



Living with breast cancer, a Lebanese experience

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ABSTRACT

Keywords:

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Aim: The purpose of this qualitative phenomenological study is to provide in-depth understanding of the experience of Lebanese women living with breast cancer.

Background: Breast cancer is the most frequently diagnosed cancer in women worldwide. In Lebanon, a country of 4 million people, breast cancer is as well the most widespread type of cancer among Lebanese women. The meaning of cancer diagnosis, the meaning of childbearing and femininity all have cultural bases in Lebanon. The international literature lacks information on how Lebanese women live with breast cancer when compared with women of other cultures.

Method: The study followed purposeful sampling and saturation principles in which 10 participants with a mean age of 51.3 years were chosen based on their actual knowledge of the phenomenon, and their readiness to share that knowledge. Data were collected between December 2007 and May 2008. All interviews were audio-taped and transcribed verbatim. Data were analyzed based on the Utrecht School of Phenomenology.

Findings: Four major core themes describing the participants' lived experience emerged from the interviews: Living with losses; living with guilt feeling; living with fears and uncertainty; Living with the need to know and to share that knowledge.

Conclusion: The experience of Lebanese women with breast cancer revealed distinctive themes not reported by other women from other cultures. The results of this study challenge health care providers and educators to be aware of the difficulties that Lebanese women are facing when they are living with breast cancer.

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Introduction

The burden of cancer is elevated and is escalating worldwide. Cancer is the second leading cause of death with 6.7 million people dying from it annually (World Health Organization, 2005). It is an event that threatens not only one's life, but also affects all facets of the person's life. Generally, cancer is perceived to be a menacing illness. In Lebanon, even the diagnosis of cancer can be perceived as overwhelming. It is not unusual for the families and physicians of cancer patients to avoid use of the word and to avoid telling patients that they have cancer. Due to the relatively high probability of cure with a diagnosis of breast cancer, this pattern of informing is changing, but the emotionally powerful reaction to cancer has not changed overall (personal experience and personal communication with other nurses, physicians and Lebanese families).

Breast cancer is the most frequently diagnosed cancer in women worldwide (American Cancer Society, 2007; WHO, 2003). In Lebanon, a country of 4 million people, breast cancer is as well the most widespread type of cancer among Lebanese women. It represents 42% of all female cancers (Ministry of Public Health, WHO, & National Non-Communicable Diseases programme [NCDP], 2003). The latest statistics of the Lebanese National Cancer Registry report are 7888 new cases of diagnosed cancer in 2003. Of the 7888 cases, 51.3% were in women and 49% in men. The age-specific rates of breast cancer per 100.00 females were reported as follows: 15.2 for age group 25–34; 123.9 for age group 35–44 and 237.4 for age group 45–55 (Ministry of Public Health, WHO, & National Non-Communicable Diseases programme [NCDP], 2003).

A study by El Saghir et al. (2002) assessing the age distribution of breast cancer in Lebanon, reported that a significant number of women were in younger age groups than those reported for western countries.

In Lebanon, health care professionals caring for patients with cancer are likely to emphasize the survival rates associated with particular types of the disease or treatment, but they rarely

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examine the quality of that survival (El Saghir et al., 2002; Shamseddine, 2004; Shamseddine et al., 2004). Patient survival is examined and documented in studies as disease-free intervals, changes in tumor volume, toxicity of the treatment and, occasionally, patients' performance status. The approach used in these studies provides little information about the physical, emotional or social well being of the patient. One approach to capture the personal and social context of patients is to study their lived experience using a phenomenological approach. It is worth noting that the literature is rich with studies addressing the experience of living with breast cancer from different cultural perspectives but to date no published studies related to the Lebanese experience are documented which represents a gap in the literature that needs to be compensated.

Background literature

Several databases were systematically searched, including: Medline 1990–2008; CANCELIT 1990–2008; and CINAHL 1990–2008. A manual search was conducted to search and retrieve information not available on the web such as Arabic articles if available, and articles published in journals not included in the above databases. It is worth noting that the researcher was not able to find any related Arabic article. The electronic search was limited to English language studies with abstract or full text. Articles and abstracts that were considered potentially useful were retrieved for further selection. Eligibility was based on whether the article was able to provide recent and different cultural information on the topic. The focus was on selecting recent research studies. However, the final decision for inclusion was based on the article's findings.

