visitations to my house. I have been hiding; people think I have travelled. The injections have really disfigured me”.

4.5.2. Change in Skin colour
Regarding changes in skin colour (complexion), the majority of the women expressed worries about the change in their skin as a result of chemotherapy and radiotherapy. The women reported that the changes occurred at exposed areas of the body such as the face, palms and feet and were difficult to hide. This was a source of stress to the women and prevented them from going out to social functions such as church. Yaayaa compared her darkened skin to her hair loss and she shared her experience as follows;

“The dark skin is more worrying than the hair loss. My hair is always covered but not my skin. I was fair but I have become dark after the injections. My friends could quickly notice the changes. I don’t go anywhere except to the hospital because I don’t want people to gossip about me”.

Dzifa became darker and her chest was burnt with radiotherapy. She said;

“I have become darker and my gum is darkened. The machine burnt my chest too and it became dark. As for cancer and its treatment, it is not easy”.
Afiba’s complexion and appearance were destroyed by cancer treatment. She commented; 

“The cancer tablets and the injections darkened my complexion. My face, palm and entire body has become like I work with black dyes. I was fair and not dark like this. The treatment has destroyed my complexion and appearance”.

4.5.3. Weight Loss

All the respondents reported a loss of weight resulting from a loss of appetite related to chemotherapy and radiotherapy. The women expressed worry and discomfort about their extreme weight loss and this prevented them from mingling with the public to avoid gossip. Nyamekye could not go to church because of her weight loss. She was worried that people will talk about her. She said;

“I have lost weight. Seeing my current state in a mirror worries me. How can I go to church with this? People will talk about me and speculate on false information about me”.

Afiba did not want people to ask her questions like ‘why have you lost weight?’ She said;

“This was not how I used to be, I have really lost weight and this has stopped me from going to church and other social gatherings. I don’t want people to ask me questions”.

4.6. Physiological Effects

Regarding this major theme, the women shared their experiences on the effect of chemotherapy and radiotherapy on their physiological functions. The data revealed sub-themes such as nausea and vomiting, loss of appetite, anaemia, and diarrhoea.
4.6.1. Nausea and Vomiting

Although all the women had chemotherapy, not all had radiotherapy. The majority of the women were still receiving treatment at the time of the study. One of the debilitating side effects was nausea and vomiting which made the women weak. The women reported that they experienced nausea, vomiting or both. Nyamekye disliked chemotherapy, saying;

“One of the things I hate about breast cancer is the injections. You will be nauseated and have the urge to vomit. Sometimes I vomit the whole week and I become weak. Even last week, I was rushed to a nearby clinic for infusions because of excessive vomiting and weakness”.

Asaaba described what she went through with her first three cycles of chemotherapy;

“Receiving three cycles of chemotherapy with radiotherapy has not been easy. I vomit excessively. The vomiting starts immediately the nurse administers the drug. I don’t like the scent at all; I taste it in my throat and mouth. The nausea and vomiting becomes worse when I get home. I vomit the whole day”.

Ama had dried skin due to vomiting from chemotherapy. She narrated;

“As for the chemo [chemotherapy] and the machine [radiotherapy], they are also another thing to deal with. Vomiting makes me loss my appetite and I become very weak. My skin too is dry”.

4.6.2. Diarrhoea

Frequent passage of watery stools was one of the side effects of chemotherapy and radiotherapy reported by the women in this study. The majority of the women stated that it made them very weak and made them bed ridden for weeks. The individual experiences are as follows: Asaaba had severe diarrhoea and had to use diapers. She sometimes soiled herself. She said;

“In fact, before I started the injections, the nurses told me everything I may experience including diarrhoea on the third day. Truly on the third day of the
injections, I had severe diarrhoea that weakened me, I could not get up and I used diapers. Sometimes, I had to defecate on myself and this was not pleasant at all”.

Nyamekye experienced diarrhoea after her fourth cycle of chemotherapy and could not sit nor stand. She echoed;

“It was the fourth cycle that made me experience severe diarrhoea. I was very weak and could not sit nor stand”.

4.6.3. Loss of Appetite

All the women taking treatment for advanced breast cancer reported loss of appetite which caused them to be weak and lose weight. The women stated that, the most worrying aspect of this was its effect on their blood cells which further interrupted their chemotherapy and radiotherapy. Asaaba could not eat due to chemotherapy. Her cycles were always delayed as a result of low blood counts. She said;

“I cannot eat when I come for the injections. I always feel the bitter taste of the drug in my mouth. This causes me to lose my appetite for food. My blood counts are always low and I am always asked to go home and eat before the next cycle. This always delay my cycles”.

Aku disliked the aroma of every food and she expressed;

“I can’t eat after the chemotherapy. The aroma of every food smells bad to me. My entire mouth is sore so I don’t even have the appetite for food”.

Maame shared her experience with radiotherapy;

“I have been on the machine for some weeks and I feel pains with swallowing of food. My throat is sore and the doctor said it is from the machine. The machines burn you too, especially your throat and prevent you from eating”.
4.6.4. Anaemia

The majority of the women stated that they were anaemic chemotherapy. The women attributed this to the treatment itself and also to their inability to eat well after chemotherapy and radiotherapy. The women expressed worry about this as it subjected them to blood transfusions in extreme cases. The women recounted some of the challenges they went through with transfusion, like difficulty in getting blood donors and reaction to blood transfusions. They further stated that their treatment cycles were mostly delayed at least for a week as a result of anaemia. Afiba had low Hb after receiving treatment and received eight pints of blood to enable her continue the treatment. She echoed;

“I have received eight (8) pints of blood because my hemoglobin (HB) is low whenever I come for the treatment. Also I cannot eat for the blood count to increase, so I am mostly transfused to help me continue the treatment. The blood is very expensive even when you get somebody to donate and getting all the eight (8) people was difficult. I had to pay”.

Yaayaa reacted to blood transfusion and she prayed against future transfusions. She narrated;

“Normally, when I come for my labs, the doctors will say that the HB is low, so I have to be transfused. I am O negative, so getting donors is very difficult. I don’t have any one to donate for me so I have to pay. Now I pray not to go for transfusion again because I had severe shivering and rashes with my last transfusion”.

Ama refused blood transfusion because of her faith and it delayed chemotherapy for some weeks. She shared her experience as follows;

“Any time my HB is low, the doctors first prescribe blood for me but I refuse because of my faith. I am a member of Jehovah Witness church. I delay the chemo for at least two weeks and then build my blood up with drugs and green leaves”.

Subsequently, in response to the third research question: “What are the psycho-social experiences of advanced breast cancer on women?” four (4) major themes were identified from
the study and these were; emotional reactions, support, lost hope, and coping. These are presented with sub-themes and quotations from participants.

4.7. Emotional Reactions

The study revealed sub-themes such as pain, sadness, fear and anxiety, and suicidal tendencies. It was realized that these women experienced great pain that led some of them to have suicidal thoughts. The women employed alternatives practices such as praying and lying on the floor to cope with their pain when pain medications failed. Also, the women expressed sadness whenever they heard that their cancer had spread to other parts of their bodies. They cried due to high cost of treatment and loss of their future, and were concerned about the future of their children. The women reported periodic preoccupation with fear of death which made them anxious. It was realized that women were emotionally supported by their spouses, family, other women with breast cancer, and health professionals to cope with their emotional difficulties.

4.7.1. Pain

All the women in this study admitted experiencing pain and described the pain they suffered with the disease. Some of the women stated that others needed to experience “their pain” to understand what they go through and further expressed that they wish to die rather than to go through the pain. Afiba compared her cancer pain to her labour pain eight (8) years before, and expressed her anguish;

“When I am in pain, maybe you need to go through pain to understand what I mean. When I compare my labour pains eight years ago with this one, cancer pain is really pain”.
Maame wished to die than to go through prolonged pain. She bemoaned;

“The pain does not stop, sister, even with medication. I wish to die instead of suffering”.

Asaaba could not describe her pain; she had support from her sisters when she screamed due to pain. She narrated;

“Sister, I don’t even know how to describe the pain for you to understand. It is very painful, intense, and unbearable and it causes me to scream, I am dying. My sisters run to surround me and ask, what can we do for you?”.

The women also described the nature, duration, and effect of their pain. They described it as piercing of a burning knife. The women could not eat, sleep, think, or pray as a result of the pain from advanced breast cancer. Maame felt her breast was being pierced with a burning knife and that caused her great pain such that she could not sleep. She said;

“The pain feels like a knife is being used to pierce my breast and it is burning. It is as if the knife was first put in fire before it was used. It is really painful and I cannot sleep”.

Asaaba cried throughout the night because of pain and could not sleep. She was anxious about when the pain will cease. She echoed;

“I cry throughout the night and cannot sleep. I cannot even eat. I cannot think, pray nor do anything because of the pain. My entire mind is always on the pain and I become very anxious about when it will go down. I am suffering. It is not easy”.

The women further shared their experiences on how they managed and coped with their pain. The women stated using prescribed syrup morphine for their pain. However, it was realized that, the women did not experience total pain relief after using the syrup morphine and resorted to alternative therapies such as opening of windows to improve ventilation and prayers to cope with
pain. Asaaba’s doctor prescribed morphine syrup for her pain but she was not completely relieved of her pain. She narrated:

“My doctor gave me syrup morphine when I reported my pain to her. The drug reduces the severity of my pain but I don’t get complete pain relief”.

Dzifa kept quiet when she was in pain but she shouted when the pain was very intense. She expressed her experience as follows:

“I am always quite when in pain and unless I tell you, you may not know that I am in pain. Sometimes the pain pushes me to shout especially when it is very intense for a very long time”.

Three of the women used non-pharmacological measures of managing their pain when the pain medications failed to relieve their pain. Asaaba bandaged her joints, opened windows and slept on the floor in the prone position to feel the cold on the floor whiles Dzifa resorted to prayer with the rosary.

