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Lived Experiences of African American Women Coping With Breast Cancer in Rural Northeastern North Carolina

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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MPH, University of North Carolina at Greensboro, 2006

BS, North Carolina Central University, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This qualitative study examined the phenomenology of breast cancer among seven African American female participants who reside in rural, medically underserved communities in Northeastern North Carolina. The aim of this descriptive study was to explore the answers to the overarching question of how African American women with breast cancer self-manage the emotional, physical, financial, and social issues associated with the diagnosis and treatment. The transactional model of stress and coping provided the theoretical framework for examining the role of social reinforcements, beliefs, attitudes, and intentions on the health behavior of African American women with breast cancer in some rural, resource-stricken communities in Northeastern North Carolina. Oral data were collected to extract participants' interpretations of their social support and applied coping processes, and psychosocial experiences of living with breast cancer. Analysis of their narrative data suggested a set of themes: a difficult reality, the meaning of social support, rural health narrative, learning how to cope in the face of uncertainty, and a desire to serve and future aspirations. The participants reported that having support from family, friends, and the community helped them to better cope with the issues associated with breast cancer. Findings suggest that these women experienced greater understanding regarding the significance of social support and their ability to cope with the diagnosis and treatment of breast cancer. This study's findings could lead to positive social change by encouraging medical professionals working with African Americans with breast cancer in rural sectors to consider creating interventions that promote survivorship support programs.

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Dedication

This dissertation is lovingly dedicated to the following individuals. First – to my mother who has been my biggest fan by providing me with encouragement when I wanted to give up and always believing in me to complete this incredible achievement despite having to deal with symptoms from multiple sclerosis and being diagnosed with advanced stage ovarian cancer (cancer-free since October 15, 2019). For this, I am forever grateful. To my life partner, Fred, for the compassion, reassurance, understanding, and love. To the seven African American women who so generously shared their time and experiences by participating in this study. The information shared reminded me of the incredible ways the human spirit can display resilience in the face of adversity. This would not have been possible without you!

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To my late grandparents – MaBay and Daddy Walter. I never forgot what I promised you - to never stop thinking about the people (community) that played a significant role in the person I am today. I feel your presence often and know you are watching over me. I hope you are proud of me.

To my beautiful nieces – Ellie, Faith, Gabrielle, and Hope. I love you to the moon and back for an eternity. I pray you reach all the goals you desire and more. Just remember to reach back and pull someone up along the way. One person alone does not achieve success.

Lastly, but most importantly – Thank you **Heavenly Father** for your grace and mercy. For loving me more than I can ever love myself. For your countless blessings, even when I did not deserve them and for responding to my prayers.

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Chapter 1: Introduction to the Study

Introduction

In North Carolina, as in other parts of the United States, breast cancer is the second leading cause of death, and racial disparities in cancer care and outcomes remain a substantial problem (Centers for Disease Control and Prevention [CDC], 2019; North Carolina State Center for Health Statistics [NCSCHS], 2017). For the past decade, cancer death rates were higher for African Americans than for Caucasians (American Cancer Society [ACS], 2019). The ACS (2019) projected that the United States would experience 202,260 new cases of breast cancer, and 73,030 breast cancer deaths were expected among African Americans in 2019. North Carolina was expected to experience 10,946 new breast cancer cases and 1,467 estimated deaths from breast cancer in 2019 (North Carolina Central Cancer Registry [NCCCR], 2019).

The racial disparity in cancer mortality and morbidity was intensified by geographic location (National Institutes of Health [NIH], 2017). African Americans in rural areas have higher mortality rates in different cancers compared with Caucasian rural dwellers (Tang et al., 2015). Racial disparities in breast cancer diagnosis and treatment continue to adversely affect minorities who are disproportionately affected by the ongoing epidemic. During 2012-2016, the percentage of breast cancer deaths in the United States was 20.6%, with North Carolina being 21.6% (CDC, 2019). While breast cancer mortality has declined due to a robust increase in awareness, early detection, and treatment (ACS, 2019), not all women have benefited equally (Bennett et al., 2012; NIH, 2017). Rural populations, specifically rural minorities, experienced greater disparities in health and health care access. These differences were compounded for minorities who live in counties with higher poverty rates, have less education, be unemployed or underemployed, and have lower insurance rates (Bennett et al., 2012). According to Fuqua et al. (2019), geographic disparities existed between poor areas with low population densities versus economically prosperous areas with higher population densities. All differences were associated with the health care disparities gap between Caucasians and African Americans (Bennett et al., 2012; Fuqua et al., 2019).

Several studies have described the factors that contributed to health disparities. These factors included lower socioeconomic status (SES), underinsured or no insurance, delayed care due to cost (Bennett et al., 2012), limited or no preventive cancer screening programs for poor and underserved (Fuqua et al., 2019), and few or no medical support programs that addressed the disproportionate burden of breast cancer with African American women (Molina et al., 2016). These factors added to the growing rates of delayed diagnosis and significantly lower five-year survival rates for African Americans compared to Caucasian women (ACS, 2019; NIH, 2019). It is probable this data will continue to create a burden in the United States until there is equality in healthcare.

For the past few years, researchers emphasized interventions that focused on breast cancer awareness for African American women that educated and promoted mammograms (ACS, 2019; CDC, 2019; Molina et al., 2014). Although much literature exists on the biopsychosocial factors as they related to mammography screening practices, risk education, and prevention of breast cancer among minority populations, very little research has been done to explored African American women and their lives with and beyond breast cancer (Bollinger, 2018). Recently, researchers have focused on the social and cultural influences, quality of life implications, and reliable support networks for African American women with breast cancer (S. Heiney, 2014; Kennedy & Rollins, 2016; Molina et al., 2016). Less research, however, has explored facilitators and barriers of coping mechanisms, that is, aspects of the health system, social environment, or physical environment that assisted breast cancer survivors in obtaining necessary health care (Ustjanauskas et al., 2017) or levels of social support that improved self-advocacy among underserved minority populations (Molina et al., 2016). Tejeda et al. (2017) theorized the use of social support as a promising intervention for African American and Latina women with breast cancer while acknowledging further studies are warranted. However, further research was needed to determine what effective and ineffective coping strategies are for African Americans with breast cancer (P. D. Henderson et al., 2003).

Background to the Problem

Northeastern North Carolina is comprised of the following counties: Edgecombe, Granville, Halifax, Northampton, Vance, and Warren. At the time of this study, the area was primarily rural (59.1%), and Warren County was 100% rural. The area had a population of 248,644 (*American Community Survey*, Census Bureau, 2014-2018). Nearly half (46.2%) of the residents lived on incomes below 200% Federally Poverty Level [FPL], a total of approximately 114,869 individuals (*American Community Survey*, Census Bureau, 2014-2018). The residents of this unique region faced unique challenges to health and well-being. Recent trends pointed to slow employment and population growth in rural areas, accompanied by increases in poverty. Residents of rural areas also had lower levels of educational attainment when compared to their urban counterparts (United States Department of Agriculture [USDA] Economic Research Service, 2019). In addition, rural Americans face numerous health disparities compared with their urban counterparts. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts are. In general, rural U.S. residents tend to be older and sicker than their urban counterparts (CDC, 2020; Schlegel et al., 2009).

Access to care is limited, as there is documented shortage of primary care providers available to serve rural residents. All six counties have Health Professional Shortage Areas (HPSASs) and Medically Underserved Areas (MUAs) designations (HRSA, 2020). The population to 1.0 full-time employee (FTE) primary care physician ratio is 26,034:1, many times higher than the state (1,410:1) and national (643:1) ratios. (HRSA, 2020; Robert Wood Johnson Foundation, 2020). The lack of local providers presents a significant barrier to care, particularly for low-income residents. In addition, Northeastern North Carolina residents were faced with an average unemployment rate of 8.5% in July 2020, higher than both the state (6.5%) and national (7.9%) averages (US Bureau of Labor of Statistics, 2020). Because North Carolina is not a Medicaid expansion state, the number of uninsured residents continues to exceed the national average. In Northeastern North Carolina there are 13.2% uninsured, compared to 12.7% in NC, and 10.6% in the United States (Census Bureau, 2018). Studies repeatedly demonstrated that the uninsured are less likely to receive preventive care and services for major health conditions and chronic diseases compared to individuals with insurance (Kaiser Family Foundation, 2019).