Perreault and Bourbonnais (2005) conducted a phenomenological study in Canada exploring the experience of suffering as lived by women with breast cancer. The exploration showed the participants experienced a transformation as a response to the suffering experience. The descriptions were deeply spiritual and connected to nature. Physically, the long-term effects include premature menopause (Tish, 2004) and fertility problems (Partidge and Winer, 2004). The effects of fatigue, osteoporosis, and weight gain were also reported (Andrykowski et al., 1998; Schultz et al., 2005).

Breast cancer permeates every facet of a woman's life, touching her self-identity, daily schedule, family and social relations, in addition to her perceptions of the past, present and future (Loveys and Klaich, 1991). In a meta-analysis of 30 qualitative research reports conducted between 1990 and 2003 with a total of 795 women from various countries, Bertero and Chamberlain Wilmoth (2007) reported that recognition of women's own mortality made them live in fear, believing that they were facing a pending death. But, the women were not paralyzed by this fear; instead, it offered the women chances to pose existential questions and to find out their psychological resiliency. The women made a life assessment and reorganized their life priorities. Likewise, Landmark et al. (2002), in a grounded study conducted on ten Norwegian women diagnosed with breast, reported that existential aspects are a fundamental matter in recuperation and survival.

On the other hand, Howard et al. (2007) in a meta-synthesis of 15 qualitative studies published between 1994 and 2005, focusing on women from Asian American, Aboriginal, Hispanic and African American diagnosed with breast cancer revealed that regardless of ethno cultural background, the experience of being diagnosed and treated for breast cancer led women to think about their own mortality, and spirituality played a major role in helping them cope. Spirituality was portrayed as a source of inner peace, comfort, and emotional strength when the women were afraid, concerned or in pain. Furthermore, relying on God and religion in dealing with the diagnosis of cancer is part of the Lebanese culture, as reported by

Doumit et al. (2007) in a qualitative study conducted on ten Lebanese cancer patients receiving palliative care. Muniz da Costa Vargens and Bertero (2007) revealed that the diagnosis of breast cancer transformed the life of Brazilian women. These women became more aware of their own mortal condition as human beings and this awareness made them change their life values. Similarly, Ganz et al. (1996) reported that women experienced a good change in them as a result of breast cancer such as closer family relationship and a new appreciation and a positive outlook on life. They also reported that they found life richer in many ways. On the other hand, women diagnosed with breast cancer in Taiwan reported that improvement in social support and disease uncertainty were linked to continuing supportive caring intervention (Liu et al., 2006).

This review of the different cultural experiences with breast cancer illustrates the challenges and commonalities that woman from different cultures are confronted with when living with breast cancer. These issues exist on multidimensional levels including physical, psychological, social, and spiritual. However, so far no information has been documented on the lived experience of Lebanese women with breast cancer.

In general, culture fundamentally shapes how individuals make meaning out of illness, suffering and dying. Therefore, an understanding of the experience as lived by Lebanese women is needed to permit health professionals to offer appropriate information and to start to explore relevant and acceptable interventions. It is worth noting that only the women themselves can portray how they experience living with diagnosed breast cancer. Therefore, this study aims to understand the lived experience of Lebanese women diagnosed with breast cancer.

The study

Aim

The purpose of this study is to describe and interpret the lived experience of Lebanese women living with breast cancer.

Design

The study design is based on the Utrecht School of Phenomenology which combines characteristics of descriptive and interpretive phenomenology based on the Dutch School of Phenomenology as described by Barritt et al. (1984). This approach is selected because it permits descriptions of phenomena as experienced in life, and tries to provide an understanding of the internal meaning of a person's experience in the world (Van Manen, 1990). Thus, a comprehensive, culturally competent understanding of the phenomenon is elicited. The goal of this method is not to generate theory, but to comprehend and illustrate a clear picture of the lived experience (Sorrell and Redmond, 1995).