4.7.2. Sadness

The majority of the respondents said they cried after hearing that their cancer had spread beyond the breast. Some cried because of the cost of treatment and the suffering that accompanied the advanced disease. Dzifa cried because of her future and was concerned about the future of her children. The women expressed their feelings of sadness through crying. The women were consoled by their spouse, family; other women with the same disease, and health care professionals when they cried.

Maame cried because of the cost of treatment and she narrated:

“The drugs are expensive, the operation is expensive, and how do I get such money? This is what makes me cry so much”.

Dzifa hid her feelings from her children and worried about their future. She lamented;

“When I see my children coming, I pretend and smile like everything is ok; but inside me, I am a different person, I am suffering and I cry within me. Just envisaging the future of my children without me causes sorrow and sadness”.

Asaaba was concerned about defaecating on herself. She compared herself to other healthy women of her age group and wished to be like them. She said;

“A lot of things make me cry, worried and sad. Defaecating on myself is disgracing and embarrassing but I do not do it intentionally. Sometimes if I see a healthier woman of my age going about her normal activities, I mostly ask; why me? Why can’t I go up and down like them? What have I done to deserve this?”.

4.7.3. Fear and Anxiety

Regarding fear and anxiety, all the women reported that they feared they may die from advanced breast cancer and were concerned about where they will go after death. Hearing about the death of friends and remembering the death of a family member with advanced breast cancer caused anxiety and further reminded them of their own death. In addition, the media and public presentations of advanced breast cancer as a terminal illness constantly reminded them of their mortality. Maame shivered when she thought of her grave. She echoed;

“Yes, when I think of my death, I become afraid. I imagine lying in my grave alone. It makes me shiver and switch on my lights and radio”.

Dzifa was concerned about media presentation of advanced breast cancer as a ‘killer’. She said;

“I am anxious and afraid because of what is being said about the disease. Even on the radio, they say that breast cancer kills especially when you don’t report it early. I thought it was just a boil initially, so I was using herbs on it. I never thought it to be cancer so I didn’t come early and all that I know is that I will die and that makes me afraid”.

She continued to say;
Asaaba’s aunties died from advanced breast cancer and she is also afraid to die. She narrated;

“I have the fear that I may die. When I was diagnosed with advanced breast cancer, I cried because my aunties died from the same condition. Sometimes I am anxious about what will happen to me some days to come. I saw my two aunties suffering before they died”.

4.7.4. Suicidal Tendencies

Four of the respondents expressed the desire to end their lives rather than going through the suffering and pain caused by advanced breast cancer. All the four women stated that they wished to take a poisonous drug. Dzifa could not sleep because of pain. She said;

“The pain is so severe, I cannot sleep and I don’t even know what to do. If I get any poisonous drug, I will kill myself and leave this world. This world is bitter and it is made of incurable diseases. Cancer is difficult; no drug can cure it and the treatment is difficult”.

She continued to say;

“I become weak with diarrhoea, I have sore in my mouth, difficulty swallowing and a lot more so killing myself will end all the suffering. It is better to die than to stay with a disease which is incurable”.

Asaaba also preferred to die. She said;

“As for me, I prefer to die and end it than to suffer like this. Sister, it is not easy; even with pain medications round the clock, the pain remains the same”.
4.8. Support

Regarding support, women with advanced breast cancer reported that having advanced breast cancer and its symptoms were very demanding both physically and emotionally. All the women stated that without receiving support from spouses, family, friends, workplace, and health care professionals, they wouldn’t be alive by now. Spousal support was indicated by the women as a very important tool to cope with the disease. However, not all the women received support from their spouses. They further stated that they depended on spiritual advisors and financial support to go through advanced breast cancer. The sub categories are presented subsequently.

4.8.1. Spousal Support

All the women were married with the exception of Nyamekye and Aku who were divorced at the time of the study. It is worth noting that, Nyamekye and Aku had their divorce years back before the occurrence of the disease. All the married women were living with their husbands except Afiba whose husband lived in a different region because of his work. The majority of the married women stated that they had support and encouragement from their spouses. In addition, the women reported that they received assistance with physical care, emotional, social, and financial help from their spouses. Some of the spouses also accompanied their wives to the hospital when going for chemotherapy or reviews. Dzifa’s husband accompanied her to the hospital for chemotherapy and shared in her sorrow. She narrated;

“The last time I came for injections, thus the cycle four, I came with him. When we returned home, I was crying in the evening because of breast pain and he also came and sat with me crying. We cried till the next day”.
She continued to say;

“My husband’s behaviour has not change. He advices me when I am sad. He also encourages me to have a positive attitude. I think if you develop this disease and you don’t get your husband’s support, you will suffer and go through more hardships”.

Ama was grateful to God for a supportive husband. She prayed with her husband. Her husband encouraged her to have faith in God. She echoed;

“I am very grateful to God for my husband. He has really helped me; in fact, he does everything for me. Our children are grown up so we live alone and truly, I wouldn’t have survived without him. We pray together and he also encourages me to have faith in God”.

Maame had a history of marital dispute prior to the diagnosis of advanced breast cancer and she did not receive emotional support from her spouse. She stated;

“My husband buys food but he does not have time for me. No affection, attention and care”.

She continued to say;

“Even if I am sick and weak, as a husband, you should share meaningful time with me. At least, be close to me; hold me and talk with me and encourage me with words from the Quran. I think this can give me strength and even help me to hold on with the condition. He goes to his second wife and leaves me to suffer alone”.

4.8.2 Family Support

In the Ghanaian tradition, the family plays an important role especially, when one is in need. The majority of the respondents reported that they received physical, emotional, financial, and social
support from their families (mother, sister, brother and children) during diagnosis and the treatment of advanced breast cancer. Although others received help from their siblings; the help came only at the point of emergencies. Two (2) of the women stated that, their family neglected them because they believed they would die so there was no need wasting time and money on them. Maame had generous support from her sisters and she said;

“As for me, I never imagined that in my sick bed, my sisters could care for me like this. They have cared for me well. When they come here, they cry when they see me in pain”.

Asaaba felt her sister was supporting her well. She narrated;

“My sister is really supporting me from her heart and I know that I have been able to cope with this difficulty because of the support she gives me”.

Aku, on the other hand was neglected by her half siblings. She however received support from her siblings when they realized she was dying. She said;

“I live with my father’s children and they neglected me. Nobody cared but when they saw me dying, they looked for money and gave me 5 million. That is what I used last week to pay for my chemo drugs”.

4.8. 3. Support from Workplace

Some of the women who were gainfully employed had emotional support from their bosses and colleagues. The women reported that they have not been able to go to work since the diagnosis of advanced cancer but their bosses cover-up for them and they still receive their salaries. Maame was informed by her boss to go for her salary when he visited. She said;

“My boss visited me and told me to go for my salary because they started with the payment yesterday. This has been helping with my treatment”.
Afiba was told by her boss to rest at home until she was fit to go to work but she received her full monthly salary. She was visited by her managers any time she went on admission. She commented;

“Concerning my work, I am not disturbed. My boss told me to rest at home till I feel strong enough to come to work. Even up till now, my monthly salary comes in full. Any time that I come on admission, management come and visit me at the hospital”.

4.8.4. Support of Health Professionals

All the respondents except Aku had adequate support from health care professionals; nurses, doctors, radiotherapist, and health care assistants. Some of the women commended nurses and doctors for the teaching and assistance they offered them when they were emotionally disturbed. Maame felt shocked when she saw her nurse shedding tears with her. She said;

“The doctor and the nurse were very supportive. They did not stop me from crying; they allowed me to cry for a much longer time but they were still standing around me rubbing my back. I was shocked to see the nurse shedding tears, she was empathetic”.

Asaaba and her family were given some teachings on wound care by the head nurse. She narrated;

“The head nurse taught my sister how to prepare flagyl tablet with KY jelly. She gave us some dressing pads to absorb the exudates. This has helped especially with the odour”.

Despite the positive attitude of the health care professionals reported, Aku’s experience with the health care professional was negative. She commented;

“The doctors were wicked to me. It was as if they knew I was dying so they did not bother to give me any medications to control my pain. I even said, ‘even if I will die, do I have to die with suffering and pain?’ ”.
4.8.5. Spiritual Support

Nine (9) of the women were Christian and one (1) was a Muslim. The respondents’ reliance and state of dependency on God were very clear in all the interviews. All the respondents described themselves to be fully dependent on God. Faith, hope and trust in God and having a relationship with God were the most common experiences and were expressed by all the women; they saw faith as a source of strength. Most of the respondents described spiritual faith as a way of coping and source of strength to deal with advanced breast cancer, side effects of treatment, the uncertainty of illness, or for actual physical healing. The participants’ relation with God was associated with great optimism and hopefulness. The researcher observed that spirituality was very important to all the women and they all attested that, they wouldn’t have been living had it not been God. Maame who was a Muslim said;

“Any time I come to the hospital, I pray before I enter. I pray to God to show the doctor my problems and also the drugs that can heal me”.

Nyamekye had faith in God. She believed that her cancer was little for her God. She echoed;

“I have faith in God. He will heal me because He did it for Hannah and Sarah. I know that my healing from cancer is small thing for God so He will do it for me”.

Dzifa’s experience drew her closer to God and she narrated;

“Yes, I pray every day. I think this disease has even drawn me closer to God. Now I pray often; sometimes when I am thinking and crying I turn it to prayer”.

4.9. Lost Hopes

The majority of the women were worried about the uncertainty of the future. They felt a deep sense of loss about their work, marriage, parenting, and grand parenting.
4.9.1. Work

Some of the women who were self-employed were worried about the shuttered future of their work. It was their main source of income. The respondents stated that, they could not manage their business as a result of weakness from advanced breast cancer and side effects of treatment.