The United States has experienced unprecedented numbers of breast cancer survivors due to early detection and treatment programs, yet research further confirmed disparities remained between African American and Caucasian women (ACS, 2019; NIH, 2017). It is common for all women to experience some level of stress when dealing with a diagnosis and treatment for breast cancer. Research conveyed the everyday stressors included concerns about survival, emotional distress, fear of reoccurrence, body image and relational changes with support network (Gaston-Johansson et al., 2013; Kennedy et al., 2016; Torres et al., 2016). Additional challenges existed for African American women in being able to understand information regarding diagnosis terminology, treatment and support options, and guidelines for follow-up care (Mollica & Nemeth, 2015; Palmer et al., 2015). Tejeda et al. (2017) study found African American and Latina women reported greater psychological challenges to their breast cancer diagnosis due to unmet social support needs. To support this theory, another study acknowledged African Americans with breast cancer acknowledged keeping their cancer a secret and not receiving information on survivorship and education resources (Adams et al., 2017; Myers et al., 2016).

Women with breast cancer face challenges to cope with a wide variety of psychological stressors during the different stages of cancer and treatments (Gaston-Johansson et al., 2013). A study conducted to determine strategies for coping with various physical and psychological symptoms among advanced, symptomatic lung cancer patients and their primary caregivers, found individuals to be more receptive to religious approaches and less drawn to peer support (Mosher et al., 2015). Other researchers found women diagnosed and treated for breast cancer would consider a variety of coping strategies that included seeking social support, positive framing, active problem solving, and avoidant coping strategies such as isolating (Gaston-Johansson et al., 2013; S. Heiney, 2014). Religious coping was found in the literature that included patients with advanced lung cancer and HIV patients who experienced stigma (Galvan et al., 2008; Mosher et al., 2015). Unfortunately, there was insufficient attention to how African American women who live in medically deprived communities such as Northeastern North Carolina coped with the diagnosis and treatment of breast cancer — given that African American women tend to be diagnosed at more advanced stages and have higher mortality rates because of the disease (ACS, 2019).

Problem Statement

African American women experienced lower survival rates for breast cancer compared to other racial and ethnic groups (ACS, 2019; CDC, 2019). The racial disparity in cancer mortality and morbidity has intensified by geographic location (NIH, 2017). African Americans in rural areas have higher mortality rates in different cancers compared with Caucasian rural dwellers (Tang et al., 2015). Possible contributing factors included, but are not limited to, lower SES, limited insurance or uninsured (Ustjanauskas et al., 2017), delayed care-seeking due to cost (Bennett et al., 2012), limited or no preventive cancer screening programs (Fuqua et al., 2019), and late-stage breast cancer diagnosis. CDC (2019) encouraged efforts to monitor breast cancer survival because achieving equity in breast cancer outcomes remains a top priority. In addition, investigations that focused on efforts to evaluate the effectiveness of health services, measured inequities in outcomes between populations (i.e., rural vs. urban) and informed efforts to improve the effectiveness of cancer management and treatment was warranted (CDC, 2019).

Bennett et al. (2012) reported that underserved minority women were less likely to receive cancer screening services and optimal survivorship care following breast cancer treatment. Furthermore, this underserved population also experienced higher breast cancer mortality rates (Ustjanauskas et al., 2017). The ability for a woman to cope with the diagnosis and treatment of breast cancer can be tied to psychological distress (e.g., depression, anxiety) and physical symptoms (i.e., pain, fatigue; V. P. Henderson et al., 2012). Research affirmed the way breast cancer patients coped would have an impact on their physical and emotional well-being, and long-term quality of life adjustment (Torres et al., 2016). A growing body of literature demonstrated differences in the way African American women coped with breast cancer (Lewis et al., 2012; Torres et al., 2016). Only a few studies examined the coping strategies used by rural, African American women diagnosed with breast cancer as it related to their faith and support networks, psychological well-being, and quality of care issues (Adams et al., 2017; S. Heiney, 2014; Kennedy et al., 2016; Torres et al., 2016).

The CDC (2019) declared that African American women have a 70% less chance of survival of breast cancer compared to Caucasian women. One reason for this disparity was that African Americans experienced the highest rates of healthcare discrimination.

Healthcare discrimination could lead to poor outcomes in breast cancer screenings (i.e., mammograms; Jacobs et al., 2014). Another reason was the growing number of African Americans who were diagnosed with breast cancer combined with treatments, which suggested an increased number of African Americans who faced challenges with cancer survivorship (Mollica & Newman, 2014).

One potential barrier for early diagnosis is distrust among the African American community and healthcare system. The unique and severe forms of racism African Americans experienced within the healthcare system was associated with anxiety, depression, and perceived lower quality care (Molina et al., 2014) that contributed to lack of engagement in treatment and continuity of care (Ferrera et al. 2016). As evidenced from the literature, when faced with a life-threatening disease, research should consider the factors that make a population vulnerable, as it is necessary to identify the elements that promoted advancement in the face of adversity (Molina et al., 2014). Two studies found that many community resources were available to African American breast cancer survivors (Keesing et al., 2016; Molina et al., 2014). Unfortunately, the constant presence of cancer-related health inequalities showed that, despite the accessibility of preventive and supportive resources, African Americans were still more negatively impacted by cancer than were other groups (ACS, 2019; CDC, 2019; NCSCHS, 2017).

It is vitally important to reduce cancer health disparities among minority populations (Levine et al., 2015). Yet, coping strategies among African Americans with breast cancer has received insufficient attention and research. Therefore, there was a knowledge gap that warranted an examination to see whether breast cancer survival rates are projected to improve because individuals learned how to view life through an optimistic lens, created encouraging affirmations by praying and trusting life would improve through social engagement activities (Gaston-Johansson et al., 2013; Haynes-Maslow et al., 2016; Levine et al., 2015). The coping experience of African American women with breast cancer and who live in rural communities was not well documented. I explored the interpretations of social support and psychosocial events in the lived experiences of African American women diagnosed with breast cancer and living in various rural communities in Northeastern North Carolina. Research indicated that active social support networks led to favorable long-term psychological adjustment among African American women with breast cancer (Gaston-Johansson et al., 2013). I sought to determine whether the coping mechanisms could be used or credited to the increase in the number of African American women surviving breast cancer.

Purpose of the Study

In this phenomenological study, I explored the lived experiences of seven African American women who were diagnosed with breast cancer, and I identified inner resources, specifically, the role of sense of support and applied coping processes to manage the physical, emotional, financial, and social issues associated with the diagnosis and treatment. The purpose of this study was to examine the lived experiences of African American women in rural Northeastern North Carolina who were diagnosed with breast cancer between the years 2009-2019. By engaging these women through semistructured in-depth interviews, I was able to document their lived experiences through personal narratives related to coping strategies used after diagnosis, during and after treatment of breast cancer while living in a resource-stricken community. According to Ustjanauskas et al. (2017), few researchers have explored the facilitators of survivorship for underserved minorities, that is, aspects of the social environment, health system, or physical environment that assisted vulnerable breast cancer survivors in obtaining necessary health care and support services. Understanding psychological consequences among women early in their breast cancer journey would help to identify points of intervention to address minority patients’ needs (Tejeda et al., 2017).

Women with a diagnosis of breast cancer, particularly African American women, face multiple barriers to survival. Although research existed about the unique barriers faced by African American women with breast cancer, there was little research into the coping needs or coping strategies used among African American women (Davis et al., 2013). Several studies reported that distress was related to a woman's physical and psychological adjustment to breast cancer, which can be detrimental to a woman’s ability to make proper medical decisions that can lead to inadequate treatment compliance and outcomes (Keesing et al., 2016). Evidence suggested survivors who experienced stigma associated with a breast cancer diagnosis might create social isolation and prevent the desire to seek support services (Lewis et al., 2012). Unsuccessful coping practices could lead to significant psychosocial distress (Davis et al., 2013).

