African American Women’s Emotional Responses to Breast Cancer

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Breast cancer is an emotionally challenging disease for women. Little is known about African American women’s emotional responses to breast cancer. This exploratory study focuses on the emotional responses of African American women throughout their breast cancer experience. Sixty-six African American women, age 35 to 76, living in the southeastern United States participated in focus group interviews. There were five emotional response themes consisting of response to discovery, diagnosis, treatment options, treatment, and recovery. Findings from this study may assist healthcare professionals with a richer insight regarding the emotions and feelings of African American women with breast cancer. This may help with providing culturally sensitive and appropriate care throughout their illness trajectory.

Among African American women, breast cancer is the leading cause of cancer deaths, and African American women also have a poorer survival rate from breast cancer when compared to women from other ethnic/racial groups (American Cancer Society, 2003; Joslyn & West, 2000). African American women have been found to be more fearful of breast cancer and to find little hope in one’s chances of survival after diagnosis when compared to Caucasian women (Barroso et al., 2000; Facione et al., 2002; Miller & Champion, 1997). The feelings, beliefs, and attitudes that may be shared among African American women regarding breast cancer may impact their decision to seek or delay seeking care for breast cancer symptoms and/or treatment (Facione & Giancarlo, 1998; Facione et al., 2002; Gates, Lackey, & Brown, 2001; Phillips, Cohen, & Moses, 1999; Phillips, Cohen, & Tarzian, 2001; Williams-Brown, Baldwin, & Bakos, 2002). Although several qualitative interviews with African American women reveal their psychosocial and cultural beliefs toward

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breast cancer (Phillips, Cohen & Moses, 1999; Phillips, Cohen & Tarzian, 2001; Williams-Brown, Baldwin & Bakos, 2002), these studies are limited because they focused on African American women with no prior history of coping with the emotional challenges of an actual breast cancer diagnosis.

Numerous studies have documented that a diagnosis of breast cancer is an emotionally challenging disease for women (Epping-Jordan et al., 1999; Koopman et al., 2001; Stanton et al., 2000; Vickberg et al., 2000), and that women face emotional challenges in each phase of the breast cancer experience (Lyons et al., 2002; Taylor, 2000). Some important correlates for potential emotional distress to breast cancer among women include younger age at diagnosis (Compas et al., 1999), uncertainty of illness and fear of disease recurrence (Mast, 1998), fear of rejection and sexuality concerns (Spencer et al., 1999), side effects related to cancer treatment (Mock et al., 1997), and having a mastectomy (Harcourt et al., 2003).

In the few studies that compare the psychological adjustment and/or emotional well-being among a multiethnic sample of women with breast cancer, African American women report less emotional distress and depression from breast cancer than Caucasian or Hispanic women (Culver et al., 2002; Reynolds et al., 2000; Spencer et al., 1999). Additionally, African American women use less emotion-focused coping than women from these other ethnic/racial groups, and also tend to use more religious coping than Caucasian women (Culver et al. 2002; Reynolds et al. 2000). Reynolds et al. (2000) suggest that differences in how African American and Caucasian women express their emotions about breast cancer may help to explain their differences in survival. There is a paucity of literature providing in-depth analyses of African American women’s emotional responses throughout the breast cancer experience, since most studies focus primarily on Caucasian women’s emotional responses to the breast cancer experience (Henderson et al., 2003; Gates, Lackey & Brown, 2001; Lackey, Gates, & Brown, 2001). A few studies show that African American women breast cancer survivors perceive that there are unique cultural differences in how they respond to breast cancer as compared to Caucasian women, and that health-care professionals are not necessarily culturally sensitive to their emotional needs and concerns (Ashipping-Giwa & Ganz, 1997; Henderson et al., 2003; Wilmoth & Sanders, 2001).

Also, health-care professionals report that they are often not aware of the cultural experiences that influence how African American women cope with breast cancer (Ashipping-Giwa & Ganz, 1997).