Maame, a business woman who imports goods from Togo had this to say;

“This disease has destroyed my business which was my life. My life is wasted now. I could not get anyone to take up my business and I have used all my capital for the treatment. I have nothing, not even one (1) Ghana cedi”.

Nyamekye could not continue with her farming. She narrated;

“I am a farmer but I no longer farm because of the disease. I don’t have the strength to continue with the farming. Today, I have lost the acres of plantations I had and I no longer think about the farm because there is nothing I can do about it”.

Ama was worried about her lost business. She used all her capital for the payment of her treatment. She commented;

“I don’t want to even think about my business because it is one of my biggest worries. That was my only source of income but today it is destroyed by this disease. I don’t even have any hope that I will one day restart. Where is the money? All is gone; I have used my capital for the treatment so I have lost everything to advanced breast cancer”.

4.9.2. Marriage

Three (3) of the married respondents expressed lost hope and gradual breakdown of their marriages. It was realized that participants lived separately from their husbands because of distance of the treatment centre of advanced breast cancer. Also, women reported that their current status did not attract their husbands’ affection. Dzifa had her marriage plans distracted because of advanced breast cancer. She echoed;
“I have no hope in my marriage. We no more discuss anything about our marriage like we used to. All the plans we had concerning our future are now hanging”.

Afiba could not live together with her husband because of the treatment of advanced breast cancer. She said;

“All my plans are messed up. My husband and I planned to live together but it could not materialize because of the disease. He is in the Eastern region but looking at the distance, I cannot travel from there to the Ashanti region for treatment all the time”.

Maame’s husband came home late and went straight to bed. She lamented;

“My husband does not show interest in me anymore. My current state does not attract him. He comes home late and sleeps off. What can I do?”.

4.9.3. Parenting

Parenting was an important phenomenon for the women. All the women apart from one, had children; some were young and depended on their mothers for survival. Some women expressed worry about the future of their children. They reported feeling a deep sense of loss about not being able to train and educate their children and also be present as their children grow up. They were also concerned about not being able to make plans or enjoy the fruits of their past achievements. Afiba was not happy about the training her son received. She puts it;

“I am not happy about my only son not living with me. I don’t like the training he is receiving. I wish to train him myself”.

Nyamekye was concerned about not seeing her grandchildren. She narrated;

“I farmed to pay for my children’s education. All the children are working now but I am dying. I will not enjoy the fruits of my hard labour and I will not see my grandchildren”.

Dzifa cried for the future of her children. She echoed;

“My children are young and there is no one to take care of them. The future of my children will be disorganized. If I die; there will be no mother to guide them”.

4.10. Coping

The women reported using a number of strategies to cope with their situation. Sub themes such as acceptance and the will to live were identified. These are presented subsequently.

4.10.1. Acceptance

All the women shared their experiences of living and moving on with advanced breast cancer. They all had the “Why me?” but then followed it directly by acceptance as they said, “let His will be done”. The individual expressions are as follows:

Maame used to cry but she has given everything to God. She expressed;

“ei Allah, why me? I used to cry everyday because of the suffering I go through with advanced breast cancer but what can I do? It is only God that I prayed to..., I have given everything to Him. Let His will be done”.

God was Nyamekye’s hope as she said;

“Now it is only God that I look up to; I do not have anything to say, let His will be done”.

Afiba accepted her disease and prayed for the will of God to prevail. She commented;
“I used to ask God that ‘why me?’ and ‘why now?’ and then cry. Sometimes I pray too. But I have seen that the crying will not help me so I have stopped. I have to accept it as it is because I cannot do anything about it unless God decides otherwise. He is the only one I look up to. Any time I pray about this disease, I tell God to let his will prevail”.

4.10.2. The Will to Live

Some of the women stated that their positive will to live has been keeping them strong till now. The women further reported that they consciously ignored negative thoughts such as fear and death and believed that they will live on with the disease despite the difficulties they go through.

Afiba prayed and she believed that she will not die. She puts it;

“I pray positively and I do not entertain negative thoughts. I believe that I will not die but live; this has always been my prayer to God and I am alive today because of this”.

Nyamekye looked forward to seeing her children married. She narrated;

“I am looking forward to see my children marry and also see my grand children grow up. As a result, I have developed the mindset that I will not die but live”.

Maame ignored the spirit of fear and death and she echoed;

“I mostly pay no attention to the spirit of fear and death. I no more entertain them in my mind. Now, I am only looking forward to see my grand children. I will not die”.

4.11. Summary

The above findings were based on data generated from participants receiving treatment or attending review at the Oncology unit of Komfo Anokye Teaching Hospital. The participants’
experiences illumine the challenges that women diagnosed with advanced breast cancer go through and the need for comprehensive care in order to promote comfort, support, and relief from symptoms. The findings are discussed into details in the next chapter.
CHAPTER FIVE

5.0. Discussion
5.1. Introduction

The current study aimed at exploring the experiences of women diagnosed with advanced breast cancer in the Kumasi Metropolis. The main themes that emerged from the data included impaired activities of daily living, malignant wound, body image, physiological effects, emotional reactions, support, coping, and lost hopes. This chapter discusses the findings in relation to existing studies. Patients diagnosed with advanced breast cancer are largely treated palliatively with chemotherapy, hormonal therapy and radiotherapy. The aim of treatment at this stage is not to cure but to relieve symptoms, improve quality of life and prolong life. Thus sufferers live with the symptoms and sufferings of the disease till death. The effects of advanced breast cancer identified in the present study are discussed subsequently. Lymphoedema, impaired activities of daily living, and malignant wound are discussed together as physical effects of advanced breast cancer.

5.2. Physical Effects of Advanced Breast Cancer

Metastatic breast cancer can affect many parts of the body, particularly the lymph nodes, bones, lungs, brain, soft tissue, skin, and liver. It causes a wide range of symptoms as observed in this study, particularly lymphoedema, malignant wound, pain, and fatigue. Other problems such as persistent coughing, loss of appetite and difficulty sleeping were also identified. In his study, Lacroix (2006) indicated that breast cancer primarily metastasizes to the regional lymph nodes, bone, lungs, liver, skin, and brain. The primary tumour begins in the breast itself, but may progress beyond the breast to the regional lymph nodes or metastasize to other organs in the body. A spread of the cancer cells to the axillary lymph nodes may compromise the ability of the
lymphatic system to effectively return fluid and other products such as proteins and minerals from the breast tissues back to the blood circulation. Fluid that would have traveled within lymphatic vessels and capillaries now pools in the tissues, resulting in swelling of the affected arm and this is the hallmark of lymphoedema (Williams, 2011).

Lymphoedema was one of the physical effects of advanced breast cancer experienced by women in this study. Six (6) of the study participants had lymphoedema and complained of symptoms such as pain, mobility impairment, and change in posture. In support of these findings, other studies have reported that women diagnosed with advanced breast cancer or treated with chemotherapy, radiotherapy or surgery are more likely to develop lymphoedema (Kawn et al., 2010; Quirion, 2010). According to Williams (2011), a woman with lymphoedema may complain of gradual swelling of her arm, hand, breast, and/or upper body, heaviness of the hand, pain, tightness, fatigue, sleep disturbances, deformity and mobility impairment due to the accumulation of fluid (Chachaj et al., 2010; Hayes et al., 2009; Meikeljohn, 2011; Preston, Seers & Mortimer, 2008; Ridner, 2009). The symptoms of lymphoedema impeded the women’s ability to raise, swing, and use the affected arm, thereby limiting their ability to carry out their routine activities of daily living. Common activities of daily living that women in the current study could not perform include bathing, grooming, laundry, cooking, and going out for groceries. In a related study, Greenslade and House (2006) noted that the symptoms of lymphoedema impair activities of daily living in 48% of breast cancer patients. Other studies report that house hold chores such as cooking, cleaning, caring for children, and grocery shopping posed a challenge for women with lymphoedema making the women to be dependent on others (Johansson et al., 2003; Paskett & Stark, 2000; Radina & Aimer, 2001; Thomas-Maclean et al., 2005). Inability to
cook made the majority of the participants in this study live with hunger which sometimes led to the experience of symptoms indicative of hypoglycemia.

Also, invasion of the skin by malignant cells can cause malignant wound. As observed in the present study, five (5) of the participant presented with breast wound at the initial diagnosis. According to Probst et al. (2012), women usually report with breast wound on first visit. Dowsett (2002) and Naylor (2002) also found that approximately 62% of malignant wounds originate from breast cancer. Women with breast wound in this study suffered pain, odour, excessive exudates, and contact bleeding. This is supported by other studies (Grocott, 2007; Lo et al., 2008; Lund-Nielsen et al., 2011; Probst et al., 2010; Probst et al., 2012). For instance, women in Probst et al.’s (2012) study reported odour, exudates, pain, contact bleeding, and itching as some of the symptoms commonly experienced with malignant breast wound.

Further, it is known that women are concerned about their outward appearance, hygienic needs and practices (Helms, O’Hea, & Corso, 2008). Routinely, women bathe, grooms, and wash their used clothes to ensure and maintain personal care. However, it was revealed in this study that, the combined effects of the symptoms of advanced breast cancer and the side effects of treatment limit the ability of women to carry out personal hygiene needs. Consequently, it was noted that women were worried over their body image and this negatively impacted on their social life specifically, social avoidance. In line with this, Johnson (2012) noted that personal hygiene is maintained for psychosocial and health reasons. Basically people, especially women hate to be talked about in a negative manner. Therefore, by maintaining clean body and being well groomed, people will be assured of projecting a positive body image that reflects their
personality. Also, the study found that wound exudates and odour caused embarrassment, and further led to social withdrawal. These findings particularly resonate with the work of Lo et al. (2008) who examined the experiences of women with malignant breast wounds. One of the themes that emerged from their study was “wound related stigma” (p. 2702). Women in Lo et al. (2008) experienced sufferings from wound-related symptoms as well as humiliation due to symptoms like mal odour, and leakage of exudates. The authors noted that the women’s social life were extremely affected by wound symptoms and resulted in a degree of social isolation (Lo et al., 2008). In an attempt to control odour and its related stigma, it was noted that strategies such as the use of perfume and air refreshners were adopted but this could not control the odour adequately in this study. Similarly, in Probst et al.’s (2012) study, it was reported that women in Switzerland used self adopted strategies such as perfumes, guaze, and essensial oil to control and mask wound odour.