Lewis et al. (2012) reported outlining stigma would interfere with the means of spirituality as a coping mechanism for some African American women with breast cancer. Other research suggested that trust in the healthcare system had important implications for African Americans timely adherence to breast cancer screening, diagnostics procedures, and treatment (Molina et al., 2014). Although there was evidence medical mistrust with the healthcare system created anxiety, depression, and lower quality of life among African Americans with breast cancer, there is limited information about individuals from rural sectors (Molina et al., 2014). The knowledge gap presented a significant opportunity for this study to investigate the characteristics of African American women with breast cancer and the environment in which they live to determine whether they can positively affect survivorship. There is significance in helping women explore their experiences regarding the impact of breast cancer and the social supports that were useful in managing their cancer experience while living in a rural community.

Research Question

The questions included on the interview guide provided a starting point for an in-depth conversation and used with flexibility. The interviews were semistructured conversations, guided by open-ended questions. Participants were asked about their experience with breast cancer and what supports they found useful. The questions were based on the key ideas found in the literature. The interview semistructured format allowed changes to be made to reflect new, additional or unexpected information received from the participants. This study aimed to answer the following overarching question: What are the lived experiences of rural, African American women diagnosed with breast cancer in the development of coping strategies to manage the emotional, physical, financial, and social issues associated with the diagnosis and treatment?

The aim of this study was to contribute to the growing evidence base in order to improve existing support practices and to possibly inform the development of new models of supportive care targeted at the specific needs of African American women with breast cancer. I used a qualitative research design (semistructured interviews) to explore the lived experiences and support needs of African American women with breast cancer and living in various rural communities in Northeastern North Carolina. Whiting (2008) defined an interview as “a method of data collection in which one person (interviewer) asks questions of another person (a respondent).” Semistructured, in-depth interviews have often been used in qualitative research because they are intimate encounters in which open, direct, verbal questions are used to elicit detailed narratives and stories (Whiting, 2008).

Theoretical Framework

Theoretical Foundation

The theoretical framework that shaped this study included the transactional model of stress and coping (TMSC), conceived by psychologists Richard S. Lazarus and Susan Folkman in 1984. The theory proclaimed that an event by itself is not a stressor. Instead, the event was considered a stressor only after a person considered it as harmful or threatening within the limits of the environment (Lazarus & Folkman, 1984). Lazarus (1966) hypothesized that support reduces the effects of stressful life events on health through either the supportive actions of others (e.g., reassurance, advice) or the belief that support is available. According to Lazarus and Folkman’s (1984) theory, social support would be useful when promoting coping and reducing the effects of the stressor. Some examples of coping techniques included avoiding, diminishing, changing, or accepting a stressful situation (Lazarus & Folkman, 1984).

Conceptual Framework

Through the TMSC theory, the evaluation process demonstrated how thoughts shape feelings and in turn, how feelings shaped thoughts and behaviors. The determination of risk could lead to sorrow, nervousness, terror, and irritation due to stress. These emotions influenced people to choose coping techniques to manage their stress (Lazarus & Folkman, 1984). The present study described the phenomenon of coping with breast cancer in a rural community, from the African American woman's perspective. This study supported the need for more research regarding the use of interventions and strategies to improve coping skills used among African Americans with breast cancer (Davis et al., 2013). TMSC theory provided an understanding of African American women's experiences of coping with breast cancer while living in rural medically deprived communities in Northeastern North Carolina.

Nature of the Study

The transcendental (descriptive) phenomenology approach (DPA) was used to analyze the lived experiences of African American women with breast cancer. The lived dimension of experience is best approached when the objective researcher moved from participant's descriptions of facts of the lived experience, to universal essences of the phenomenon at which point awareness itself could be grasped (Davidsen, 2013). In other words, DPA allowed me to bring no definitions, expectations, assumption, or hypotheses to the study; instead, I assumed the position of a blank slate that focused on each woman's experience to develop an understanding of the essence of a phenomenon (see Neubauer et al., 2019).

To generate the written and oral narratives of the seven African American women living with breast cancer, I used semistructured interview questions (see Appendix B). In an effort improve understanding concerning the factors that influenced the psychological impact of breast cancer among minorities, studies must investigate the individual and social support factors (Tejeda et al., 2017). Mollica and Newman (2014) further suggested future research to examine the many characteristics of the individual with breast cancer and the environment (i.e., physical and social) and its potential to encourage an optimistic survivorship experience. By analyzing an experience as it was subjectively lived, new meanings and appreciations can form to enlighten, or even re-orient, how we understand that experience (see Neubauer et al., 2019). I was curious about the role of social support and their ability to cope from the experiences of African American women diagnosed with breast cancer while living in a limited resource community. Minorities living in isolated resource-limited areas are typically at the lower end of the spectrum concerning financial stability and have the most difficulty coping with a chronic illness (Greer-Williams et al., 2014; Patel et al., 2014; Whitehead & Hearn, 2015).

Definitions

- *Breast cancer*: breast cancer is the type of cancer that starts in the breast (ACS, 2020).
- *Health disparities*: health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities (CDC, 2019).

- *Psychosocial social support*: resources to help the person, family, and friends deal with their own emotions and challenges associated with the diagnosis, treatment, and survivorship trajectory (ACS, 2020).

Assumptions

The assumptions underlying this study included that the study participants would answer all interview questions truthfully. I also assumed that each participant would understand each question, and if a participant did not comprehend the question, she would ask for clarification before proceeding with the interview. In addition, I also assumed that rural residents are more disadvantaged because of a potential lack of medical and financial resources and low health literacy (Tang et al., 2015). I assumed that some of my project participants would confirm this data. Lastly, I assumed the survivor rates among African American women with breast cancer in rural communities would continue unchanged if not addressed.

Scope and Delimitations

The delimitations for this study were African American women, diagnosed with breast cancer between the years 2009-2019, and living in various rural communities in Northeastern North Carolina. The research participants were located throughout the regions of Edgecombe, Halifax, Northampton, and Warren Counties within Northeastern North Carolina. Since the focus of the study included African American women with breast cancer, the results were limited and cannot be generalized to other ethnicities or other cancers.

Limitations

This qualitative research was open to a minimum of six and up to no more than eight participants who were African American women diagnosed with breast cancer between 2009-2019 with survivorship based on the time of diagnosis to the time of participation in the study and lived in various rural communities in Northeastern North Carolina. The small sample size represented a limitation; however, researchers stated that such a small sample could provide sufficient opportunity to identify and classify themes (Creswell, 2009). I used NVivo software (https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home) to assist with identifying frequency of words and phrases and sorting information to develop themes for the research data. The results of this study are limited to African American women with breast cancer and live in various rural communities in Northeastern North Carolina. Others with breast cancer and living in Northeastern North Carolina are not within the scope of this study, which limits the scope of the study to solely African American women. This qualitative study would not yield the same results if reproduced.

Another possible limitation that might be of some concern was the differences in participant characteristics (i.e., income, education, health insurance, etc.). If the study was conducted in the same methodology and research design, but with different participants, the outcome might slightly change. Since this is a phenomenological study, one could never obtain an undeniable outcome. For that reason, the results of this study could not be statistically measured. Lastly, the limited current literature (from the past 5-

7 years) on the topic that included minorities from medically underserved rural communities with breast cancer presented a limitation.

Significance

The purpose of this study was to explore the extent to which African American breast cancer patients and survivors developed, possessed, or utilized various coping skills in managing their cancer experience while residing in Northeastern North Carolina. In this research, I examined coping and social support approaches among African American women with breast cancer residing in various rural communities to determine significance and the implications for future interventions. Historical explorations have included more affluent samples that were well educated, more informed about breast cancer, and living in urban areas (Lewis et al., 2012). This project was unique because it addressed an underresearched and underserved population. The results of the study shed light on the social and cultural meanings of living with breast cancer in rural Northeastern North Carolina and how both dimensions of meaning are instrumental to how an individual coped with the disease. African American women are more adversely impacted by breast cancer than other groups; supporting their successful execution of coping methods could allow for increased survival rates among the broader population.