Participants. Ten participants were chosen based on purposive sampling, saturation principles and according to the following inclusion criteria: 1) Lebanese Arabic speaking; 2) living in Lebanon; 3) age of 25 years or above; 4) diagnosed with breast cancer; stages (I–III); 5) patients without distant metastases, previous history of mental disorders, or the existence of other forms of cancer or other chronic diseases; 6) agreement to be interviewed without the presence of a third person in order to ensure liberty for the participant to express her feelings. It is worth noting that saturation is reached when no new themes emerged from the participants and the data were repeating (Speziale and Carpenter, 2003; Thomas and Pollio, 2002).

Recruitment strategies and techniques. The primary researcher (PR) discussed the study with community intermediaries (nurses, house wives, friends,) and oncologists. "A sample in a phenomenological

study is drawn from a population that has experience with the phenomenon of concern. In this respect, it is purposive and participants are chosen to provide as much variability as possible in their responses" (Kennedy, 1995 p.412). As soon as the community intermediaries identified the participant the PR called each potential participant by phone and extended an invitation to participate in the study and further explained her interest in learning more about the experience of living with breast cancer. Then the researcher agreed on an interview date, time and place with each participant according to her preference. Group diversity within purposeful sampling was observed. According to Lincoln and Guba (1985), the most useful sampling for the naturalistic approach is maximum variation sampling. This strategy aims at illustrating and describing the central themes or principal outcomes that cut across great participant or program variation. For small samples, a large amount of heterogeneity can be a drawback because individual cases are so diverse from each other. However, Patton (1990) changes that apparent weakness into strength by using the following logic: "Any common patterns that emerge from great variation are of particular interest and value in capturing the core experience and central, shared aspects or impacts of an experience" (p. 172). Heterogeneity in this study was associated to participants' age, educational level, marital status, years since diagnosis, and treatment modalities.

Sample description. The sample consisted of ten females, their age ranged between 36 and 63 years with a mean age of 51.3 years. Participants' experience with breast cancer ranged between four months and nine years.

Three females underwent total mastectomy of one breast, one participant endured partial mastectomy of one breast, and six participants had lumpectomy on one side. Eight participants were still married at the time of the interview and two were widowed. Three participants were living in rural areas and seven in urban areas. All participants had children. The participants' educational background varied between intermediate (3), secondary (2) and university (5).

Setting. All interviews took place at the participants' homes in rural and urban areas of Lebanon.

Interviews. In-depth interviews along with observation field notes were used as data sources to describe and gain an understanding of the lived experience of Lebanese women living with breast cancer.

At the beginning of each initial interview the researcher re-explained the purpose of the study. Data were collected between December 2007 and May 2008. Interviews were conducted in Arabic (the native language of the participants) by the researcher. Each interview was translated to English by a translator and back translated to Arabic to check for accuracy of translation. In each interview, the participant was the major speaker and the researcher was mainly a listener and a facilitator. The participants were reminded that their participation was voluntary and that at any time they could decline or withdraw from the study without any obligation.

The interviews were audio-taped and field notes were recorded. Each interview was coded so that only the researcher has knowledge of the individuals who participated. Participants were assured of confidentiality and pseudonyms were used. The code list and the original tapes are kept in a locked file cabinet in the researcher's office for a period of three years, at which time the notes will be destroyed and the tapes erased.

The time lapse between the first and second interview was two weeks. The first interview took 50–60 min and the second interview 30–40 min. The purpose of the second interview was to validate the

preliminary analysis with the participant. It is worth noting that all participants agreed to the PR's analysis without any changes.

The first set of interviews was based on the following broad or grand tour question: "What has it been like for you since you received a diagnosis of breast cancer?" Participants were asked to provide examples that helped to describe their experience. Probing was tailored to the participant's story, such as: "Please tell more about it. What does that mean to you? Is it possible to give an example? Describe to me what that was like for you".

