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"The Body Gives Way, Things Happen": Older women describe breast cancer with a non-supportive intimate partner

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A B S T R A C T

Purpose: Many women identify their intimate partner as important source of support during cancer diagnosis and recovery, but little is known about how women deal with breast cancer while in a relationship self-described as difficult. The purpose of this article is to describe the aging-related experiences of older women who were diagnosed with breast cancer while in a non-supportive, difficult intimate relationship.
Method: Semi-structured qualitative interviews were conducted with a convenience sample of 16 women aged 55–84 years (mean 68.1 years) in community settings in the mid-Atlantic United States. Data were analyzed using hermeneutic phenomenological analysis.
Results: Participants self-identified as being in a difficult intimate relationship (relationship length range: 1 year- 60 years, mean 35.6 years). Reasons for relationship difficulty ranged from intimate partner abuse to terminal illness. The findings included the themes: "At my Age": participants reflect on aging and breast cancer; breast cancer, sexuality, and aging; and silence.
Conclusions: Issues related to aging such as changes in sexual relationships, comorbidities, and partner illness complicated the women's breast cancer experience. Despite relationship difficulties, these women coped effectively with breast cancer in various ways. Study findings will increase awareness about the unique, complex needs of older women facing breast cancer with non-supportive intimate partners. Nurses should assess older breast cancer patients keeping in mind physical functioning, comorbidities, social support network, and quality of intimate partner support.

Introduction

The majority of women diagnosed with breast cancer are at least 60 years old (Ganz et al., 2003); the median age at diagnosis is 61(Carlson et al., 2008). The risk of breast cancer diagnosis increases with age, with a peak in incidence at 75–79 years old (Sweeney et al., 2004). Older women, however, are underrepresented in breast cancer research (Carlson et al., 2008; Mandelblatt, 2006) and may experience breast cancer differently than younger women because they have other issues to face (Cameron and Horsburgh, 1998) and perceive cancer in a different way (Grunfeld et al., 2003).

Older women, the cutoff point for which is debated (Carlson et al., 2008), are unique because of differences in treatment, screening, and clinical outcomes. Functional status, life expectancy, cognitive function, mortality risk, physiologic reserve, social support, and presence of comorbidities vary for older women (Carlson et al., 2008). Partnered women rely heavily on intimate partner support while going through cancer diagnosis and treatment (Manne and Glassman, 2000). However, this is not possible for all women. Some women are in relationships self-described as "difficult" or non-supportive. The purpose of this article is to explore the lived experience of older women who dealt with breast cancer while in non-supportive intimate partner relationships. For these participants, non-supportive behaviors included intimate partner abuse (IPA), partner illness and caregiving, lack of physical or emotional support following diagnosis and treatment, and/or extra-marital affairs.

Psychological adaptation to breast cancer

Researchers comparing breast cancer experiences of older and younger women report varied results. Older women may be more likely to anticipate chronic illness onset, and are psychologically better equipped than younger women (Mosher and Danoff-Burg, 2006). Although quality of life for older women (>65) has been

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shown to be lower, mostly due to interactions between breast cancer and comorbidities, younger women tend to have a more difficult time psychologically dealing with the breast cancer diagnosis (Ganz et al., 2003). Older women are more likely to have developed optimistic coping mechanisms than younger women, either because of wider life experience (Kantor and Houldin, 1999) or because older people underreport depression and scales may not be age-adapted (Mosher and Danoff-Burg, 2006).

Aging, sexuality, and breast cancer

Sexual activity may change with aging, but it is a myth that aging eliminates the need or the desire for all older people (Rheaume and Mitty, 2008; Watters and Boyd, 2009; Kennedy et al., 2010). For some older adults, particularly women, sexual activity may become focused on emotional connection and intimacy rather than sexual activity (Watters and Boyd, 2009). Even controlled chronic health conditions including hypertension and cancer can negatively impact frequency of sexual activity in older adults (Lindau et al., 2007; Rheaume and Mitty, 2008).

Breast cancer seems to present a unique problem due to disruptions in feminine self-identity and body image, sexual function, and self-perception (Ganz et al., 1999). Generally, older women report less body image disturbance than younger women (Kantor and Houldin, 1999), possibly treatment based. Breast cancer for post-menopausal women can create additional concerns about sexual dysfunction because of sexual issues associated with menopause (Greendale et al., 2001). Menopause does not diminish sexual desire in all women; some women become more sexually aggressive following menopause (Kennedy et al., 2010). If the woman is in a relationship, sexual activity with her partner may change.