The aim of treatment of advanced breast cancer is mainly to control the growth of cancer cells and to relief symptoms. Modalities of treatment such as chemotherapy, radiotherapy and hormonal therapy have adverse effects that often compound the primary symptoms of breast cancer. Loss of hair, change in skin colour, weight loss, nausea and vomiting; diarrhoea, loss of appetite, and anaemia were the side effects of treatment identified in this study. These effects are discussed in details in the ensuing paragraphs.

5.3. Body Image

Women are known to be concerned with their outward appearance, body weight, and body image (Helms, O’Hea, & Corso, 2008). Can, Demir, Eroland, and Aydiner (2012) defined body image
as the way every individual pictures his or her own body mentally and this is influenced by interpersonal, environmental, and cultural factors. According to the authors, body image incessantly develops and depends on components such as sexual image, occupation, relationship with family or friends, physical appearance, or change in any of these components (Can, Demir, Erol, & Aydiner, 2012; Dougherty, 2007; Hurk, Mols, Vingerhoets, & Breed, 2010; Hansen, 2007). According to Vihuer (2008), advanced breast cancer and its treatment affect the physical appearance of women. In the current study, body image was a major concern to the women. They were obviously worried about the changes in their bodies as a result of treatment. Treatment with radiotherapy, chemotherapy and hormonal therapy commonly results in hair loss, change in skin colour and weight loss (Cebeci et al., 2011; Vihuer, 2008). These changes were also identified in this study. Women perceived the changes as disfiguring and uncomfortable. As a result, they avoided social gatherings such as going to church in order to avoid gossip from others as reported in an earlier study of women with mastectomy in Ghana (Aziato, 2009).

In the literature, chemotherapy induced hair loss has been largely reported by women diagnosed with breast cancer (Aziato, 2009; Cebeci et al., 2011; Doumit et al, 2010; Vahuer, 2008). The hair is a major feature of body image representing life and identity. It plays a significant role in social communication; portray social class, gender, profession, religious belief, and social or political conviction (Rosman, 2004). However, the initiation of chemotherapy following the diagnosis of breast cancer causes severe hair loss that negatively affects the body image of women (Cebeci et al., 2011; Doumit et al., 2010; Hurk et al., 2010; Rosman, 2004; Vihuer, 2008). All the study participants experienced hair loss from chemotherapy. Although the women were informed about potential hair loss prior to chemotherapy, the sudden loss of hair was
shocking, upsetting, distressing, and demoralizing because it negatively affected the body image and the ability to groom and socialize. Studies that evaluated the impact of hair loss on body image revealed that cancer patients with hair loss experience increased negative perception of body image and decreased self-esteem (Can et al., 2012; Doumit et al., 2010). In Doumit et al.’s (2010) study, hair loss was described by women as ‘distressing’ and ‘demoralizing’ (P. 5).

According to Doumit and colleagues, the culture of Lebanon demands the Lebanese woman to have a good and attractive look. This cultural call has been described as mainly to attract men and keep their interest. In view of this, loss of hair associated with chemotherapy was a major concern to women in Domit et al.’s (2010) study. This was perceived as a threat to femininity and their self-identity as Lebanese women. Similarly, other studies have argued that hair is symbolically related to women’s femininity, sexuality, attractiveness and personality. As a result, chemotherapy-induced hair loss adversely impacts feminine identity (Frith, Harcourt, & Fussell, 2007; McGarvey, Baum, Pinkerton, & Rogers, 2001). The women coped with hair loss by wearing scarves, wigs, and weave on. This observation was also made by Cebeci et al. (2011). In agreement with the findings of Aziato (2009) and Vahuer (2008), women who suffered hair loss also resorted to withdrawal from the society.

Change in skin colour was also identified as a major effect of treatment. This was related to radiotherapy or chemotherapy or both. The nature of change in complexion ranges from skin burns, moist desquamation to skin darkness. Darkening of the skin started gradually in the course of treatment, and the skin remained dark even after the treatment. A study conducted in the United States reported skin reaction as one of the most common side effects of chemotherapy and radiotherapy reported (Ryan et al., 2007). Ryan et al. (2007) and Lopez et al. (2005) reported
that cancer patients receiving radiotherapy usually experience skin reactions. Changes in the skin colour during cancer treatment have also been linked to ionizing radiation and toxic effects from radiotherapy and chemotherapy respectively (Eide & Weinstock, 2005; Ryan et al., 2007). According to Alley et al. (2002), the common dermatological manifestations from chemotherapy and radiotherapy reported by cancer patients include alopecia, hyperpigmentation, hypopigmentation, erythema, moist desquamation, necrosis and atrophy. It is worth noting that easily noticeable parts of the body such as the face, gum, neck, palm and feet are usually affected by skin changes and this was found as a source of worry to the participants in this study. This resulted in social withdrawal to avoid the attention of others.

Weight loss was another significant effect of treatment in the current study. This was related to the combined effect of advanced disease and loss of appetite resulting from treatment. According to Potter, Hami, Bryan, and Quigley (2003), the most common symptoms of advanced breast cancer are weight loss (Hopkinson, Wright, & Corner, 2006) and loss of appetite (Poole & Froggatt, 2002). Poole and Froggatt (2002) examined loss of weight and appetite in patients with advanced breast cancer and indicated that the prevalence of weight loss among these patients ranges from 39%–82%. In another study which looked at the prevalence of concern about weight loss and change in eating habits in people with advanced cancer, 79% of the participants reported weight loss (Hopkinson, Wright, McDonald & Corner, 2006). Weight loss can be a source of worry to patients especially when it becomes very obvious (Hopkinson et al., 2006). In addition weight loss is reported to poorly affect the quality of life of patients (Davidson et al., 2004; Hopkinson et al., 2006). The above findings were also observed in this study. Weight loss was a source of concern to the participants and this negatively impacted on their
social lives. The presence of wasted muscles and protrusion of bony prominences made the participants in this study avoid using public transports and attending social functions. This was to avoid questions by other individuals about the sudden change in appearance. The concerns discovered in this study confirm the report by Hopkinson et al. (2006) that weight loss does not only affect patients physically but psychosocially. According to Poole and Froggatt (2002), weight loss can act as a symbol of advancing disease and can negatively impact on patients’ sense of control. It is noted that outward appearance in healthy individuals shows worthiness, control, and self-discipline (Chamberlain, 2004). However, Hopkinson et al. (2006) observed weight loss as a symbol for loss of control in patients with advanced cancer. Weight loss can be undermining because it mirrors physical and emotional weakness of the individual. These weaknesses were considered to be undesirable as they symbolized a loss of control of the disease (Hopkinson et al., 2006).

5.4. Physiological Effects

One of the objectives of the study was to explore the experiential effects of cancer treatment in women with advanced breast cancer. The use of a qualitative method led to a rich description of women’s experiences with chemotherapy and radiotherapy. The present findings reveal that women experience nausea and vomiting; diarrhoea, anorexia, and anaemia during chemotherapy and radiotherapy and these experiences had a profound effect on their quality of life. Similarly, reports from a number of studies examining patients experience with cancer treatment maintain that the main concern for cancer patients is the treatment related symptoms. These include nausea, vomiting, diarrhoea, anorexia, anaemia, and fatigue (Aziato, 2009; Bokemeyer &
According to Zachariae et al. (2007) and Hsieh et al. (2008), the main purpose of using chemotherapy is to rid the body of cancer, but, it is documented as having a range of adverse effects including nausea and vomiting. The current study found nausea and vomiting distressing and unpleasant to the participants that led to loss of appetite, weakness and dry skin. This was also reported in other studies (Dibble, Casey, Nussey, Israel, & Luce, 2004; Fabi et al., 2003; Grunberg et al., 2004). In a related study, Bergkvista and Wengströmb (2006) explored the symptoms experience among nine (9) Swedish women with different types of cancer during chemotherapy treatment. The findings of the authors were that nausea and vomiting severely impacted the daily lives of the respondents; for instance, a negative effect on food intake, weight loss, social interaction, different sleeping patterns, and anxiety. Chronic nausea and vomiting rendered cancer patients exhausted for days after the chemotherapy. As a result, recovery period between treatments cycles were lengthened (Bergkvista & Wengströmb, 2006).

Further, this study identified frequent passage of watery stools as an adverse effect of chemotherapy and radiotherapy. Diarrhoea was experienced mainly on the third day of chemotherapy and lasted for a long period. As a result, women experienced severe weakness which rendered them bed ridden. While others used diapers to avoid soiling themselves; those who could not afford the use of diapers frequently soiled themselves. Consequently, the women had to routinely go through the unpleasant ordeal of lying in soiled linen, expressing this concept as…… “I had to do it on myself and this was not pleasant at all” (Asaaba, p. 88). Estimates of
the incidence of chemotherapy induced diarrhoea suggest that 10% of patients with advanced cancer experience acute or persistent diarrhoea that may range from troublesome (grade 1) to fatal (grade 5), based on National Cancer Institute–Common Toxicity Criteria (NCI–CTC) (NCI, 2004). Other studies also reported the incidence of all grades of diarrhoea during chemotherapy to be ranging from 30% to 82%, with up to one third of patients experiencing severe (grade 3 or 4) diarrhoea (Arbuckle et al., 2000; Benson, et al., 2004; Kabbinavar, Hurwitz, & Fehrenbacher, 2003; Kornblau, Benso, & Catalano, 2000). Severe and persistent diarrhoea can result in fluid and electrolyte losses, which can cause potentially life-threatening dehydration, electrolyte imbalances, and renal insufficiency (Arnold et al., 2005; Benson et al., 2004; Maroun et al., 2007; Rothenberg, Meropol, Poplin, Van Cutsem, & Wadler, 2001; Sharma, Tobin, & Clarke, 2005). The experiences and impact of chemotherapy induced diarrhoea was not explored in these studies. However, it was noted that chemotherapy induced diarrhoea can negatively affect quality of life (Arnold et al., 2005; Benson et al., 2004; Maroun et al., 2007; Rothenberg et al., 2001; Sharma et al., 2005). This may result in death directly or indirectly from adjustments in cancer treatment which result in suboptimal therapy (Arnold et al., 2005; Benson et al., 2004; Maroun et al., 2007; Rothenberg et al., 2001; Sharma, Tobin, & Clarke, 2005).