In an effort to prevent socially pleasing answers the researcher clarified at the beginning of the interviews that she was concerned about the individual's thoughts, feelings and meanings about the experience of being a woman living with breast cancer. This type of inquiry typified the format generally used in phenomenological interviewing (Kennedy, 1995). Because of the role status in Lebanese society, and the researcher by definition occupied a high status role in the interview; the issue of socially pleasing answers is perhaps of more concern in Lebanon than in Western cultures. In instances where the researcher thought the participant could be offering socially pleasing answers, further questions were asked to elicit deeper thoughts on the subject under examination.

Data analysis. Data were analyzed using the phenomenological approach based on the Utrecht School of Phenomenology as described by Barritt et al. (1984).

Analysis of the data began following the first interview (data collection and analysis were concurrent). Each taped interview was repeatedly reviewed following its completion. The tapes were transcribed by the researcher verbatim. The researcher read each interview line by line at least twice with a fresh eye, organized transcriptions into themes, and extracted excerpts that supported the emerging themes. Then the researcher compared themes between the different interviews. A list of themes was created. After the analysis of the first interview, the researcher asked the participant to comment on the accuracy of the interpretation and analysis and obtained her reaction. In all interviews, a high degree of consensus was noted between the researcher's interpretation and the participants. Inter-coder reliability was simultaneously performed with peer debriefing which was accomplished with another rater examining the interview transcripts.

Data were managed using electronic software NVIVO (QSR NVivo 1.2) (QSR International, 2002; Morse and Richards, 2002).

Ethical considerations

The study received Institutional Review Board (IRB) approval from the American University of Beirut. At the beginning of the first interview each participant was invited to read and sign a consent form.

Rigor

In keeping with the phenomenological approach, to ensure credibility, within-method triangulation for data collection, peer debriefing and member check were followed. Lincoln and Guba (1985) believe that a study meets the criterion of transferability when findings can be applied in different contexts. In this study, the PR interviewed women who are different on the age scale, educational level, marital status, years since diagnosis, and current activities, which contributed to validating the themes found in the interview data. Dependability and confirmability were secured by doing inter-coder reliability as suggested by Polit and Beck (2004) and Marques and McCall (2005), and by selecting and integrating participants' quotes to describe the results which contribute to the neutrality of the research findings.

Findings

Four themes illustrating the lived experience of Lebanese women living with breast cancer were identified. It is worth noting that these themes represent the first documented study of the journey lived by Lebanese women living with breast cancer.

Living with losses

In describing their current experience with breast cancer all women emphasized several losses: loss of a body part in case of mastectomy, loss of a normal life, and loss of hair. Participants reported that the most demoralizing and devastating loss was the hair loss. Though the hair loss was expected by most of them, they all described it as shocking, distressing and upsetting. Tina a 48-years-old woman said:

After 15 days of the first chemo while I was combing my hair it started to fall. Though I knew it was coming, though I knew about it before but for me it created a problem. I made me feel anxious, I became nervous I started to feel disturbed and tried to foresee myself without hair. I looked at the pillow case and it was full of hair, on the floor everywhere so I wished somebody told me to shave it before seeing it like this, better for me to shave it rather than seeing it like this. I felt very disturbed. How am I going to appear now, ugly, so this subject annoyed me a lot.

Irene, a 59-years-old woman revealed:

I knew that my hair was going to fall out and because I felt distressed, the second day I went and bought a wig. I told my daughter: Shave it all! I do not want to see it falling bit by bit.

In addition to the hair loss Luma, a 62-years-old lady mentioned:

I feel a big loss without a breast. When I lost my breast I felt that I was missing something important. This lost breast is affecting me though I try not to show it; from inside I feel disturbed. When I saw myself without the breast this was the catastrophe; I wish I had not made this hasty decision. This breast removal affected me a lot and also this loss of hair. Though I have taken a mild treatment ...only 4 injections... and I did not take radiation, but still I had this hair loss. I feel pity for myself because I feel that I am missing something, I have something missing in me; to lose a part of your body is very difficult.