The purpose of this paper is to report the findings of a qualitative investigation designed to provide an in-depth understanding of African American women's experiences with breast cancer.
American women’s emotional responses to their breast cancer experience. This study used a focus group approach to explore African American women’s emotional responses to the discovery, diagnosis, treatment, and recovery phases of the breast cancer experience. The aim for the study was to provide health-care professionals with research findings that would assist them in the development of culturally sensitive and culturally appropriate breast cancer education programs. Such programs could make a positive contribution toward the emotional well-being of African American women throughout their breast cancer experience. Ultimately, this may hold promise in reducing and possibly eliminating the disparity in breast cancer survival rates among African American women.

METHODS

Design
A qualitative study utilizing focus group methods was used to explore African American women’s emotional responses to breast cancer. Focus groups are used to obtain in-depth information about individuals who share similar experiences and usually involve sensitive topics (Morgan & Krueger, 1998; Streubert & Carpenter, 2003). The focus group method was chosen because previous studies have shown that African American women report focus group interviews as beneficial. They report that focus groups with other African American women provide them with an opportunity to share and compare their stories about breast cancer and establish supportive networks with other African American women (Henderson et al., 2003; Henderson & Fogel, 2003; Williams-Brown, Baldwin & Bakos, 2002; Wilmoth & Sanders, 2001).

Sample
A purposive sampling technique was used to identify and recruit participants for the study. Purposive sampling is used in qualitative research to identify participants who share a similar experience and are able to provide an in-depth description of the phenomena of interest (Streubert & Carpenter, 2003). African American women were eligible to participate in the study if they: 1) self-reported a confirmed diagnosis of breast cancer; 2) lived within the southeastern United States; 3) were able to read and speak English; and 4) were willing to discuss their breast cancer experience in a group setting with other African American women.

Procedures
Consent was obtained from the appropriate Institutional Review Boards to conduct the study. Flyers were posted in oncology clinics, breast
cancer support groups, and churches with predominately African American congregations. These flyers contained information about the purpose of the study and how to contact the principal investigator (PI) via phone if interested in participating. Since only a few African American women responded to the flyers, the PI identified and contacted breast cancer support group facilitators who helped to promote the study. Breast cancer support group facilitators were found to be very supportive of the study and encouraged African American women to participate. African American women who were interested and eligible to participate in the study were given a date and time that was most convenient for them to participate in one focus group session. All participants provided written informed consent before participating in the study. Confidentiality was explained to participants and maintained throughout the study.

Demographic data were collected via a background data sheet (BDS). Each participant completed the BDS which took approximately 5-10 minutes, prior to participating in the focus group. The BDS asked participants to respond to personal questions such as age, marital status, and medical characteristics such as type of treatment and length of time since diagnosis. A semi-structured interview guide was used to conduct the focus groups. The interview guide was developed by the PI and reviewed and approved by a team of nurse researchers. The semi-structured interview guide consisted of open-ended statements to elicit responses among participants regarding their emotional responses to breast cancer.

The semi-structured interview guide flowed from general to specific questions (Morgan & Krueger, 1998). Participants were asked to respond to statements such as: 1) “Tell me how your breast cancer was discovered”, 2) “Please describe to me how you felt when you discovered your breast lump”, 3) “Tell me how you felt when you received a confirmed diagnosis of breast cancer”, 4) “Please tell me how you felt about your treatment options”, and 5) “Please tell me how breast cancer has affected you emotionally”. Probes were used to clarify or elicit additional responses among participants (e.g., “Please describe how that made you feel.” and “Has anyone else had that experience?”). All sessions were audiotape recorded. The tape recorder was placed on a table in full view of all participants. Each participant was given an opportunity to respond to each question, but were reminded that they did not have to do so if they felt uncomfortable answering a particular question. The moderator encouraged group members to speak to one another.

Focus group interviews were held in a private room at doctors’ offices, historically black churches, breast cancer support group sites, and community centers consistent with focus group methodology. Group
rules were established at the beginning of each focus group interview (Morgan & Krueger, 1998). For example, participants were asked to allow one person at a time to speak to ensure that everyone had an opportunity to speak and to be heard. The first author was the moderator for all focus groups. African American female registered nurses were trained as research assistants to observe group process and to record focus group data. Length of the focus group sessions ranged from sixty to ninety minutes. At the completion of each focus group session, the PI and research assistants met to debrief and to discuss the focus group sessions, including salient themes that emerged.