Cancer and intimate partner support

Many patients identify their partner as their most valuable source of support during their cancer experience (Manne and Glassman, 2000), and overall relationship quality affects the way a woman adjusts to her breast cancer diagnosis (Manne and Glassman, 2000; Ballantyne, 2004). The degree of partner emotional support contributes to overall well-being for women with breast cancer (Wimberly et al., 2005). Conversely, having a non-supportive partner can create harmful disease outcomes and poor adjustment to breast cancer (Ballantyne, 2004). In several studies of male and female cancer patients, Manne and colleagues found that spouses have negative responses to decreasing functional ability (Manne et al., 1999a,b; Manne and Glassman, 2000; Fang and Manne, 2001; Manne and Schnoll, 2001).

Women with breast cancer tend to reach beyond their intimate partner for social support, and good quality social support has been shown to increase quality of life in cancer patients (Turner-Cobb et al., 2004). However, for many elders, social support networks are reduced by the deaths of family members and friends (Straka and Montminy, 2006), making breast cancer harder to cope with for women in non-supportive intimate relationships.

Older women experience breast cancer differently than younger women. Although there have been several studies focusing on the importance of intimate partner support for women with breast cancer, none considered non-supportive relationships and older women.

Methods

Participants in this study were older women ($n = 16$) who self-identified as having been in a "difficult" (non-supportive) intimate relationship while being diagnosed with or treated for breast cancer. Some ($n = 9$) of the women were in relationships that included IPA, operationalized by scores on the Women's Experience with Battering (WEB) Scale (Smith et al., 1995). The remaining participants experienced non-support in various other ways, such as extra-marital affairs, caregiving for their intimate partner, terminal illness, and bereavement.

Recruitment procedure

Participants were recruited over six months in a variety of ways, all approved by the University of Virginia Institutional Review Board. The principal investigator advertised in newspapers and contacted breast cancer support group leaders and cancer centers.

The primary investigator then called potential participants and verified eligibility. The eligibility criteria were 1) ability to speak English 2) either post-menopausal or minimum age of 55 at the time of the interview 3) self-described as having been in a "difficult" intimate partner relationship at the time of breast cancer diagnosis and/or treatment 4) Scoring at least 23 on the Mini-Mental Status Exam (Kurlowicz and Wallace, 1999). If participants met these criteria, they signed the consent form and completed a demographic instrument. Participants completed the Women's Experience With Battering (WEB) Scale to determine the nature of the difficult intimate partner relationship. The WEB measures the psychological vulnerability that women experience, especially in the areas of mental health, anxiety, and depression (Smith et al., 1995; Smith et al., 1999). Participant WEB scores ranged from 10 to 59 out of 60 (mean 26.8). Nine women scored above 19, indicative of emotional abuse.

Participant sample and setting

Older women were defined as women who were either post-menopausal prior to their breast cancer diagnosis or at least 55 years old, the outer limit of the average age range for menopause onset (Stoppler and Shiel, 2008). The participants ranged in age from 50 to 84 at the time of interview (mean 68.1 years). Age at diagnosis ranged from 50 to 75 (mean 60.7). Time between interview and diagnosis ranged from 1 to 31 years (mean 7.4 years). The participants were all in relationships with men that ranged from less than one year to 60 years (mean 35.6 years). Breast cancer stage ranged in this subset from Stage I – to Stage IV. Five women did not know their cancer stage. Ten of the sixteen women had a mastectomy and five women had lumpectomies as treatment. One woman was not yet undergoing treatment. Fourteen of the women were White and two were African American.

Interview

Identity of all participants was confidential. The interviews were conducted in-person or by telephone, and were digitally recorded. Either the author or a transcriptionist transcribed the interviews. The interviews lasted between one and two hours and were guided by probes and closed questions (Table 1).

Analysis

The investigator used a hermeneutic phenomenological strategy of inquiry for data analysis. In hermeneutic phenomenology, the researcher analyzes and interprets the narratives of those who have experienced a phenomenon first-hand in order to gain understanding of that lived experience (Creswell, 1998; Van Manen, 1990). The person interviewed is considered to be an expert on her own experience (Van Manen, 1990), and provides a thick