Sirine a 63-year-old lady spoke about this loss of the normal life that she was living and described cancer as a "drop in her life". She said:

It is a drop and it is also a big drop. You feel finished... that this is the end. This is the end. This disease is the end... as if it is your end. This is how you feel.

Living with guilt feelings

Living with guilt feelings prevailed in the interviews with women who have daughters and granddaughters. Lebanese culture is still somewhat considered a somewhat conservative culture where most of the marriages are controlled by parents and mainly by the mother of the groom. Even in cases where partners choose each other without the interference of parents, parents have the final and decisive role in the organization of the marriage. The habit of collecting information about the behaviour and health of the mother of the bride is also considered an important and influential factor for approving the relationship from the groom's family side.

Therefore, the guilt feelings lived by the participants of the study come from the fear that the genetic predisposition that exists with breast cancer might stigmatize the future of their daughters and granddaughters; in addition to the feeling that they are the ones who started this disease in their families.

Hala a 36-year-old lady cried while reporting about the guilt feelings that she is living with.

I cried but not from pain. I was sad from myself. Why this happened to me? I will not forgive myself. I feel guilty because I introduced the disease into the family. I have sisters. I think of them. I think of my daughters, too. Should I tell them when they grow up? What if their future husbands refused to marry them because their mother has cancer?

Luma also cried while she was describing this feeling and she said:

No one has it in the family; no one in the family passed through this. So I started thinking if this comes by heredity. I have fears for my daughter and for my granddaughter. I am afraid that later she may develop this disease like me. So you know how far the ideas were taking me. I started thinking; I am her grandma so she might develop it. There are things that you start thinking about that never occurred to you before. I am thinking of my children and my grandchildren. I have fearful ideas concerning my daughter because you hear that it goes by heredity (cancer). I am scared for my grandchild to inherit this from me. While I was looking at her playing last week, I said to myself she is still 4 years old. Oh My God! I hope she does not develop this disease like me! Those are the fears that I am having. This disease did not exist in our family and I brought it to the family. My nephew visited me and he said: Aunt why you are afraid? We do not have it in our family I told him I started it...

Living with fears and uncertainty

Fear and uncertainty permeated the life of all participants. Several types of fears were reported by all participants.

Kathy, a 44-year-old lady, spoke about her feelings of fear of reoccurrence and uncertainty with emotions and said:

Now the thing that I am most scarred of is that it might come back. This is the thing that I think of the most and I keep searching the internet. I feel all the time that there is a high probability that it might come back. You feel scarred all the time that maybe after many years, 5 years 7 years, it might happen again.

Lamis, a 50-years-old lady, explained her fears of reoccurrence and of being pitied by others:

The idea that the disease might come back hits my mind because there are people who get it back. I am afraid to be in pain. In her fears of being pitied by others Lamis said:

I am not used to let anyone pity me. I am not used to accept pity.

Tina, while reporting about her fears from separation and feelings of uncertainty, said:

I was trying to show that I am not anxious or disturbed but in reality I was disturbed because I did not know what was waiting for me. I did not know where I was going to reach or how severe my case would be. Fear of leaving my children... I told you this was my essential fear. I consider that I have not finished my mission. I still have many things to do that I have not done yet, so this was my fear. I was anxious not knowing how my life would

be after it (cancer). On which train I am going to be or on which trail I am going to walk?

Luma reported about her fears from pain and said:

Pain is the most important thing for me. The most important thing is to be free of pain. And I keep on saying, GOD kill me but do not let me feel the pain. I cannot tolerate the pain.

Living with the need to know and to share that knowledge

Mutual sharing of information appeared to be a need. The participants felt the need to know more about their condition from their treating physician, and from other women who passed through the same experience. At the same time, they felt the need to share their experiential knowledge with other women who are starting a similar experience.

Sandra, a 48-years-old woman, said:

When I am sitting at the doctor's clinic, other patients ask me the same questions: How did you know? How did you discover it? How were you taking the treatment?

I feel relaxed when I give this information because you feel that you are relieving someone who is newly starting with her disease and she is afraid, and you are calming her. You feel that you have strengthened that person and maybe I was in need of someone to strengthen me. My doctor has a caring attitude but does not give me enough time to discuss my future with the disease....