Six focus groups were conducted, consisting of 10-12 participants in each group. Data saturation was used to determine the number of focus groups needed to fully explore the topic of interest. Data saturation was achieved when no new information was generated from focus group interviews and participants were making repetitive comments and statements of previously collected data (Morgan & Krueger, 1998; Streubert & Carpenter, 2003).

Analysis of Data

Demographic data were analyzed with descriptive statistics. Focus group data were analyzed as group data (Morgan & Krueger, 1998). The tape-recorded focus groups were transcribed verbatim. Lincoln and Guba's (1985) four criteria for establishing trustworthiness of qualitative data were used for this study: credibility, dependability, confirmability, and transferability. Credibility was established by in-depth investigation of topic and having prolonged engagement with participants for at least 90 minutes per focus group session. The researchers and research assistants met at least once a week and compiled comprehensive notes about the process of data analysis to ensure credibility of the data. The transcripts were read and compared to audiotapes on two occasions by the PI and two other nurse researchers to ensure accuracy of the data transcription. Dependability and confirmability were established by keeping detailed and accurate records of the study materials such as raw data, field notes, summaries, formulated meanings, and themes. Confirmability occurred by maintaining links between the data (words of participants and the findings). The PI and two nurse researchers read transcripts and used line-by-line coding. After the data were labeled and coded, the researchers met as a group and compared coded data and analyzed focus group data for recurring themes and content. If there was disagreement among researchers, the differences were discussed and coding was reviewed until mutual agreement was reached. Transferability was addressed by collecting a detailed description of the data and our sample.
FINDINGS

**Demographic Characteristics**

Sixty-six African American women living in the southeastern United States participated in the study. Participants ranged in age from 35 to 76 years (M = 52.36 years). Participants’ length of time since diagnosis ranged from two months to 21 years (M = 4.39 years). Of the 66 African American women, most were recruited from African American breast cancer support groups (n = 43). Table I summarizes the demographic characteristics of this sample. The majority were married (48.5%). More than half had at least a high school diploma. The majority had incomes that ranged from $30,000 to $59,999 (48.5%). Participants reported receiving various combinations of surgeries and treatments for their breast cancer.

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Table II. List of Categories & Themes Among 66 African American Women with Breast Cancer

Recognizing the Severity: Response to Discovery
- A sense of urgency: What do I need to do?
- A sense of uncertainty: How do I know for sure?

Confronting Reality: Response to Diagnosis
- Hearing the cancer diagnosis
- Turning to God for a sense of peace
- Focusing on the family

Making Decisions about Care: Response to Treatment Options
- Moving forward
- Doing it for the children
- Being young or being old

Facing the Big Challenge: Response to Treatment
- Anticipating the unknown
- Going through treatment
- Overcoming with faith and strength

Beginning the Healing: Response to Recovery
- Reaching out or pulling away
- Getting in touch with emotions
- Gaining a new perspective: changing priorities
- Sharing the testimony with others

Major Themes
The major themes that emerged from this qualitative study are depicted in Table II.

Recognizing the Severity and Response to Discovery of a Lump: Participants described their initial reaction to the possibility of having breast cancer. A sense of uncertainty but also urgency characterized their descriptions of this pre-diagnosis phase. They recognized breast cancer as a serious disease and a potential threat to their well-being.

A sense of Urgency“ What do I need to do?” The majority of participants reported that they discovered their breast lumps through self-breast examination (SBE) (n = 33) followed by mammography (n=26). Other discovery methods included through their health-care provider (n = 4) and during sexual intimacy (n = 3). Many of the participants expressed concern about the seriousness of finding a breast lump. They
reported that they sought care immediately because they wanted to know if the lump was cancerous. Several participants gave vivid and verbatim accounts of breast lump discovery. For example, a 64-year-old woman who found her breast lump through SBE stated: “... I ran my hand across my breast and said what is that ... I went to tearing off my clothes and went ‘what in the world?’ I said, ‘where did this come from?’ Then I said, ‘Oh, God, I need to go see the doctor.’ Now, I was ready to go to the doctor that Saturday night... and I did go... I went to a nearby E.R.”