Ill health has been noted by researchers as a turning point mostly accountable for change of food choice (Winkler et al., 2010; Sobal & Bisogni, 2009). In the literature reviewed, it is reported that cancer in its advanced stages significantly affects the eating habits of patients diagnosed with the disease (Bell et al., 2009; Hopkinson, 2007; Mroz, Chapman, Oliffe, & Bottorff, 2010). In their work, Kubrak and colleagues maintained that nutritional symptoms such as anorexia and dysphagia interfere with the ability of cancer patients to eat adequately (Kubrak et al., 2010).
According to Poole and Froggatt (2002), loss of appetite is a sign of progressive disease in cancer patients, as well as the result of undergoing toxic cancer therapies. This was also observed in the present study in which respondents reported loss of appetite from advanced disease and treatment. Chemotherapy and radiotherapy adversely affected the sense of smell and taste and further caused sore mouth which interfered with the ability to eat. Side effects of radiotherapy such as dysphagia resulting from throat burns also impeded on patients ability to eat (Kubrak et al., 2010). The women in this study had reduction in blood cell counts because they were unable to eat adequately after chemotherapy and radiotherapy. This resulted in delays in treatment cycles. In line with this, reports from several studies have indicated that chemotherapy can alter the sense of taste and smell. This may result in decreased food intake and nutritional deficiency (Hutton et al., 2007; Bernhardson, Tishelman, & Rutqvist, 2007, 2008, 2009; Brisbois, de Kock, Watanabe, Baracos, & Wismer, 2011b).

Loss of appetite and its resultant deficiencies affects the production of red blood cell that can result in anaemia. Anaemia is reported as one of the most occurring problems observed in cancer patients (Ludwig et al., 2004; Smyth & Zumbrink, 2005). Among the numerous causes of anaemia in cancer patients is myelosuppressive effect of chemotherapy and radiation therapy (Bokemeyer & Foubert 2004; Foubert, 2006). Anaemia experienced by participants in the current study was also related to chemotherapy and radiotherapy. Severe anaemia was reported as a source of distress as it subjected the women to blood transfusions and its challenges. In a related study, Smyth and Zumbrink (2005) argued that due to the implications of anaemia on prognosis and quality of life, treatment of anaemia in patients diagnosed with cancer is very necessary to positively improve treatment outcomes. In view of this, blood transfusion has been reported as
the appropriate option if urgent correction of anaemia is needed (Smyth & Zumbrink, 2005). Although blood transfusions remain the fast and reliable means of correcting anaemia, it is associated with a number of risks. Reported potential risks of blood transfusion in the literature reviewed include allergic/febrile reactions and circulatory overload (Smyth & Zumbrink, 2005). It is worth noting that blood transfusions also depend greatly on factors such as volunteer donors and is therefore strictly reserved for patients with severe anaemia (Bokemeyer et al., 2004; Rizzo et al., 2002).

Similarly allergic rash, shivering and febrile reactions were also reported in the present study as some of the immediate reactions experienced during blood transfusion. Additionally, some of the women also reported financial burden and difficulty getting blood donors. These difficulties were perceived as hindrance to blood transfusion. One respondent refused to be transfused because of her religious affiliation and resorted to nutritional supplements and drugs. Even though this is a single occurrence, it is important for health care professionals to be sensitive to religious issues when giving care and respect the belief, faith, and autonomy of individual patients. Delay in correcting anaemia may result in chemotherapy dose reduction or interrupted treatment cycles to aid erythropoietic recovery. However, anaemia is noted to decrease the overall chemotherapy dose intensity and may compromise therapeutic efficacy (Obermair et al., 2000; Obermair et al., 2001). Participants in this study reported delays in treatment cycles for at least a week or two weeks because of anaemia. Perhaps this was to allow erythropoietic recovery for the subsequent cycles as reported in the literature.

The combined effects of treatment of advanced breast cancer manifested by physical deterioration of body mass (weight loss), loss of bowel control (diarrhoea), nausea and vomiting,
poor eating habit and nutritional deficiencies had psychosocial implications on sufferers and these are discussed below.

5.5. Psychosocial Experiences of Advanced Breast Cancer

The third objective of this study was to explore the psychosocial experiences of women diagnosed with advanced breast cancer. The analysis of data generated revealed a number of psychosocial experiences and these include emotional reactions (pain, sadness, fear and anxiety; and suicidal tendencies), lost hope (parenting, marriage, and work), support (family, spouse, workplace, healthcare providers, financial, and spiritual) and coping (acceptance and the will to live). The devastating symptoms of advanced breast cancer and the crippling adverse effects of treatment rendered women incapable of controlling their personal, family and other social activities. Consequently, it was found that women were worried over their incapability and this was a source of stress. The debilitating symptoms of advanced disease compounded by the unpleasant effects of treatment made the women powerless. This led to a range of psychological responses; sadness, fear of death, anxiety, and uncertainties. In related studies, the psychosocial impact of breast cancer has been reported as distressing and life changing. Also it is related to degree of uncertainty, anxiety, fear, sadness, pain, and suffering (Macmillian, 2006; Shime & Hahm, 2011; Vilhauer, 2008; Warran, 2010).

In the wake of declining ill health, physical strength, and the emotional responses that resulted, women received support from family, spouse, workplace, and healthcare providers. This need is confirmed by reports from other studies (Bloom et al., 2001; Julkunen et al., 2009; Raupach & Hiller, 2002). Forms of support that were sought and anticipated by the study participants were physical, emotional, social, financial, and spiritual support. One of the earliest studies (Sarpong,
1975) in Ghana often cited in literature on family systems in Ghana reported the importance of family network to Ghanaians and the support of family to its members in all aspects of life such as illness, death, birth, education, and marriage (Sarpong, 1975). In the current study, spousal support was common and usually in the form of physical, financial, emotional, and spiritual. It is important to note that some of the participants had been divorced at the time of the study. Also, there was a report on spousal neglect and abuse. Children and siblings mainly assisted with household chores, grooming, and maintaining personal hygiene though some actually provided financial support for treatment as well as emotional support. Health personnel on the other hand were expected to provide efficient care with sympathy. This form of support was satisfactory despite few instances of claims of unsatisfactory care. The women received emotional support and teachings on cancer and its treatment from healthcare professionals. In contrast to the present study is a report from Cebeci et al. (2011). The authors noted that women reported receiving only information on chemotherapy but not psychosocial support from health service providers.

Work is considered an important source of financial support which enhances health and psychosocial wellbeing (Friesen et al., 2001; Holland-Elliot, 2004). Some of the women in this study were employed in the formal sector but were on sick leave at the time of the study. Report from a number of studies argue that having a gainful employment significantly improves quality of life (Kennedy et al., 2007; Rasmussen & Elverdam, 2008; Frazier et al., 2009; Johnsson et al., 2010). Several studies from Europe and other high income countries observed poor health as a factor that compromised cancer patients’ ability to work and further led patients to restrictions and a range of challenges relating to work (Bednarek & Bradley, 2005; Bouknight et al., 2006; Bradley et al., 2002; Bradley et al., 2005; Bradley et al., 2006; Bradley et al., 2007; Farley Short et al., 2005; Farley Short et al., 2008; Gudbergsson et al., 2006; Hewitt et al., 2003; Schultz et
In the present study, women reported similar experiences of inability to go to work because of weakness from advanced breast cancer and side effects of treatment. However, women received significant support and understanding from their managers and colleagues. The support received ranged from extended sick leave with full monthly salary for one year to visitations to offer practical help. Financial support from employers was used to defray the cost of treatment and personal needs. As in the current study, positive workplace support from supervisors and colleagues and its importance have also been highlighted in other studies (Main et al., 2005; Bouknight et al., 2006; Kennedy et al., 2007; Nachreiner et al., 2007; Johnsson et al., 2010). Unlike women who were gainfully employed, those who were self employed could not work effectively in their work. The women were concerned about the future of their work which was their main source of income and livelihood. Their inability to manage their work meant gradual decline or collapse of their businesses since they were the sole proprietress. At the time of the study, it was realized that, all the women who were self employed had used all their working capital in treating the disease and had no hope of restoring their business in the future.

Another support received by women in the current study was spiritual. The women exhibited trust and reliance on God as the ultimate source of healing. All the women were Christians with the exception of Maame who was a Muslim. The majority of Christian participants reflect the general Ghanaian population which consists of 68.8% Christians (Ghana Statistical Service, 2011). Also, reports indicate that religiosity is a common phenomenon in Ghana (Nukunya, 2003). All the study participants received regular prayer support from religious ministers and this increased their faith in God and further helped them to cope with the challenges of advanced breast cancer. Support was a significant determinant of positive coping. Women who had
adequate support from family, spouse, friends, workplace as well as financial and spiritual support had a psychological morale in accepting their faith and coping with the condition positively.