Summary of Chapter 1

This chapter provided the introduction and overview of the problem, research approaches, and ideas that contributed to the significance of this study. This included examples of coping processes, the physiological and psychological impacts of breast cancer, the implications social support has on the survivorship process, and the social implications of the study. In this research, I examined the voices through stories told of women diagnosed with breast cancer and their lived experiences conveyed by thoughts, feelings, and beliefs surrounding coping and social support approaches utilized during the cancer continuum of care. It was my intent to shed light on how social support, in particular, through family, friends, and community engagement, influenced the psychological adjustment of African American women living in various rural communities as they transitioned from the initial shock of being diagnosed with breast cancer to a feeling of being empowered and not defeated. Moreover, the findings in this study endorse interventions that promote ways for support systems to be actively engaged with African American women with breast cancer in rural communities.

Chapter 2 includes an in-depth examination of the existing research and strategies that support the concepts from Chapter 1. Chapter 3 contains a review of the methodology used, including participant information, data analysis, and data collection. Chapter 4 contains the results of the study, whereas Chapter 5 contains the findings from these results in relation to the literature and social change.

Chapter 2: Literature Review

Introduction

Levine et al. (2015) declared that social support was associated with fewer depressive symptoms and decreased levels of emotional anguish. Although social support was linked to African American breast cancer survivors and caregivers (Haynes-Maslow et al., 2016) the availability of social support has often been overlooked as an essential influence on breast cancer outcomes. The purpose of this study was to examine the lived experiences of African American women in rural Northeastern North Carolina with breast cancer. Although cancer survivorship brings a host of additional health and life challenges, such as increased risk of second cancer occurrence, psychological issues, social concerns, and economic problems (Ashing et al., 2016), researchers have argued that living in rural areas might heighten exposure to unequal social conditions that perpetuated disparities in access to care (Caldwell et al., 2016).

African American women diagnosed with breast cancer were chosen for this study primarily to examine the role of social support and their ability to cope from the emotional, physical, financial, and social issues associated with their diagnosis and treatment while living in a limited resource community. This study provided an opportunity to examine African American women with breast cancer and coping mechanisms to manage the disease. Information gained from the study will add to the existing partial literature on this topic. African American breast cancer survivors are understudied (Ashing-Giwa et al., 2013). However, compared to nonminority cancer survivors, African American cancer survivors tend to have poorer cancer outcomes with greater mortality and morbidity (Ashing et al., 2016). Yet very few studies have acquired survivors' perspectives (Gibson et al., 2014; Haynes-Maslow et al., 2016; Torres et al., 2016). There were even fewer studies that engaged African American cancer survivors in conversations about their challenges and preferences for coping with chronic diseases (Black et al., 2018; Hamilton et al., 2015; Haynes-Maslow et al., 2016; Torres et al., 2016).

Breast cancer is the most common type of cancer among African American women in the United States, and they have had the lowest five-year survival rate (ACS, 2019). African American families presented a disproportionate cancer burden compared with any other ethnic or racial group in the United States (ACS, 2019). The method of understanding the real-world experiences provided participants the opportunity to identify and envision culture-specific coping strategies as they describe the process towards survivorship. In this chapter, I have compiled an exploration into the meaning of TMSC theory, concepts of stress and coping, and African American women with breast cancer, which is the focus of this study.

Literature Search Strategy

For this review, the main topics researched were African American women and breast cancer, psychosocial needs, barriers to care, coping mechanisms, and survivorship. First, several interdisciplinary searches were explored for clarification of African Americans and coping. I examined definitions from philosophers, social scientists, and authors. In addition, an examination of multiple peer-reviewed journals from various disciplines were included. The following search engines were used: PubMed, Academic

Search Premier, PsycArticles, and CINAHL Plus with full text, and Google Scholar. I used the keywords *African Americans* and *breast cancer* as the root of all inquiries. With these terms, other search words such as *coping, stigma, diabetes, rural communities, breast cancer survivors, healthcare,* and *mistrust* were used to narrow the search.

Second, after reviewing the search results, I conducted a review of references from previous authors to establish additional resources that the general search did not discover. The reviewed articles indicated that active support networks were important coping tools for women diagnosed with breast cancer. However, while the articles were specific to African American women, the majority covered women living in urban areas, which did not correspond with this study's population of women in rural communities.

Third, additional terms were searched, including *vulnerable minority populations*, *health promotion interventions*, *cancer survivorship*, and *coping processes*. Obtaining references from articles though a primary reference search offered more supported materials, including studies using quantitative and mixed methodologies, and interviews. My research garnered information on variables that lessen or mitigate distress, access to health care, psychological impacts, the role of spirituality and coping in African Americans with breast cancer, yet very little literature was found dealing with psychosocial needs and impacts of African American women with breast cancer and living in a rural community.

Theoretical Foundation

Lazarus and Folkman's concept of stress and coping was implemented in this study. Lazarus and Folkman (1984) theorized that, when individuals recognized that the stress outweighed the resources, they would be engaged in coping strategies. The theoretical framework implied that stress was experienced as an appraisal (an evaluation) of the situation dealt with. TMSC theory suggested there were two stages of appraisal before feeling and responding to the stress.

1. Primary appraisal – when a person evaluated the situation to determine its relevance by asking, would the stress create gain or harm,
2. Secondary appraisal - a person only moved into this component if they recognized the stress was dangerous and would create harm.

Within this appraisal, the individual decided if they had the ability to cope with the situation. An analysis of the situation required one to assess perceived resources (i.e., social support, finances, etc.) versus situational demands (i.e., risk, uncertainty, difficulty, etc.). The literature also found that it is important to determine the demographic, social, psychological variables that lessened or mitigated distress among persons with breast cancer, as this information could set the course for coping with the disease and its treatments (Chirico et al., 2015).

The TMSC theory supported this study. The strength of the theory included the association between the effect of the behavior and social practices towards coping capability through cultural norms, access to care, and quality of care (Torres et al., 2016). The literature also found an area of weakness in the fact that behavioral intentions were often concerned with the cultural relevance of keeping secrets and how it influenced seeking treatment, fear of disclosure, cancer scrutiny, survivorship behavior among underserved communities (Adams et al., 2017).

Conceptual Framework

Stress and Coping

Psychologists have long been interested in ways that people coped with stressful situations. Arguably, Lazarus and colleagues' theoretical and empirical work significantly advanced our understanding of coping responses. Lazarus (1966) was among the first to offer a conceptual framework of stress and coping. This theoretical model consisted of the following three processes: primary appraisal, secondary appraisal, and coping (Lazarus, 1966; Lazarus & Folkman, 1984). Primary appraisal was the process of perceived threat to oneself, such as the impending occurrence of something wrong, harmful, or painful, or the perception of loss of something valued. The secondary appraisal was the process of recalling a potential response to that threat, and coping was the process of executing that response (Lazarus, 1966; Lazarus & Folkman, 1984). Thus, the Lazarus model of stress, appraisal, and coping acknowledged the importance of individual differences. What could be extremely upsetting to one individual could be a minor aggravation to another (Lazarus, 1966; Lazarus & Folkman, 1984). For example, one person could become incredibly distraught about failing a course, whereas another person could be relatively unaffected by the experience. Additionally, people vary in the way they choose to respond to stressful situations. Some might act immediately to try to eliminate the stressor, while others might merely try to stop thinking about the aggressor or refuse to acknowledge that the stressor exists.

Historically, African American women with breast cancer faced unique stressors such as poor patient-provider communication, fearful perceptions of treatment, distrust of the healthcare system, economic challenges, and a reluctance to share their illness with others (Whitehead & Hearn, 2015). Former literature also suggested African American women with breast cancer were more likely to report lack of social support, higher cancer-related stigma, and reduced breast cancer-related quality of life than Caucasian women (Whitehead & Hearn, 2015). Findings from prior research on perceived social support in breast cancer patients were mixed. Prior work revealed that individual differences with coping responses to diagnosis and treatment of breast cancer caused psychological adjustment (Haynes-Maslow et al., 2016; White-Means et al., 2015). In one research study, African American women reported that their close female relatives expressed discomfort when they attempted to discuss their illness, and close friends and partners withdrew support after learning of their diagnosis (Whitehead & Hearn, 2015). Psychological distress (e.g., depression, anxiety) and burdensome symptoms in African American women with breast cancer had negative effects on emotional and cognitive functioning (Gaston-Johansson et al., 2015). However, a strong coping capacity was associated with lower psychological distress and higher quality of life (Watkins et al., 2017). Therefore, African American women with breast cancer could benefit from learning how to increase their coping capacity and use of helpful coping strategies that could decrease psychological distress (Haynes-Maslow et al., 2016; Watkins et al., 2017; Whitehead & Hearn, 2015; White-Means et al., 2015).