Some participants shared the discovery of their breast lump with a close friend or family member, and that individual gave encouragement to seek immediate medical attention. A 38-year-old woman stated: “...When I found my breast lump while taking my shower I panicked and I called a friend of mine who is an OB/GYN doctor and she had me come over late that night... She felt the same thing and told me to ‘go to the doctor right away’...” If the women knew, or someone else knew, of another African American woman who had been diagnosed with breast cancer, then they attempted to contact that person for some form of guidance.

A Sense of Uncertainty “How do I know for sure?” Some participants reported that they found their breast lumps through SBE, but it was not detectable by mammogram. There were also women who reported that their breast lump was not palpable on SBE, but it was detected by mammogram. For example, one woman stated, “I was blessed to have my breast lump show up on my mammogram because my breasts were too large for me to feel it on my own.” Also, participants expressed concern about the reliability of a mammogram to detect breast cancer. Notably, this concern was expressed in each focus group session. One woman stated: “I was able to feel the lump and my doctor felt it also, but the mammogram did not show it. At first he said, ‘it was probably nothing to be concerned about since it was not showing up on my mammogram’, but I agreed to do more testing and it turned out to be cancerous. It makes you wonder about mammograms.”

Confronting Reality: Response to Diagnosis

Participants discussed how they were “nervous” about confronting the reality of possibly having breast cancer. Many of the women described how it was important for them to know the status of their health and physical condition. Receiving the news of breast cancer was an emotionally painful experience for participants.

Hearing the Cancer Diagnosis: Many of the women responded to the diagnosis with crying and a feeling of shock and disbelief, but they also described a reliance on their faith in God, and seeking support from a family member or friend to cope with the diagnosis. They also discussed
how they relied on a family member or a close friend for support in anticipation of a diagnosis of cancer. One participant stated, “I took my husband with me because I knew that I could not handle hearing the news alone.”

At diagnosis, the way in which they were informed was critically important. A few participants discussed how emotionally upsetting it was for them when the news was conveyed by health-care professionals other than their physicians. For example, one woman described how she had received the news, “…I received a call at home by the lab technician and that is how I was told that I had breast cancer… I was upset because I did not think it was his place to tell me something like that.”

Turning to God for a Sense of Peace: Participants discussed how they immediately turned to God and relied on their faith when they were diagnosed with breast cancer. Having faith in God was vital to being able to accept their diagnosis of breast cancer. They recognized God as being in control of their disease. For example, one woman stated, “…God did give me a peace I had never had in my life… I was at peace, I wasn’t worried about anything, it was just so peaceful and I knew that God was going to get me through. That everything was going to be all right…”

Some women reported a fear of dying upon diagnosis. For example, “…the first thing I thought about was dying, I didn’t know what to expect. I didn’t know I wasn’t going to die. That’s the first thing I thought of when he told me I had cancer, was death. I thought it, then I prayed.” Not all participants reported a reaction of fear of dying from breast cancer upon diagnosis. These women tended to feel that their faith in God and their family support would help them cope with living with breast cancer. For example, “I seriously did not think about dying. Even my daughter said ‘momma, we are going to fight this thing and we are going to fight it together.’”

Focusing on the family: For several participants, a vital concern at diagnosis was the role and responsibilities as a mother and/or a wife. Some women reported being unable to physically cry because of a desire to focus on being alive to take care of their children. For example, a 39-year-old woman stated, “…my doctor told me he thought I would cry and I told him at that time ‘I couldn’t cry’. All I wanted to know is what we do to resolve this. I don’t have time to cry now because I have a little girl to take care of.”

Several of the participants reported concern about revealing their diagnosis to a significant other or spouse. Also, they tended to have difficulty sharing their diagnosis or even the possibility of having breast cancer with their children. Their reasoning was that they did not want their children to worry about them. They mentioned that their children
had more difficulty with their diagnosis than they did. Some of the
participants reported that although they wanted family support to help
them cope with their diagnosis, they refrained from saying anything until
after completion of their treatment. For example, one older woman stated,
“...I did not tell my son because he would have worried about me the
whole time, and I did not need to worry about him and take care of
myself... so I didn’t tell him until everything was over and boy was he
upset with me.”