“Acceptance” and “the will to live” (p. 96) were the main coping strategies employed by the women in this study. The will to live was demonstrated by the women praying positively and being hopeful for long life despite their suffering. Also, they derived joy in looking forward to meeting their grandchildren with or without their present predicament. Also, accepting the disease condition was one of the strategies employed by the women as a way of coping with the disease. Acceptance in this study implies the women coming to terms with the realities of advanced breast cancer and striving to live positively with it rather than attaining a complete cure. This was manifested by following treatment regimen religiously, surrendering themselves and their concerns to God and praying for the will of God to prevail.

Owing to the physical, social, and emotional impact of breast cancer, coping measures are important for adaptation (Reynolds et al., 2000; Stanton et al., 2000). A number of studies have explored coping measures and their effect on cancer (Aranda et al., 2005; Cebeci et al., 2011; Doumit et al., 2010; Doumit et al., 2007; Svensson et al., 2009). Among the strategies used by women to cope with the suffering of advanced breast cancer include faith in God, spirituality, acceptance, will to live, seeking for information, and social support (Aranda et al., 2005; Cebeci et al., 2011; Doumit et al., 2010; Doumit et al., 2007; Svensson et al., 2009; Vilhauer, 2008). On the other hand, women who did not receive the necessary financial, physical, and emotional
support had difficulties coping with the sufferings of advanced breast cancer. Participants also reported depression, worthlessness, lost hope and a feeling of neglect.

5.6. Lost hopes

The synergic effects of advanced breast cancer and the side effects of chemotherapy, hormonal therapy, and reconstructive surgery resulted in debilitation, fatigue, and low self-image. Consequently, the women in this study reported loss of job, marriage and mothering roles. The women felt repressed and disrupted from performing their gender roles as women thereby causing them to lose hope in their future wellbeing and those of their children. The women in the study bemoaned their inability to bond with and bring up their children as they would if they did not suffer breast cancer. They could not continue their occupations nor were they hopeful of regaining jobs lost because of their conditions. The loss of hope regarding the role of women as mothers because of debilitating breast cancer was prominent in the literature. Women found their loss of mothering roles as a result of breast cancer as distressful and disruptive (Vallido et al., 2010; Colleen & Moira, 2012). Campbell-Enns and Woodgate (2012) noted that mothers with breast cancer described how they have lost control of their bodies because of the physical changes related to breast cancer and breast reconstructive surgery. These mothers described these changes as not only mitigating negative feelings about their bodies but also affecting bonding with their young children.

As identified above, women who received adequate support had better coping strategies and hope for the future. Though support and coping were found to be sources of strength in dealing with debilitating cancer symptoms, it is emphasized that some of the participants did not have the luxury of coping adequately with their condition. This could be attributed to inadequate support. For instance, lack of financial support meant skipping treatment cycles. Further, the devastating
condition left the women down-spirited with a decrease in energy and yet they did not have the emotional and spiritual support to boost their morale and energy level. This resulted in the feeling of lost hopes, mal adaptation and suicidal ideations.

Though suicidal ideations and the act of suicide were not desirable to women on religious, legal and moral grounds, it was seen as a means to ending their unrelenting pain, powerlessness and loss of hope. It can be inferred that suicide would not be an option if these women had the necessary social and psychological support to cope with their conditions as well as adequate relief of pain and treatment effects. In consistent with these findings, inadequate pain management, lack of support, powerless hopelessness and other physical symptoms of cancer have been associated with suicidal ideations in other studies (Mystakidou et al., 2006; O’Mahony et al., 2005; Oh, 2005; Rodin et al., 2007; Shime & Hahm, 2011).

In the current study, it was found that women experienced pain despite the use of analgesics specifically morphine syrup. All participants reported their feelings of pain. The women described their pain as severe and intense which was not relieved with analgesics. They described the intensity of the pain as burning and piercing. The participants expressed the wish to die and end it than to go through suffering with pain. In a similar study conducted by Doumit et al. (2007), the lived experiences of 10 Lebanese oncology patients receiving palliative care was explored. The focal concern of the respondents as observed by the authors was “pain”. Doumit and colleagues noted that, pain and death expressions by the women were in conformity with Henry Fielding (1707–1754), who wrote, “it is not death, but dying, that is terrible” (p. 317). The respondents maintained that the most awful aspect of their cancer was primarily “pain” and craved relief by any means even if it is killing the cancer itself. A growing body of evidence
suggest that the majority of patients with cancer continue to experience pain regardless of pharmacological interventions (Lynn et al., 2009; Zeppetella, O’Doherty, & Collins, 2000).

In conclusion, this chapter discussed the results obtained from the study based on the literature reviewed.

In the next and final chapter, the summary and conclusion as well as recommendations made are presented.
CHAPTER SIX

6.0. Summary and Conclusion

6.1. Introduction

This chapter presents the summary and conclusion of the study. It also focuses on the implications for nursing practice, education, research and policy. The insight gained in the study by the researcher as well as recommendations made are also stated in this chapter.

6.2. Summary and Conclusion

This qualitative study explored the lived experiences of Ghanaian women diagnosed with advanced breast cancer. The study adopted a purposive sampling technique to illuminate the perceptions of women living with advanced breast cancer. Ten (10) Ghanaian women, residing in the Kumasi Metropolis and receiving care at the Oncology unit of KATH were involved. Each participant was interviewed once and data analyzed using techniques of content analysis. The eight themes that emerged in this study were impaired activities of daily living, malignant wounds, body image, physiological effects, emotional reactions, support, coping, and lost hopes. The diagnosis of a disease such as cancer is a critical life incident that can alter an individual’s life. Dealing with the advanced breast cancer, its physical symptoms, social and emotional suffering experienced both after diagnosis and during treatment, can interfere with living a normal life. Exploring the experiences of women diagnosed with advanced breast cancer revealed a number of issues consistent with the findings of other authors regarding the phenomenon; however, there were also new discoveries peculiar to the Ghanaian context. Declined activities of daily living experienced by women as a result of advanced disease and debilitating effects of treatment appeared to be a major source of worry to the women. The
spread of the malignant cells to the regional lymph nodes caused lymphoedema of the arm on the affected side which further compounded impaired activities of daily living. This rendered women dependent on others in carrying out their daily activities. In this study, it was recognized that malignant wound and its related symptoms such as pain, odour, exudates, and bleeding subjected women to humiliations and embarrassments. As a result, women avoided social interactions and gatherings to prevent being stigmatized by others. An emotional reaction to distressing symptoms of advanced breast cancer was recognized as the commencement of the grieving process. In this study, pain was acknowledged as a distressing symptom of advanced disease which was experienced physically and emotionally. It appeared from this study that inadequate pain management affected women’s quality of life and further influenced their will to live. Women in this study expressed the desire to commit suicide due to unrelieved pain. It was recognized that the will to live was negatively impacted not only by the pain they went through but also the suffering that accompanied advanced breast cancer. Also, the sense of being a burden on others and lost hope were factors associated with the desire to commit suicide.

A person’s belief has an influence on the will to live. In view of this, spirituality as a source of support increased the faith and hopes of the women and kept them going despite the sufferings of advanced disease. The study participants received physical, emotional, and financial support from family, spouses, and workplace. It is worth noting that one woman received financial support from her church. Support was also received from health care providers though some conflicts also occurred during these interactions. Some of the women complained of inadequate care and pain management. Support was a significant determinant of good coping. Women who had adequate support had a psychological morale in accepting their faith and coping with
advanced breast cancer positively. The two main coping strategies employed by the study participants were acceptance and the will to live. On the other hand, women who did not receive the necessary support had difficulties coping with the sufferings of advanced breast cancer and had their condition worsened with depression, worthlessness and hopelessness. In this study, it was recognized that the combined effects of advanced breast cancer and the side effects of treatment resulted in debilitation, fatigue, and low self-image. As a result, the women in this study reported losses of jobs, marriage and mothering roles.

It was recognized from this study that the high cost of chemotherapy, hormonal therapy and radiotherapy as well as changes in living created a financial burden for these women. All the study participants suffered from adverse effects of chemotherapy and radiotherapy such as lose of hair, change in skin colour, weight lost, nausea and vomiting, loss of appetite, diarrhoea, and anaemia. The curiosity and gossiping nature of some Ghanaians caused all the women to withdraw and avoid using public transport, attending church, and other social gatherings. In conclusion, the overall meaning of the experience of Ghanaian women with advanced breast cancer is described as one of uncertainty, fear, lost hope, and acceptance of the disease. Acceptance of disease resulted in positive changes and healthy choices; enjoying life, accepting support, and trusting in God through prayer, faith, and hope.

6.3. Implications for Clinical Nursing Practice

The results of this study have implications for nursing practice. Understanding the lived experiences of women with advanced breast cancer can help nursing and medical practitioners to provide proficient care that meets the continual needs of their patients. Nurses have the privilege
of accompanying women through the ups and downs of this journey, and it is well documented that dealing with issues early in the disease trajectory may prevent or reduce ensuing negative effects. Therefore, nurses should make every effort to assist women living with advanced breast cancer and explore ways to meet their needs as early as possible. The emotional reactions associated with advanced breast cancer diagnosis and treatment requires nurses and other health professionals to be empathetic and caring. Nurses need to explore patients’ ideas, beliefs and experiences regarding advanced disease and their symptoms such as pain, lymphoedema and malignant wound. Early educational interventions about pain, lymphoedema, malignant wound, and their management should occur immediately after diagnosis, and pain should be recognized and treated promptly.

Understanding the concerns of women can help in the design of interventions such as counseling, treatment advice, and symptom management, informational and psychosocial support to improve the quality of life of women with advanced breast cancer. Further, the work of physiotherapist is very significant in the management of lymphoedema. All women diagnosed with advanced breast cancer with lymphoedema need to be taught arm exercise and bandaging, and also helped with exercise and bandaging to management lymphoedema.