Sonia, a 55-years-old woman, spoke about this issue and said:

I want to exactly know the degree of malignancy. I want to be told the truth. I want to know what is going on. It means a lot because I would know how to pursue my life. This is how I consider it. There are many things that I would like to do if I know that I do not have much to live. You know how? I might change my life's organization, my plans...Of course I knew that I was going to do chemotherapy, but I did not know what might happen after it or while receiving the chemo... there should be someone to help those patients. The first thing that might relieve them is to know where they are heading. One of my classmates that I newly met told me that she had the same experience, but had had her whole breast removed. I mean I used to feel happy while talking with her, asking her what happened with her, and she used to always tell me what was waiting for me... mainly during the chemotherapy, because she did not do radiotherapy. It is very important for the person to know where she is heading. For example, I used to anticipate the feelings or the steps... and this is what is missing here. I knew it because of my friend. She told me about everything. Without her I would have gone to the unknown, not knowing anything.

Hala expressed her wishes of sharing her experience with people who could understand her best and she said:

I wish I could talk with someone who passed through the same experience because they do understand what I am talking about or feel. I wish there were a patient support group and I am ready to help

Discussion

Living with losses

Lebanese women are known for their love of having a good and aesthetic looking. This focus on feminine role is thought to be associated with the role of women in Lebanese society. This role has

been described as primarily to attract a man, to bear him sons, and to keep his interest in her. The hair loss associated with chemotherapy created a threat to their self-identity as Lebanese women and it was considered as the most disturbing element of all losses lived by those women. The losses experienced by Lebanese women were experienced at the physical and emotional levels. These losses are congruent with what Howard et al. (2007), Arman and Rehnsfeldt (2002) and Browall et al. (2006) reported about losses lived by breast cancer women from different ethno cultural groups. The physical losses experienced by the Lebanese women negatively affected their emotional status, which concurs with Landmark's et al. (2002) study, reporting that loss of a breast and the resulting physical changes impinged on the identity of women.

Living with guilt feelings

Participants reporting hereditary causes for breast cancer provided negative description of their conditions and its cause. Their narration of the situation revealed that their perceived genetic predisposition for breast cancer implied high vulnerability for their female relatives which emphasized their guilt feelings. This idea of guilt feeling did not appear in any of the reviewed studies except in two studies which reported findings contrary or substantially different from the current study. Tishelman (1997) reported that patients dissociated themselves from personal guilt but opened up probabilities for their own positive responsibility in a cure and recovery. Sankar et al. (2006), while exploring the relationship between genetic cause and stigma of breast cancer, reported that the study participants focused on the duty to instruct relatives about cancer risk rather than on personal responsibility or guilt. On the other hand, Ganz et al. (1996) reported that women with breast cancer who had daughters expressed concerns about the hereditary risk of breast cancer. Nevertheless, the guilt feeling theme is worth further enquiry within the Lebanese culture due to its repercussions on the lives of these women.

Living with fears and uncertainty

All participants without exception talked about their feelings of fear and uncertainty. The fears were reported to be at different levels and domains. Fear of the disease reoccurrence; fear of pain; fear of separation from loved ones but not fear of death; and fear of being pitied by others. The uncertainty in this study was related to the unknown future. The different fears and uncertainty feelings reported by the Lebanese women are consistent with results of studies reported in the literature about cancer in general and breast cancer in particular (Bottorf et al., 2007; Browall et al., 2006; Doumit et al., 2007; Ganz et al., 1996). The fear of disease reoccurrence and fear of pain made the women's lives very unhappy. On the other hand, the fear of being pitied made them continue their life normally as much as possible in order to prove to self and others that they are capable of fighting and going on with life. However, this fear of being pitied was considered as an additional burden because it prevented them from living their status of patients or discussing their feelings with others in order not to be pitied. The fear of separation from family members is related to the strong bonds that exist within the Lebanese families. It is worth noting that while talking about separation, the participants who belong to different religions clearly differentiated this idea from death. They all negated their fear of death because they viewed the disease and death as something coming from the merciful God, whose decisions they cannot refuse. This idea was not found in any of the reviewed literature and it needs further studying within the Lebanese culture. In the literature, uncertainty was assumed to be negatively linked with education (Mishel, 1988), but in this

particular study education showed an inconsistent relation with uncertainty. All interviewed women regardless of their educational level reported a high level of uncertainty which was influenced by their different fears, and these fears are mostly related to the Lebanese culture.