Making Decisions about Care: Response to Treatment Options
Participants talked about the many factors that influenced their decision
about treatment and how to proceed. The process of moving forward, as
well as the motivation for seeking treatment, were integral components of
this phase of the breast cancer experience.

Moving Forward: After receiving the diagnosis of breast cancer, the women
talked about how they wanted to move forward with treatment and
recovery. They discussed their fear of side effects from chemotherapy
and/or radiation therapy because they knew the experiences of other
people who had received these treatments for cancer. When probed to
describe side effects of most concern, they responded with concerns about
hair loss, weakness, nausea, and vomiting. Doing it for the Children:
Several African American women in this study reported that they wanted
immediate treatment so they could live and take care of their family
members, especially their children. For example, “... the first thing I
thought about was my babies, they aren’t going to have anybody, no
mother, no father that was my thing when I found out... I want to be here
to see my little children grow up.”

Being Young or Being Old: There were apparent differences in focus group
sessions between younger and older women’s emotional responses to
treatment options. Younger women expressed greater concerns about a
mastectomy than older women. An older woman stated: “... so I opted, if
it’s cancer remove it, do a radical mastectomy and get it over with.” A
younger woman stated, “... I’m like stop me in my tracks... and I freaked
out, I did, I flipped out... she [oncology physician] was in the background
saying ‘you know it is 99% curable, we can really cure this’ and then
proceeds to tell me all this stuff and then she says, ‘you may want to think
about a mastectomy’ and then I thought, you got to be kidding. You want
to cut something off of me? I don’t think so!”

Facing the Big Challenge: Response to Treatment
Getting treated for breast cancer was viewed as both a challenge for
participants and something they had to do to survive the disease. Once
the women began treatment, they discussed how physically and emotionally challenging it was for them. 

*Anticipating the Unknown:* Participants talked about their specific concerns related to cancer treatment. Some women were nervous and anxious about starting treatment, but they relied on God, friends, family members, and their fellow breast cancer support group members to assist them through the experience. Many of the participants talked to others who had gone through treatment for breast cancer and other types of cancers so they would have an idea of what to expect. Some women reported receiving a lot of helpful information about the side effects from cancer treatment from their health-care professionals, while other women stated that they did not receive enough information from their health-care professionals about what to expect. One woman stated, “I had wonderful doctors and nurses, everything they said would happen to me, did happen, they did not miss a beat and I think that helped me to know what was going to happen before it happened.” Another woman stated, “I was scared to death of what would happen, I just did not know what to expect and the doctors and nurses did not always tell you what you needed to know.”

*Going Through Treatment:* A vast majority of participants described the treatment as being worse than having the disease. Across all focus groups, many participants found it difficult to talk about the treatment itself. The women talked about the importance of completing treatment because they wanted to survive the disease, even if it added just one more day to their life. Several women reported having a loss of energy due to cancer treatment, which they described as being incapacitating in some situations. For example, one participant who was scheduled for jury duty explained, “I had just gone to chemotherapy and by the time I parked where they wanted me to park and get to the courthouse, they would have had a dead patient on their hands, so they just excused me from jury duty, it really wipes you out.”

*Overcoming with faith and strength:* There were many participants who wanted to stop cancer treatment because of the side effects. The women discussed how they relied on their faith and strength to help them cope with side effects related to cancer treatment. One participant stated: “…I could feel God within me, helping me to endure that awful chemotherapy.”

*Beginning the Healing: Response to Recovery*

Being diagnosed with breast cancer provided participants with an opportunity to reflect back on their lives to make changes for their personal growth and emotional well-being.
Reaching Out or Pulling Away: Responses varied regarding women’s involvement with others at this stage. Some participants described needing time away from their family, friends, and colleagues to deal with both the physical and emotional challenges of breast cancer. Reactions from family, friends, and co-workers were especially important. Women who needed to pull away were upset when these individuals, particularly co-workers did not seem to understand their emotional challenges. For example, a few women reported that they received insensitive phone calls at home from co-workers asking when they would return to work. On the other hand, some women described working throughout the breast cancer experience because staying busy and being around others helped them avoid focusing on the negative aspects of breast cancer. These women tended to describe a supportive work environment that helped them cope. Still others described turning away from these networks in order to cope. One woman explained, “…I just needed some down time away from people… I just wanted to be by myself for a while but some people did not understand that… but I knew I needed the time to heal physically, emotionally, and spiritually.”