To enhance the care of patients, advanced cancer patients should have a ward that is dedicated to oncology and palliative care. Women diagnosed with advanced breast cancer need to be cared for by a palliative care team to provide active and comprehensive care for the physical, emotional, psycho-social, and spiritual suffering of the patient and the family. The team comprising nurses, doctors, pharmacists, counselors, social workers, physiotherapist, spiritual
leaders or trained clergy, nutritionists among others will provide multidisciplinary management to the women and their family. Opportunities should also be created in the hospitals to enhance support from husbands from the beginning stages of diagnosis. Also, the family of women diagnosed with advanced breast cancer need to be educated on the disease and its management, the need to support the women physically, emotionally, and financially. Further, women with inadequate family support need to be supported by social workers in carrying out routine activities of daily living such as bathing and grooming; laundry, shopping, and cooking.

There is the need for nurses to include spiritual care when managing women with advanced breast cancer in the hospitals and other settings. Nurses should ascertain the spiritual needs of the women, facilitate contact with spiritual leaders when patients request for them, and arrange appointments. This will help the women to cope with disappointment, losses, and uncertainty. Also, it will allow them to talk of the meaning of life after death. Nurses need to respect cultural differences in the act of providing spiritual care. As patient’s advocates, nurses, social workers, and physicians can lobby the Ministry of Women and Children’s affair in Ghana to financially support women with advanced breast cancer. This can be done by making sure that the National Health Insurance Scheme (NHIS) covers the cost of all treatment modalities of advanced breast cancer. Also, nurses can link women with advanced breast cancer to the social welfare department of the hospital for financial assistance, especially women with financial difficulties.

6.4. Implications for Education

Nursing education is an integral part of the fight against the breast cancer menace. Nurses play vital roles in the education of patients and their family by virtue of their strategic position as
being the link between the client and other health care providers. They also stay with the patient throughout their admission and therefore benefit from sharing privileged personal concerns and information from the patient. Before nurses can impart knowledge of breast cancer to patients and their family, they themselves must be knowledgeable. Therefore, an oncology and palliative care curriculum is recommended for the commencement of post basic one year programme in oncology and palliative care. This specialized programme would provide adequate human resources required to nurse the increasing number of cancer patients in Ghana (Singer & Bowman, 2002; Stjernsward, 2002; Wiredu & Armah, 2006). Cancer management uses multidisciplinary team approach; it is therefore imperative that education be geared towards all health care team members such as doctors, pharmacists, counselors, clinical psychologist, social workers, physiotherapist, and spiritualist as well as the patients and their family. This will offer the team members an opportunity to benefit from specific training in cancer and palliative care so that they can give quality care and support to advanced breast cancer patients and their families.

Development of educational material for women with advanced breast cancer to assist them cope with the diagnosis would be beneficial. The media, through interactions with oncology specialists, can be sensitized to create awareness on breast cancer and promote the message of support for persons living with advanced cancers. Programmes designed to increase awareness about breast cancer would do much towards prevention and early detection. Educational strategies can be put in place so that procedures for breast self-examination and early signs and symptoms of breast cancer are highlighted. These will enhance early detection of breast cancer so that the number of advanced breast cancer patients will be reduced. Finally, nurse educators
need to be aware of the potential needs and concerns of advanced breast cancer patients and teach students to explore their patients’ needs.

6.5. Implications for Policy

Results of this study emphasized the importance of initiating national strategies for cancer palliative care that meet the needs of Ghanaian cancer patients. It is therefore important to institutionalize palliative care services in our hospitals and to train personnel in this area to render quality care to patients with advanced cancers. Cancer support groups and the media need to lobby government to include all aspects of the treatment of advanced cancer in the National Health Insurance Scheme. Oncology nurses can institute regular breast screening programmes to help with early detection of breast cancer. The nurses can also lobby for a policy that will offer free breast screening for Ghanaian women at all health care institutions.

6.6. Avenues for Future Research

Based on the results of this study, several potential studies can be delineated. For instance the major themes that emerged from the study can be further investigated to gain an in depth understanding of this experience. Other areas that can be explored are as follows:

- The experiences of women with malignant wound.
- The experiences of men with advanced breast cancer.
- The experiences of women with early-stage breast cancer.
- The experiences of women with advanced breast cancer compared to the experiences of women with early-stage breast cancer.
- The experiences of men with advanced breast cancer compared to the experiences of women with advanced breast cancer.
- The experiences of women with lymphoedema.

- Pain management at the terminal stage from patients, caregivers and health professionals’ perspective.

- The impact of advanced breast cancer diagnosis on marital relationship.

- The impact of advanced breast cancer diagnosis on parenting can also be studied.

- A general survey to access the knowledge and attitude of nurses on advanced breast cancer and palliative care.

- The experiences of non-formal caregivers of women diagnosed with breast cancer.

6.7. Field Experiences

The experiences of the researcher during the course of this study can be described as very rich and revealing. New friends and relationships were established in the process. This study exposed the researcher to the realities of living with advanced disease and further offered the researcher the opportunity to learn what women diagnosed with advanced breast cancer go through, and their needs in everyday life. In fact, emotional reactions such as sympathy and greater appreciation of everyday life were the feelings of the researcher at the time of the study especially, during the interview sections. The physical and emotional sufferings shared by the women with the researcher caused the researcher to shed tears with goose pimples all over her body. This was because of the emotional pain the researcher experienced during the interview. Some of the women were emotionally touched when they saw the researcher’s empathetic attitude. This made the women to open up and shared their experiences freely. The participants with malignant wounds showed their wounds without any prompting. The researcher was moved emotionally seeing a woman’s breast with maggots. Through interaction with women diagnosed with advanced breast cancer, the researcher has developed an empathetic attitude towards all
patients and families with terminal illness. The study as a whole was very emotional and elicited sadness as the women explored their thoughts and shared their experiences with advanced breast cancer. The study also offered the women the opportunity to voice their experiences to a listening ear. The researcher observed that the women looked cheerful after sharing their story. It looked like they had disposed off ‘a heavy burden’.

6.8. Limitations of the Study

As with all qualitative research, the sample cannot be considered representative of the population of advanced breast cancer women in Ghana. Only those who were willing to discuss their experiences were asked to participate in the study. Purposeful sampling of participants is a typical qualitative method and is effective when greater depth of information is required. The extent to which results of this study can be generalized to Ghanaian breast cancer women is limited; however, generalizability is not a goal of qualitative study. Guba and Lincoln (1981) imply that the findings of a qualitative study should be considered in terms of transferability. One person’s experience cannot directly become another person’s experience. Nevertheless, what can be transferred from one person to another is not the experience as experienced, but its meaning. The participants were all women so the experiences of men were not explored. The present study included only advanced breast cancer patients. Different advanced cancer types may lead to different life experiences. One of the challenges faced during data collection was difficulty locating the participants’ home because of poor housing plan in the Kumasi Metropolis. Thus women’s addresses were difficult to locate, therefore, other methods of identifications such as nearby “Kenkey”, rice or chemical drug selling places were resorted to in order to trace the women. This increased the cost of communication and fuel. The interviews
conducted in the homes were interrupted by family members and this affected the flow of the stories. Despite these limitations, the results should be seen as a contribution to an ongoing effort to fill the gap in the existing literature on the experiences of Ghanaian women living with advanced breast cancer.

6.9. Recommendations

The following recommendations were made based on the findings of the study:

1. Cancer services should be structured to provide optimal multi-disciplinary care for women with advanced breast cancer.

2. It is recommended that cancer patients should be managed by oncology specialist, palliative care specialists and associated medical specialties that understand cancer patients and give them quality care to meet their needs.

3. The recruitment and training of specialist nurses and doctors for patients diagnosed with advanced breast cancer must be a priority, and this should be done with all possible haste if current disparities in the level of support that these women experience are to be eradicated.

4. Nurses and physicians should encourage Ghanaian men to give total support to their wives when they are diagnosed of advanced breast cancer through education/counseling.

5. Through education/counseling nurses should encourage Ghanaian families to give total support to their members when they are diagnosed of advanced breast cancer.

6. Government must be lobbied to support treatment of women with advanced breast cancer by covering all the cost of treatment modalities under the national health insurance scheme.
7. The Ministry of Health (MOH) must organize regular in-service training in oncology and palliative care for nurses, physicians, pharmacists, physiotherapists, counselors, and spiritualists to enhance their skills in advanced cancer management so that quality health care services are provided to meet the needs of patients.

8. The Ministry of Health should institutionalize palliative care services in our hospitals and train personnel in this area thereby making good palliative care services available and accessible to women with advanced breast cancer.

9. Nurses should promote increased awareness about breast cancer among the public through breast health education and sensitize women on the need for regular breast self-examination to enhance early detection.

10. Nurses should lobby for free breast screening to be organized on regular basis to enhance early detection of breast cancer.

11. Nurses should introduce routine breast examination at women health clinics.
Reference


From the Original. Retrieved from


Bennett, M. I. (2008). What evidence do we have that the WHO analgesic ladder is effective in cancer pain? In: McQuay, H. J., Moore, R. & Kalso, E., (ed.). *Systematic Reviews in Pain Research; Methodology Refined*. Seattle, WA, IASP.


Appendix A: Background Information Form

1. Age (years): 18 - 29 [ ]; 30 – 49 [ ]; 50 – 69 [ ]; 70 and above [ ]

2. Place of residence.................................................................

3. Nationality................................................................................

4. Marital Status...........................................................................

5. Number of children.................................................................

6. Occupation................................................................................

7. Level of education.....................................................................

8. Languages spoken.....................................................................

9. Religion....................................................................................

10. Do you have a family history of breast cancer? ....................... 

11. How long have you been diagnosed of breast cancer? .............. 

12. Are you still receiving cancer treatment? ............................... (which type)
Appendix B: Interview Guide

Main question: Please can you share with me your story after you were diagnosed with breast cancer?