The literature suggested both positive and negative aspects of social support and access to health resources that were relevant to addressing the coping challenges among African American women with breast cancer (Haynes-Maslow et al., 2016). Researchers reported social networks offered an existing framework where health concerns were openly discussed while encouraging appropriate health behaviors among rural African Americans and other disadvantaged populations (Tang et al., 2015). Majority of the literature indicated African American women with breast cancer relied on their faith, family and friends, and church members as sources of support (Haynes-Maslow et al., 2016; White-Means et al., 2015). Although, stigmatization and fear within the community remained and would impede social support with African American women with breast cancer (Haynes-Maslow et al., 2016; White-Means et al., 2015), one study found African Americans used coping strategies tied to praying, hoping, and positive self-reflections (Gaston-Johansson et al., 2015). It was apparent that support factors (or the lack thereof) that hindered behavior change negatively affected survival rates for African Americans (Webb & McDonnell, 2018).

Unfortunately, little attention has been given to factors that facilitated survivorship care among underserved breast cancer survivors and the identification of influences that motivated them to persevere in obtaining health care despite the underlying challenges (Ustjanauskas et al., 2017). Webb and McDonnell (2018) found that study participants collectively expressed the need to learn from and support other female African American lung cancer survivors to help them cope with the physical, psychological, and social challenges. Another study found there was emotional impact on the parent with cancer when caring for children because of the complex negotiations between the need to self-care and attending to the needs of the children and extended family (Schiena et al., 2019). Research suggested African American women could benefit from learning how to increase their coping capacity, spiritual well-being, and use of helpful coping strategies to help decrease psychological distress and distressing symptoms (Watkins et al., 2017).

Researchers described multiple types of social support: emotional, instrumental, and informational support (Haynes-Maslow et al., 2016; Lazarus, 1966; Lazarus & Folkman, 1984). Emotional support referred to gestures extended to someone that provided comfort or alleviated negative emotions such as stress. Instrumental support was the provision of tangible goods or services. Lastly, informational support was defined as information that was provided to assist another in problem-solving (Lazarus, 1966; Lazarus & Folkman, 1984). All three types of social support were highlighted in past chronic disease management research studies (Durant et al., 2013; Johansson et al., 2016), yet few have included rural communities.

Future research should address the health disparities faced by African Americans with breast cancer and the impact of those challenges while living in a rural community. An understanding of the best ways that addressed the unique coping needs of African American women diagnosed with breast cancer is critical to improving morbidity and mortality outcomes in this population (Haynes-Maslow et al., 2016). Racial and ethnic survivor disparities in African Americans with breast cancer suggest that unmet needs persist, and issues related to survivorship still exist (ACS, 2017; Haynes-Maslow et al., 2016; NIH, 2017). Moreover, often researchers focused on the support needs of urban women with breast cancer but rarely examined the needs of those living in rural areas. By exploring the perceptions of African American women coping with breast cancer in rural

Northeastern North Carolina, I was able to gain a broader view of the issues and desires of a vulnerable population survivor needs. Building upon previous work, this study unveiled the stress and coping processes and utilities as described by African American women with breast cancer in rural Northeastern North Carolina.

African American Women and Breast Cancer

Current statistics indicated one in eight women will be diagnosed with breast cancer, and every 13 minutes an American woman would die from complications related to breast cancer (ACS, 2019). African American women aged younger than 45 years old had higher rates of breast cancer compared to Caucasian women and likely died from it (ACS, 2019). In addition, African Americans were clinically underserved due to not being included in clinical trials as well as narratives within the research literature. For these reasons, there was a clear gap in research that emphasized African American women and their respective attitudes towards coping with a chronic or terminal disease (Gregg, 2011). Underserved women, those who lacked health insurance and had low SES, were even less likely than their Caucasian counterparts who were insured and had higher SES to receive optimal survivorship care following breast cancer treatment (Ustjanauskas et al., 2017). Several barriers to obtaining optimal health care among breast cancer survivors were identified: health care system fragmentation, language, and communication barriers (Ferrera et al., 2016), unaffordable medical costs, and lack of health insurance (Mogal et al., 2017), and lack of information on support services (Molina et al., 2014).

Church members were viewed as an integral part of African American breast cancer survivors support network. However, if the church did not provide support in a favorable manner, but instead alienated the breast cancer survivor it would play a significant role in stimulating emotions of uncertainty and negativity (Mollica & Nemeth, 2015). Evidence suggested that survivors who experienced isolation during the treatment process were at higher risk of developing and maintaining poor coping skills (Davis et al., 2013). Another study indicated the risk of breast cancer reoccurrence was linked to lifestyle behaviors (Ansa et al., 2015) amongst the target population. Findings also pointed to the importance of spirituality among African American breast cancer patients' capability of adapting to the challenges as a way of effectively managing the disease (Thompson et al., 2017).

Gregg (2011) study focused on the coping strategies, specifically the religious and spiritual coping strategies of African American women after a diagnosis of breast cancer. Findings from Gregg's study were consistent with prior studies, as it acknowledged that when African Americans dealt with life-threatening conditions, religious or spirituality was critical to overall well-being. More findings from past studies noted the two most reported coping mechanisms for African Americans were prayer and social support (Gregg, 2011; Haynes-Maslow et al., 2016; Wells et al., 2014). Wells et al. (2014) study advocated on the importance of clinicians and social support networks being prepared to address the unique psychosocial issues encountered by breast cancer patients due to their cultural, attitudes, beliefs, and social environment. Gregg (2011) study found African Americans often relied on informal sources of health care advice such as family members and church-based supports and to not view African American women's reliance on spirituality as fatalistic. Gregg’s study found that although African American women would express their belief that God was in control it did not infer that they distinguished themselves as powerless or helpless. Furthermore, African American women were described as the ultimate caretaker by taking care of their family while denying themselves, not complaining, being in control, and never acknowledged themselves as being fragile. And African Americans were known to suffer in silence, not ask for support, which contributed to feelings of irritation and stress. To some African American women diagnosed with breast cancer, and the capacity to maintain womanly and familial duties were viewed as strength. The proposed qualitative phenomenological study strived to glean rich, essential themes at the individual, interpersonal, and institutional levels that were associated with coping and surviving breast cancer among African American women living in various rural communities of Northeastern North Carolina.

Review of Literature

In-depth literature linked people in rural areas to lower health outcomes that pertained to the experience of chronic illness, especially for breast cancer when compared to those in urban settings (Caldwell et al., 2016; NIH, 2019). Recently, one study examined if residing in a rural versus urban area exposed populations differently to social conditions associated with barriers in access to health care that implied an inability to cope with a chronic disease due to unequal social conditions (Caldwell et al., 2016). Caldwell ‘s study concluded African Americans and Hispanics in rural areas were less likely to have health insurance, made fewer physician visits, and more inadequate access to medical care compared with urban non-Hispanic Caucasian counterparts. To complement this research, Clottey et al. (2015) argued that higher proportions of African Americans and Hispanics that lived in isolated rural areas with fewer collective resources, had higher rates of poverty, and lower levels of attained health care. Counties recognized as HPSAs had lower access to health care and experienced worse health outcomes (ACS, 2019; Caldwell et al., 2016; NIH, 2019). Because rural areas remained less understood and less included in public health research than urban areas (Caldwell et al., 2016), it seemed obligatory to investigate the real-life experiences of African American women with breast cancer and how they coped with the diagnosis and treatment while living in various rural communities in North Carolina. In addition, there was a gap in the research of African American women and how they experienced breast cancer (Gibson, et al., 2014).