Getting in Touch with Emotions: Several women stated that they had become more in touch with their emotions because of their breast cancer. For example, “…I did not used to (sic) hug people and now I show my emotions all the time and hug people, especially if they are in a crisis…” Several participants who described themselves as introverted before breast cancer, and how having breast cancer taught them to speak up more for themselves.

Gaining a New Perspective: Changing Priorities: Learning how to set priorities became a more apparent need to all the women. One woman stated, “God first, family and the rest of the stuff, hey the sun is gonna shine tomorrow no matter, priorities, priorities.” Participants reported that they had developed a different perspective on life. For example, “…You think, so why are you walking around worried about all these things, you think about two times, three times or even one time. You went into surgery. You didn’t have to open your eyes. Ain’t nothing else important. You might not wake up tomorrow morning and you worried yourself to death all day about nothing. This is the day the Lord has made, and we will rejoice…” Also, women stated that there was nothing more important than living, and that breast cancer gave them a new way of living.

Sharing the Testimony with Others: A particularly poignant and intense theme expressed by several women was that a breast cancer diagnosis was a testimony to be shared with other African American women. They spoke strongly about the need to do more to help other African American
women and to understand their purpose in life. For example, “…since this has happened, I just need to do more. I want to help other African American women with this disease. I do teach women about self-breast exams, and the importance of getting regular check-ups and having mammograms…”

**DISCUSSION**

The study findings suggest that African American women’s emotional responses to the various phases of the breast cancer experience are remarkably similar to what has been reported in studies conducted primarily with Caucasian women (Lyons et al., 2002; Wang et al., 1999). This suggests that women may experience similar emotions and feelings towards the discovery, diagnosis, treatment, and recovery of breast cancer, without race being a prominent factor in how they respond to the disease.

The majority of African American women in this study reported that their breast lump was initially detected through self-breast examination or mammography. Previous studies reported that African American women avoid participating in breast cancer screening and early detection activities because of a fear of finding a cancerous lump (Facione et al., 2002; Phillips, Cohen & Moses, 1999; Phillips, Cohen & Tarzian, 2001; Williams-Brown, Baldwin & Bakos, 2002). Our study may differ from these results due to the relatively high socioeconomic status (SES) and educational background of these African American women. African American women in this study also expressed concerns regarding the reliability of SBE and mammograms to detect a breast lump. This finding indicates the need for health-care professionals to continue educating African American women about the importance of early detection and screening behaviors for breast cancer through SBE, mammograms, and routine visits with their health-care provider.

In this study, there was no uniform response about the fear of dying from breast cancer. When it was discussed, the women described how they did not let their fear prevent them from seeking diagnosis and following through with cancer treatment. Rather, they reported a strong sense of urgency to seek treatment because they recognized breast cancer as a serious threat to their health and overall well-being. This sense of urgency to seek care for breast cancer contrasts with what is reported in the literature about African American women delaying diagnosis and treatment for breast cancer (Facione et al., 2002; Facione & Giancarlo, 1998; Phillips, Cohen & Moses, 1999). This finding may suggest an improved awareness among African American women to seek early
diagnosis and treatment for breast cancer. Again, there is the possibility that these African American women were educated and had a high SES, which may help to explain our finding of the sense of urgency felt by these African American women. It could also be related to the fact that several of the women were participants of an African American breast cancer support group which provided them with the information and fortitude they needed to view their diagnosis more positively and to take more control of their situation (Henderson & Fogel, 2003).