Living with the need to know and to share that knowledge

The need to know about their condition and to share that knowledge with people who lived or are still living a similar experience appeared to be a major concern for the participants of this study. This need to information in order to maintain control and manage their illness was also reported by Schmid-Buchi et al. (2008), in a review of psychological needs of breast cancer patients and their relatives. Cancer in Lebanon is still considered a taboo or something very bad that should not be discussed. Family members do their best to protect the patient from knowing the truth (Doumit et al., 2008). However, things in Lebanon are changing and participants of this study revealed the importance of being the first ones to know about their condition in order to be able to decide about their lives. They also expressed the need to be able to discuss their experiences with people who could understand them and who could support and guide them. Participants of the study felt at times lonely in their journey with the disease. They refused to discuss their fears and worries with family members and friends in order not to worry them and also in order not to be pitied by them. Participants reported that their treating physicians show caring attitudes but do not give them the necessary time for discussion of their needs. All participants felt very relaxed after the interview was completed, and six of them said that it was the first time that they had talked about their experience and they felt as if a heavy burden had been lifted from their shoulders. They all expressed the need to create a support group for breast cancer patients. These findings are in agreement with other studies' findings in the literature (Bottorf et al., 2007; Henderson et al., 2003; Zeigler et al., 2004) which endorse the importance of creating support group.

Conclusion

The diagnosis of a disease such cancer is a critical life incident that can alter an individual's life. Dealing with the breast cancer, as well as physical symptoms and emotional suffering experienced both after diagnosis and during treatment, can interfere with living a normal life. This study's results highlighted the losses felt by Lebanese breast cancer women's, their fears and uncertainty. It also reported the feeling of guilt which is mentioned for the first time in the literature and as such needs further clarification and studying. Women emphasized the importance of knowing the truth about their conditions and their concerns of staying in the dark. Also, they articulated the wish to participate in breast cancer support groups. It is worth noting that the results of this study represent the first documented study looking at the Lebanese breast cancer women's experiences. Moreover, a good comprehension of the experience and effect of breast cancer on the lives of women is crucial to allow health professionals to offer appropriate information, and to lead to knowledge development in the field of breast cancer care.

Implications at the theoretical and practice levels

The results of this study have implications at the theoretical and practice levels. Educators need to be aware of the potential needs and concerns of breast cancer patients and teach students to explore their patients' needs. It is worth noting that the purpose of phenomenology is not to develop a theory but to help in understanding the experience as described by the people of the study.

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 breast cancer to explore ways to meet their needs as early as possible. Using findings from phenomenological studies as a basis for further studies of the phenomenon is the primary outcome of this research method. Based on the results of this study, several potential studies can be delineated such as cross-cultural comparisons of Lebanese women with breast cancer and women of other Middle Eastern cultures; beliefs of physicians and nurses about the need of breast cancer patients to compare with patients' lived experiences; and a feasibility study of starting a breast cancer support group in Lebanon.

Limitations of the study

As with all qualitative research, the sample cannot be considered representative of the population or sub-set of Lebanese breast cancer population. Only women 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. Consequently, the intentional selection of participants for this study is accepted.

The extent to which results of this study can be generalized to Lebanese breast cancer women is unknown; however, generalizability is not a goal of phenomenology. 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 experience stays private, but its connotation and significance become public (Ricoeur, 1976).

Despite all these limitations, the method followed in this study entails that the results should be seen as a contribution to an ongoing effort to fill the gap in the literature and to comprehend the lived experience of Lebanese women living with breast cancer.

Conflict of interest statement

The authors of this manuscript declare that they have no conflict of interests.

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