Some studies found that a diagnosis of breast cancer was associated with increased risk of depression, loneliness, or emotional strain (Clottey et al., 2015; Torres et al., 2016). In addition, these studies found issues of rurality, race, and poverty collided with effects of coping and multiplied its challenges. Coping studies among racial and ethnic groups revealed differences. The most robust finding in the literature was that African Americans are more likely to be engaged in religious coping compared with non-Hispanic Whites. Religious coping was found in response to many illnesses, such as breast cancer, HIV, and lung cancer (Johansson et al., 2016; Karni, et al., 2014; Torres et al., 2016,). African Americans involved in support networks, or served as the family emotional regulator, while maintaining a positive attitude are more common compared with Caucasians while coping with an illness (Best et al., 2015, Karni et al., 2014; Torres et al., 2016). One study found African American women with breast cancer faced obstacles such as transportation and family obligations that prevented them from participating in face-to-face support groups, so it evaluated the use of teleconferencing technology that delivered a virtual support group to African American breast cancer patients (S.P. Heiney et al., 2012). The study found that teleconferencing technology showed significance as participants (African Americans with breast cancer) gained knowledge about breast cancer and coping, helped them to reach out and ask for support, and improved family and work relationships. The teleconference method proved to be beneficial in reaching a disadvantaged population. Another study investigated utilization of videography that included African American cancer survivor stories as a way for individuals to adhere to follow-up care and improve overall quality of life (Palmer et al., 2015; Perez et al., 2013). This study found African American breast cancer survivors experience with treatment and living with breast cancer presented them as credible messengers of cancer information.

Best et al. (2015) presented evidence that African American cancer survivors experienced more problems related to physical and emotional distress, employment, and financial issues compared to Caucasian cancer survivors. Several studies suggested screening for distress as part of routine care (Imm et el., 2017) and urged clinicians to assess perceived social support among African American women with breast cancer the first year of diagnosis to help locate support resources for those who expressed low support networks (Thompson et al., 2017). Strengthening social support systems that promoted more prosocial coping and help-seeking behaviors early in the survivorship journey could improve overall quality of life for African Americans with cancer (Imm et al., 2017).

Likewise, living in rural, isolated communities affected how patients coped with cancer. Decision making about treatment, especially if the person lacked health insurance, transportation, and had insufficient income influenced how a person coped. Additionally, individuals that were concerned about not only their health and well-being but worried about how to shield their children and families from being distressed and maintained family routines with minimal distractions (Best et al., 2015; Karni et al., 2014) also affected how patients coped. African American breast cancer survivors that lived in rural areas were particularly vulnerable to barriers toward access to cancer survivorship services. Poverty was a major problem for rural residents (Adams et al., 2017). Other investigators identified unique challenges, such as, fear of being stigmatized by the community due to cancer diagnosis and poor interaction with healthcare providers (Haynes-Maslow et al., 2016; Torres et al., 2016). Even with the identified barriers for rural African American dwellers, Sadati et al. (2014) found that religious concepts helped African Americans find meaning to the diagnosis of breast cancer, identify coping strategies, and gain a new perspective of life and death.

Coping strategies provide essential considerations in adjustment to breast cancer and maintaining a quality of life. However, there was less attention on how African American women coped with the diagnosis and treatment of breast cancer although African Americans were diagnosed at more advanced stages and had higher mortality rates because of the disease (ACS, 2017). Identifying how African American women coped and pursued support is crucial in closing the cancer disparity gap. This information could lead to a greater understanding of their perceptions, health beliefs, and resources that tailored more culturally sensitive interventions and enable optimal coping for vulnerable communities (Karni et al., 2014).

Summary and Conclusions

In this chapter, I describe current theories and research that contribute to the ideas of social support, coping processes, and rural versus urban narrative. The focus was on the structure of meaning and social support, applied coping strategies, and social implications. This chapter provide the foundation to examine the stories of African American women diagnosed with breast cancer and living in various rural communities in Northeastern North Carolina.

This study’s findings contribute to the field of public health by enlightening the unique experiences of women diagnosed with breast cancer and the significance of meaning and social support (e.g., family, friends, and community engagement) can influence. Identification of the processes and coping mechanisms can contribute to optimal survivorship when incorporated after diagnosis. Chapter 3 will describe the methodology to begin selecting the women who want to share their stories and collecting and analyzing the research gathered.

Chapter 3: Research Method

Introduction

In this phenomenological study, I explored the lived experiences of African American women who were diagnosed with breast cancer between 2009 and 2019, and who lived in various rural communities in Northeastern North Carolina. The purpose of this study was to explore the extent to which African American breast cancer patients and survivors developed, possessed, or utilized various coping skills in managing their cancer experience while residing in Northeastern North Carolina. The structures of social support were also examined within the context of applied coping strategies. Additionally, several narratives describe the potential social implications of these research findings.

This chapter outlines the phenomenological method used to explore participant experiences. Additional sections describe the framework of the study, the role of the researcher, the research methodology, the participant selection process (i.e., inclusion and exclusion criteria), data collection instruments, the process of data collection and analysis, and the measures taken to protect the participants.

Research Design and Rationale

Qualitative research methodology enables researchers to explore social and behavioral issues related to public health that are not achievable with quantitative methods (Isaacs, 2014). Qualitative research is useful when the research focuses on complex issues such as human behavior and felt needs. The goal of qualitative research is therefore to help us understand social phenomena with the help of views and experiences of all the participants (Mays & Pope, 1995). Based upon this rationale, the methodological framework, Phenomenology, was selected to guide the development of this research study, an in-depth examination of the lived experiences of African American breast cancer patients and survivors, residing in Northeastern North Carolina, between 2009-2019.

Neubauer et al., (2019) articulated the foundational premise of research, to discover information or to achieve new understanding of the subject. A detailed study often required understanding the experiences of others, so we can glean new understandings about a particular phenomenon. Phenomenology utilizes a distinctive method to study the structural features of experience and of things as experienced (Teherani, et al., 2015). Creswell (2009) postulated that through phenomenological research, stories collected of lived experiences, using an open-ended interviewing format (p. 16).

Most historians credit Edmund Husserl for defining phenomenology in the early 20th century. Husserl's approach sought to find a universal foundation of philosophy and science (Kafle, 2011; Staiti, 2012). There are different kinds of phenomenology, each rooted in different ways of conceiving the "what" and "how" of human experience (see Neubauer et al., 2019). For instance, Heideggar and Gadamer's (as cited in Neubauer et al., 2019) ontological assumptions were hermeneutic (interpretive) phenomenology that emphasized the lived experience is an interpretive process situated in an individual's lifeworld (realities are invariably influenced by the world in which they live). Researchers, utilizing this framework, reflect on essential themes of the participant experience with the phenomenon while simultaneously reflecting on their own experience. This process consisted of iterative cycles of capturing and writing reflections towards a strong and distinctive analysis, considering how the data contributed to the evolving understanding of the phenomena (Manen, 1997). Interpretive phenomenology analysis (see Neubauer et al., 2019) requires the researcher to interpret the narrative provided by the research participants in relation to their own individual contexts in order to illuminate the fundamental structures of participants' understanding of being and how that shaped the decisions made by the individual (Heidegger, 1867).

In contrast, Husserl (as cited in Neubauer et al., 2019) emphasized that the reality is internal to the knower, what appears in their consciousness and labeled as transcendental (descriptive) phenomenology. With DPA, I must remain unbiased during data collection and analysis. During the data analysis phase, the phenomena is considered from different perspectives; units of meaning are identified and clustered into themes to form textural description (the "what" of the phenomenon). To determine the "how" of the phenomenon, imaginative variation is used to create structural description. By combining both descriptions, the essence of the phenomenon is formed (see Neubauer et al., 2019). The subjective and objective knowledge are intimately intertwined; therefore, to understand the reality of the phenomenon as lived by a person. This lived experience is a dimension of being that had yet to be discovered (Staiti, 2012). Understanding the lived experiences makes phenomenology the philosophy and method that involved studying a small number of subjects through engagement to develop patterns and relationships of meanings (Moustakas, 1994). In this study, I used DPA to explore how African American women with breast cancer managed their diagnosis, treatment, and survivorship while living in a limited resource community.