Although the majority of the African American women in this study recognized God as being in control of their illness, they also actively sought medical advice and treatment for their breast cancer and, in some cases, referred to God as a partner in their fight against the disease. This is consistent with the literature showing prayer and spirituality as important to African American women coping with breast cancer (Ashing-Giwa & Ganz, 1997; Ashing-Giwa, 1999; Henderson et al., 2003; Lackey, Gates & Brown, 2001). Recent studies were found that suggest African American women may offset their negative emotions toward breast cancer with faith and spirituality (Lackey et al., 2001; Taylor, 2000).

Fear of disease recurrence was not a common theme identified among these African American women. It may be that the women did not feel comfortable discussing the possibility of disease recurrence or the open-ended questions did not lead African American women to respond to this issue. Recent studies suggest that African American women prefer to be more optimistic in their thinking about breast cancer (Henderson et al., 2003; Henderson, Fogel & Edwards, 2003; Northouse et al., 1999). Thus, future research is needed to understand more about African American women’s emotions and feelings toward the possibility of disease recurrence as it relates to their breast cancer experience.

In this study, some African American women discussed how healthcare professionals were insensitive to their emotions at diagnosis. This is consistent with research that African American women perceive healthcare professionals as less concerned about their unique life experiences with breast cancer as compared to their Caucasian counterparts (Ashing-Giwa & Ganz, 1997; Moore, 2001).

Participants had difficulty disclosing their diagnosis to family members. There were unique patterns where women were concerned about not adding to the stress of family members. Several younger women were specifically concerned about the care of their children. Wilmoth and Sanders (2001) found that family communication became strained for African American women because of their breast cancer. Health-care professionals should assist African American women to explore ways to inform their family members about their breast cancer.
diagnosis so that they can receive the support that may help them to cope effectively.

Similar to the findings of Lackey et al. (2001), African American women did not place emphasis on the stress and/or stressors of being diagnosed with breast cancer. These women instead focused on how to resolve their breast cancer and move forward with their lives. Studies show that African American women tend to report lower levels of emotional distress from breast cancer than women from other ethnic/racial groups (Culver et al., 2002; Spencer et al., 1999). More research is needed to determine if African American women may be suppressing their negative emotions related to their illness or are choosing to focus their efforts on survival and not on the negative consequences of breast cancer.

An important finding of this study was that African American women identified treatment as one of the most challenging parts of the breast cancer experience and had difficulty talking about it in group sessions. They realized the negative consequences associated with not completing their treatment. Since it is well known that some African American women may not seek treatment for breast cancer, this may be a critical barrier to seeking treatment among African American women. Thus, careful and thorough explanations of African American women’s fears and concerns about treatment are important to include in planning care.

There are a number of limitations to this study. First, individual interviews may have provided additional information that participants did not feel comfortable discussing in a group setting. Second, the majority of participants attended a breast cancer support group targeted towards African American women. Therefore, emotional responses of these African American women who participated in support groups may not be typical of other African American women with breast cancer. Third, there were no comparisons available with other ethnic/racial groups, which would help provide further insight about possible similarities and differences in emotional responses among women with breast cancer. However, comparisons with findings from previous studies with Caucasian women offered important insights. Fourth, these African American women were educated and had a relatively high SES. This may limit generalizability of findings beyond the sample group. Thus, further research should be conducted on a more diverse sample of African American women with breast cancer.

In conclusion, this study highlighted the tenacity and resiliency of African American women who choose to survive the disease, in contrast to portrayals of African American women as refusing treatment for breast cancer and dying from the disease. African American women should be encouraged to seek opportunities to educate themselves, as well as their
family members, about the different phases of breast cancer.

It is also important to note that our results provide further insight into the emotional dimensions of breast cancer among African American women with relatively high SES in one geographic location, thus helping to expand our understanding of what the emotional dimensions of breast cancer might be for other African American women with breast cancer. This study also provides an understanding of the emotional dimensions of African American women with breast cancer with regard to their interaction with health-care professionals. Lastly, health-care professionals should encourage African American women to participate in activities where they will receive support from others, as this consistently helped their emotional well-being. Inadequate social support and insensitive health-care professionals may add to the emotional stress of African American women with breast cancer. Thus, further research is needed to examine communication patterns among African American women with breast cancer and their health-care providers.
REFERENCES