Sub-questions (probe as needed):

1. Please tell me how you felt when you discovered that you have breast cancer.
   Probe:
   - So what happened next?
   - So what did the doctors or nurses tell you?

2. Please tell me about the treatment you have gone through so far.

3. After the treatment, what happened?
   Probe:
   - Side effects
   - Complications

4. Please tell me about a typical day of chemotherapy
   Probe:
   - How did you feel?
   - What happened?

5. Please can you share with me how you have been managing your life after the diagnosis
   Probe:
   - Work
   - Family support
   - Marriage
   - Financial issues

6. Please can you share with me a typical day of your life after the diagnosis?

7. Is there anything else you would like to tell me?
Appendix C: Transcribers Confidentiality Sheet

**Title of Study**: Experiences of Women with Advanced Breast Cancer: A Study in the Kumasi Metropolis

**Researcher**

Adwoa Bemah Bonsu, M’Phil student, School of Nursing, University of Ghana, Legon. I am a graduate student from the School of Nursing, University of Ghana, Legon and I am carrying out a study and I would like you to transcribe my interviews that were done in “Twi” or English.

**Confidentiality and Anonymity**

Respondent’s name will not be recorded on the tape or written on the paper. An odd number and fake names will be given to their interview and anything that is written about it. It is very important for you to keep all information about the interview to yourself without disclosing it to other people not involved in the study.

This confidentiality requirement was explained to me by…………………………………………

I agree to keep all information confident.

........................................... ........................................... ...........................................

Signature/thump print of transcriber Date Witness

Printed Name

........................................... ........................................... ...........................................

Signature of Investigator Date Printed Name
Appendix D: Information Sheet

**Title of Study**: Experiences of Women with Advanced Breast Cancer: A Study in the Kumasi Metropolis

**Researcher**

Adwoa Bemah Bonsu, M’ Phil student, School of Nursing, University of Ghana, Legon. I am a graduate student from the School of Nursing, University of Ghana, Legon and I am carrying out a study and I would like you to take part.

**Why am I doing this study?**

I would like to seek information from women who have been diagnosed with advanced breast cancer. I hope that when I get information on your experiences, it will help me understand what will help support women with breast cancer.

**What will happen during the study?**

I will have a conversation with you and you will be able to speak English or “Twi”. There is no right or wrong answer and you can answer in your own words. The duration for the interview will be between 30 to 90 minutes. A second interview may be arranged if necessary. The conversation will be about the things you have gone through after your cancer diagnosis. You will be asked to sign or thump print a consent form as appropriate.

**Will any one know what you told me?**

The conversation will be recorded on tape and later written in words. Your name will not be recorded on the tape or paper. An odd number and fake names will be given to your conversation.
The only people that will know about our conversation will be my supervisor and a transcriber. All information that has your name on it will be kept under lock and key at a separate place from the written information for 5 years after the study.

**What are the possible gains and harm to you?**

The study may not have any direct benefit for you at the moment, but I hope that the feelings of Ghanaian women who have been diagnosed with advanced breast cancer will be understood. This will enable health workers to design programmes that will help such women.

It is not expected that being in this study will be harmful to you but you may feel emotional about telling your story. When that happens, the researcher will refer you to someone who can talk to you to relieve you of your emotions without any financial cost you.

**Can you withdraw from the study?**

You are free to leave the study at any point during the study even after you have agreed to be part of the study. Such withdrawal will not have any effect on any health service that you require from health care providers.

**Additional contacts**

If you have any concerns, you may send an electronic mail (e-mail) or phone the researcher or her supervisor using the following addresses:

Adwoa Bemah Bonsu: bemahc2000@yahoo.com Phone number: 0244527226/0200439427

Ms Lydia Aziato: aziatol@yahoo.com Phone number: 0244719686

Prof Clegg Lamptey: clegglamptey@hotmail.com Phone number: 0244381657

Thank you.
Appendix E: Individual Consent Form

Title of research project

Experiences of Women with Advanced Breast Cancer: A Study in the Kumasi Metropolis

Principal investigator

Adwoa Bemah Bonsu, BSc. Nursing; M’ Phil student, School of Nursing, University of Ghana, Legon. Phone Number: 0244527226/0200439427

Co-Supervisor

Dr. Lydia Aziato, Lecturer; School of Nursing, University of Ghana, Legon.

Co-Supervisor

Prof Clegg-Lamptey, Medical School, University of Ghana, Legon

Consent (to be completed by respondents)

Please thick your answer:

Do you understand that you have been asked to be in a research study? Yes/No

Have you read and received a copy of the attached information sheet? Yes/No

Do you understand the benefits and risks involved in this study? Yes/No

Do you consent to the interview being audio taped? Yes/No

Have you had the opportunity to ask questions and discuss this study? Yes/No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason  Yes/No

Has the issue of confidentiality/ anonymity been explained to you?  Yes/No

Do you know the information can be used in the future for research or educational purposes?  Yes/No

This study was explained to me by…………………………………………………………

I agree to take part in the study

.................................................................................................................

Signature/Thump-print of research participant       Date       Witness

.................................................................................................................

Printed Name                                           Printed Name

I believe that the person signing this form understood what is involved in the study and voluntarily agrees to participate.

.................................................................................................................

Signature of Investigator       Date
Appendix F: Confirmation that Informed Consent was Understood

1. Please tell me what you are being asked to do?
2. Can you refuse to be in the study?
3. Could anything bad happen to you if you refuse to be in the study?
4. What bad things can happen to you if you refuse to be in the study?
5. Can anything good happen to you if you decide to be in the study?
6. What good thing could happen?
7. Are you allowed to ask the researcher questions?
8. Are you allowed to quit the study once you have started?
9. What does the person doing the study mean by keeping a secret?
10. Can the person doing the study tell anyone what you say while you are in the study?
   (Why or why not?)
11. Can anyone read what you say while you are in the study? (Why or why not?)
12. How will the researcher make sure that no one knows who you are when you are in the study?


...........................................  ...........................................  ...........................................
Signature of researcher                                      Date                                      Witness


...........................................  ...........................................
Printed Name                                      Printed Name
<table>
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<tr>
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<th>Sex</th>
<th>Education background</th>
<th>Religion</th>
<th>Marital status</th>
<th>Number of children</th>
<th>Occupation</th>
<th>Family history of breast cancer</th>
<th>Number of years of diagnosis</th>
<th>Receiving treatment</th>
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<td>1</td>
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<td>3</td>
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<td>Twi</td>
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<tr>
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<td>Married</td>
<td>7</td>
<td>Cleaner</td>
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<td>1</td>
<td>Yes</td>
<td>Radiotherapy</td>
<td>Dagaari Twi</td>
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<td>12</td>
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<td>Yes</td>
<td>1/2</td>
<td>Yes</td>
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<td>Trader</td>
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<td>2</td>
<td>Yes</td>
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<td>F</td>
<td>Tertiary</td>
<td>Christian</td>
<td>Married</td>
<td>None</td>
<td>Teacher</td>
<td>No</td>
<td>3</td>
<td>Yes</td>
<td>Chemotherapy</td>
<td>English</td>
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<tr>
<td>Madam 008 Aku</td>
<td>58</td>
<td>F</td>
<td>Middle</td>
<td>Christian</td>
<td>Divorced</td>
<td>2</td>
<td>Trader</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
<td>Chemotherapy</td>
<td>Twi</td>
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<tr>
<td>Madam 009 Yaayaa</td>
<td>46</td>
<td>F</td>
<td>Primary</td>
<td>Christian</td>
<td>Married</td>
<td>4</td>
<td>Cleaner</td>
<td>Yes</td>
<td>2</td>
<td>Yes</td>
<td>Radiotherapy</td>
<td>Fante Twi</td>
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<tr>
<td>Madam 010 Mansa</td>
<td>57</td>
<td>F</td>
<td>Tertiary</td>
<td>Christian</td>
<td>Married</td>
<td>5</td>
<td>Trader</td>
<td>No</td>
<td>1</td>
<td>Yes</td>
<td>Chemotherapy</td>
<td>Twi</td>
</tr>
</tbody>
</table>
**Appendix H: Table 3. Summary of themes**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired activities of daily living</td>
<td>Washing (laundry problems), difficulty in bathing and grooming; cooking and eating constraints; mobility impairment, and lymphoedema (painful arm swelling).</td>
</tr>
<tr>
<td>Malignant Wound</td>
<td>Nature of wound and odour</td>
</tr>
<tr>
<td>Body image</td>
<td>Hair loss, change of skin colour (complexion) and weight loss</td>
</tr>
<tr>
<td>Physiological effects</td>
<td>Nausea and vomiting, loss of appetite, anaemia, and diarrhoea.</td>
</tr>
<tr>
<td>Emotional reactions</td>
<td>Pain, sadness, fear and anxiety, and suicidal tendencies</td>
</tr>
<tr>
<td>Support</td>
<td>Family, spouses, workplace, health care professionals and spiritual</td>
</tr>
<tr>
<td>Lost hope</td>
<td>Work, marriage, parenting,</td>
</tr>
<tr>
<td>Coping</td>
<td>Acceptance and the will to live</td>
</tr>
</tbody>
</table>
Appendix I: Ethical Approval Letter

4th July, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824

NMIMR-IRB CPN 100/11-12

On 4th July, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL: Experiences of Women with Advanced Breast Cancer: A Study in the Kumasi Metropolis

PRINCIPAL INVESTIGATOR: Adwoa Bemah Bonsu (MPhil Student)

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 3rd July, 2013. You are to submit annual reports for continuing review.

Signature of Chairman:
Rev. Dr. Samuel Ayete-Mamppong
(NMIMR – IRB, Chairman)

cc: Professor Alexander K. Nyarko
    Director, Noguchi Memorial Institute
    for Medical Research, University of Ghana, Legon