Role of the Researcher

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." – Maya Angelou

My role as the researcher included ensuring that all scheduled interviews followed COVID-19 safety guidelines by offering alternative formats (e.g., phone and/or videoconference), convenient appointment times, and privacy. These measures enabled each research participant to tell her personal stories as well to further explore the meanings of social support, applied coping strategies and social implications related to living with breast cancer. I audio tape-recorded and transcribed each interview. Transcribing the interviews afforded me the opportunity to be engaged with the data by examining each participant story in depth and to capture real distinctions of meaning in the narrative. Another key aspect that distinguished transcendental (descriptive) phenomenology was my role in the inquiry. In this research design, I do not bring definitions, expectations, assumption, or hypotheses to the study, instead, I assume a blank state that use the participants' experience to develop an understanding of the phenomenon (see Neubauer et al., 2019). Polkinghorne (1993) posited that rich descriptions of phenomenological research might be characterized by qualities such as originality, depth, truthfulness, and elegance. Instead of simultaneously reflecting on my past experiences with the phenomenon as one would do with hermeneutic (interpretive) phenomenology, I used the process of bracketing by setting aside previous understandings, past knowledge, and assumptions about the phenomenon of interest (see Neubauer et al., 2019). Therefore, each participant's experience was considered individually to develop a complete description of the phenomenon meanings and essences (Moustakas, 1994).

Creswell (2009) asserted that the reader would need to understand the researcher's position on the topic. Therefore, I must provide more information. I am experienced in coping practices with a breast cancer diagnosis because her mother is a nine-year survivor and I served as her primary caretaker during this time. Additionally, I have lived with multiple sclerosis for 24 years. On, March 23, 2019, I was diagnosed with advanced stage ovarian cancer. I intimately understand the need to rely on others for care and support and recognize my potential bias. I was vigilant in making sure my individual experiences did not bias data collection, analysis, and interpretations by not inserting my own understandings, perceptions, etc. I reduced the risk of introducing bias into the research by keeping questions and tone neutral, and not offering an opinion. Each interview was audio tape recorded and transcribed. Transcribing the interviews allowed me the opportunity to examine each story in-depth and capture fundamental distinctions of social support meaning and applied coping strategies in each lived experience. In addition, each participant was given a copy of her transcribed interview, prior to the data being analyzed.

Creswell (2009) recommended, "to keep the focus on learning the meaning that the participants hold about the problem or issue," as it would allow the participants to provide the perspective of their current situation (p. 175). Information gathered provided insight into the type of support structure that existed when each participant was diagnosed with breast cancer as well as a description of activities used for coping in the context of her experiences, while residing in various rural communities in Northeastern North Carolina. Through transcendental (descriptive) phenomenology, any experienced phenomenon could be the object of study thereby pushing analysis beyond mere sensory perception (i.e., what I see, hear, touch) to experiences of thought, memory, imagination, or emotion (Reiners et al., 2017). The transcendental (descriptive) phenomenology required me to suspend personal attitudes, beliefs, and suppositions to focus on the participants' experience of the phenomenon. One of Husserl's great contributions to philosophy and science was the method that enabled researchers "to suspend the natural attitude as well as the naïve understanding of what we call the human mind and to disclose the realm of transcendental subjectivity as a new field of inquiry" (Staiti, 2012). When qualitative researchers provide detailed descriptions and many perspectives, the results are more credible (Creswell, 2009). With this combined description of a group of African American women who had experienced breast cancer while living in various rural communities of Northeastern North Carolina, a better understanding of their "lived experiences of the phenomenon" will be presented. All women were thanked for taking time to share their experiences with me. At the end of the interview, each woman received a $15 gift card as compensation for her participation. All gift cards were mailed immediately after the end interview.

Methodology

Just before the research collection phase of this research study began, a highly infectious, airborne disease (COVID-19) began spreading around the world at an accelerated rate. As a public health preventive measure, the U.S. government initiated a nationwide stay-at-home order, which led to school closings and people staying inside their homes. Walden University, the academic institution I am associated with, initiated alternative guidelines to in-person research. With Institutional Review Board (IRB) approval, I was able to utilize multiple formats to communicate with potential research participants. The global COVID-19 pandemic limited face-to-face interviews at the present time as this type of research was not considered an essential activity.

Multiple alternative formats could be ethically employed, such as phone, email, and via video conference platforms like Zoom or Skype. Recruiting materials and the consent forms were re-written with language to include permission to use alternative formats to conduct the research and remain incompliance with IRB, CDC, and local government guidelines. For example, when possible, materials could generically refer to “video conference or phone interview” instead of naming particular platforms like "Zoom interview," which gave the participants flexibility, given that platforms such as Zoom, and Skype might not be familiar or available to all potential participants. Additionally, some participants could have limited internet or equipment access, so allowing a phone option is always a good idea. Face-to-face interviews could not be conducted until revised guidelines regarding social distancing, gathering restrictions, leaving home only for essential activities, use of masks, and other mitigating practices were officially published by the CDC and the local government where data collection was occurring.

Participant Selection Logic

Since this study required the participation of human subjects, the application to pursue the research had to undergo an expedited review by the IRB at Walden University. The purpose of the IRB is to assure that appropriate steps are taken to protect the rights and welfare of humans participating as subjects in a research study. The IRB application was developed by first speaking with a member of the partner organization to share information about the research study and to request support by agreeing to assist with participant recruitment. The partner organization was comprised of representatives from diverse health and civic organizations who have direct contact with persons directly impacted by breast cancer. The organization agreed to serve in this role by providing an avenue to identify research participants and served as a catalyst to encourage participation. This organization deferred their IRB approval to the Walden University IRB.

I served as a member of the partner organization. Because this research study was separate and distinct from my role in the organization, I included a statement on the participant consent forms that explained how and why these two entities were separate and distinct. In addition, I included a statement to ensure each participant that involvement in the study would not affect her relationship with the organization.

In order to obtain support from the partner organization, I submitted a letter to them that included a brief statement about my personal and professional aspirations, the premise of the research, and a solicitation to organization members to assist with identifying potential research participants by sharing the letter to participants. The premise of the study was to identify the coping strategies to manage the emotional, physical, financial, and social issues that rural African American women used after diagnosis and during treatment for breast cancer. Once the Walden University IRB approved the study protocol, I submitted the letters to the partner organization to begin the recruitment process and answer any additional questions.

I used purposeful convenience sampling and criterion sampling technique to identify and recruit women for this study. Both techniques are used to provide a rich or dense description of the culture or phenomenon of interest (Creswell, 2009). I collaborated with a local organization to identify and recruit research participants. Each member received the letter to healthcare/community service agencies and the letter to potential participants. To be included in the study, participants had to be living in Northeastern North Carolina and an African American woman at least 40 years old with a confirmed diagnosis of breast cancer between 2009-2019, but cancer-free (no active cells) at the time of the participation in the study, and fluent in English (reading/writing/understanding). I successfully recruited nine participants for my research; however, due to unexpected participant matters only seven completed the interviews. All study participants self-identified as African American women diagnosed with breast cancer between the years 2009-2019 and lived in Northeastern North Carolina.

Phenomenological research has no set rules for the number of study participants a researcher should have. Samples in qualitative research tends to be small to support the depth of case-oriented analysis that is fundamental to this mode of inquiry (Sandelowski, 1996). Additionally, qualitative samples are purposive, that is, selected by virtue their capacity to provide richly textured information, relevant to the phenomenon under investigation (Vasileiou et al., 2018). Sandelowski (1996) recommended that qualitative sample sizes be large enough to allow the unfolding of a new and richly textured understanding of the phenomenon being investigated, but small enough so that the deep, case-oriented analysis (p. 183) of qualitative data is not excluded. The required sample size to understand the lived experiences of African American women with breast cancer was six. This sample was large enough to answer the current study research questions.

I conducted an initial telephone interview with each woman and discussed my background, the reasons she wanted to participate, and shared information about the consent form and demographic survey. After the phone interview, each participant received the consent form and demographic survey (see Appendix A) via email or mail, depending on preference. Each woman was asked to complete both documents and return by email or mail and were provided with my direct contact information if they had further questions or concerns while reviewing and completing the consent form and demographic survey. Once the signed consent form and completed demographic survey was received, I called each woman to schedule the interview (phone or videoconference) during the time most convenient to them as well as shared information on the interview process and how the data would be collected and stored. Each participant was made aware of the semistructured interview method. The list of interview questions (see Appendix B) was developed as a guide to keep the conversation flowing. However, each participant could share how much or little information she felt comfortable in sharing. This allowed me to ask additional questions that may not be listed but served as important information in understanding the phenomenon.

Since all interviews were held via phone, there was a substantial risk the research participant may not be alone while completing the interview. To reduce this possibility, I requested all participants to hold the interview in a setting that allowed them to be alone and free from distractions. In addition, because the interview included very personal and sensitive subjects, it was plausible unpleasant emotions could surface while reflecting on experiences. To prevent participants from disclosing the need for assistance to deal with these emotions, all participants were provided with the name and telephone numbers of local resources. To ease participant's physical discomfort during the interview, each interview had a prescheduled break to allow me to ask, "How are you doing?", "Is it ok to continue or do you prefer we schedule another time to complete the interview?" Lastly, to protect the participant's privacy, they were provided a code. The code included one letter of the alphabet and a two-digit number (e.g., A34). The codes were selected randomly and did not have special meaning to the participant. All research materials were kept in a locked file in my home office.

Instrumentation

The qualitative phenomenological methodology was selected to study an under-researched topic that needed to be explored. Due to lack of investigation of African

American women and their breast cancer experience, I created the instruments used in this study from the literature review based on experiences of African American women coping with breast cancer. Instruments included a demographic survey and semistructured interview questions.

The demographic survey was devised to obtain information such as marital status, education status, income, employment, insurance status, and number of years as a breast cancer survivor. The semistructured interview guide was designed to elicit participants' descriptions of how they coped with breast cancer. The women were asked to respond to statements such as the following:

- Please tell me how you would describe your initial diagnosis of breast cancer.
- Please tell me what activities helped you to cope with your diagnosis of breast cancer.
- Please tell me what the most challenging aspect of coping with the diagnosis and treatment of breast cancer was.
- Please tell me how you would describe the role of social support (coping) networks when dealing with breast cancer.

Each interview was audio tape recorded and transcribed. Transcribing the interviews allowed me the opportunity to examine each story in-depth and capture fundamental distinctions of social support meaning and applied coping strategies in each lived experience. In addition, each participant was given a copy of her transcribed interview, prior to data being analyzed. The study instruments provide sufficient responses to the study's research questions.

For Researcher-Developed Instruments

Approval to conduct this study was obtained from Walden University's IRB (IRB approval #05-22-20-0252240). Morse (2000) posited that the more usable data are collected from each person, the fewer participants are needed. Creswell (2009) contended that qualitative phenomenological studies are used "to identify the essence of human experiences about a phenomenon as described by participants" (p. 13). Kennedy and Rollins (2016) have suggested that more research was needed to capture the complexities of the African American population in coping with chronic illness. Another research acknowledged the impact of social determinants of health and the legacy of segregation that influenced African American women with breast cancer ability to conceptualize health in a resource-resisted environment (Greer-Williams et al., 2014). There were variations in actions among older women with breast cancer and these reactions impacted experiences with seeking social support at diagnosis and during treatment (Umezawa et al., 2012). Minorities living in isolated resource-limited areas were typically at the lower end of the spectrum concerning financial stability and had the most difficulty coping with a chronic illness (Greer-Williams, 2014; Patel et al., 2014; Whitehead & Hearn, 2015). P.D. Henderson et al. (2003) affirmed future research studies were needed to determine what is considered effective and ineffective coping strategies for African American women with breast cancer. This research sought to uncover the experiences with coping mechanisms African Americans with breast cancer used while residing in various rural communities of Northeastern North Carolina.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

To begin study recruitment, two documents were emailed to the partner organization. The first, a letter addressed to healthcare/community service agencies was an invitation to support the research study by identifying potential study participants. The second, a Letter to Participants, was an invitation to potential study participants. The email instructed the partner organization to identify potential research participants, and then share the Letter to Participant with them.

All women who were interested in participating in the study had to call me for additional information. All women were made aware the interview would be held via phone and/or videoconference, it would be audio tape-recorded. All information gathered from the demographic survey and the interview would be kept strictly confidential, and each participant was given a copy of her transcribed interview, prior to data being analyzed. At the end of the completed interview, participants would be mailed a $15 gift card. All participants were free to choose whether to participate and could discontinue participation at any time.

Participation

Prior to interviewing the research participants, each were given time to ask questions about the research study and the documents they were provided (i.e., consent form and demographic survey). Interviews were not scheduled until I received the signed consent form and completed demographic survey. The demographic surveys took approximately five minutes to complete. A copy of the consent form was also provided to every participant. All participants gave their consent to allow their interviews to be audio tape-recorded. To protect the participants' confidentiality, codes were assigned to each participant. The codes consisted of one letter of the alphabet and two numbers (e.g., A34). Codes were randomly selected without any relation to the participant. For example, "A" would not indicate the first participant that was interviewed.

Data Collection

Semistructured interview questions guided each interview. The interview questions were used as a guide to ease along the interview in a conversation type manner. This study aimed to answer the overarching question:

What are the lived experiences of rural, African American women diagnosed with breast cancer in the development of coping strategies to manage the emotional, physical, financial, and social issues associated with the diagnosis and treatment?

The semistructured interview questions stimulated participant responses to the following five open-ended questions:

1. What is the experience of being an African American woman with breast cancer?
2. How did you cope with the diagnosis and treatment of breast cancer?
3. How did your family and friends provide support when you were diagnosed with breast cancer?
4. What role did spirituality play in your life as you coped with breast cancer?
5. What would you like to see offered to other African Americans diagnosed with breast cancer?

All participants completed the demographic survey that took approximately five minutes to complete. Interviews ranged from 45 to 90 minutes, each were conducted by phone, and during the preferred date and time chosen by the participants. All participants were encouraged to hold the interview in a setting that allowed them to be alone and free from distractions.

Participants were made aware the interview could create psychological, relationship, and/or physical risks. To prevent participants from having to disclose the need for assistance to deal with psychological and relationship impacts they were provided with a list of local resources (i.e., counseling services, support groups, etc.) on the consent form.

To help ease participant physical discomfort during the interview, I inserted a prescheduled break to ask the participant, “How are you doing?”, “Do you need a break?”, and “Is it ok to continue or do you prefer we schedule another time to complete the interview?” The partnering organization and all seven participants received a two-page study summary highlighting outcomes and recommendations at the end of the research study via email and/or mail.

Data Analysis Plan

Creswell (2009) recommended, "Organizing and preparing the data for analysis" as the first step towards beginning the analysis process (pp. 185). Once all interviews were transcribed, the process of analyzing the data began. I used transcendental (descriptive) analysis (DPA) tool to examine the phenomena, meaning of social support, and applied coping strategies for African American women with breast cancer. DPA requires me to have an objective and organized approach for content analysis of the transcripts. I read each transcript and listened to the audio tape-recording a minimum of five times to gain a deeper understanding for the meaning of the phenomenon. The goal was to understand what type of information the data are conveying (Creswell, 2009). All transcripts were uploaded into NVivo software for data analysis by the five question domains: African Americans and breast cancer, coping methods, the role of social support, the power of religion and spirituality, and social implications for African Americans with breast cancer.

The purpose of content analysis was to examine the frequency, order, or intensity of the occurrence of words, phrases, or sentences for themes that represented the participants (Burns & Grove, 2001). I identified descriptive overarching themes and illustrative quotes. Data was categorized based on information described by the participants. These expressions represent the feelings, emotions, and actions concerning how the participant experienced the phenomenon. Phenomenology allowed me to construct the meaning for each participant to be diagnosed with breast cancer (Creswell, 2009). The connections from all women were clustered to provide a shared experience of the phenomenon. Demographic data were analyzed by descriptive statistics (frequencies, means, and percentages; Burns & Grove, 2001).

Issues of Trustworthiness

Validity

The validation of data from qualitative research is related to the trustworthiness and credibility of its interpretations and conclusions. The validity of results "mean the researcher checks for accuracy of the findings by employing certain procedures" (Creswell, 2009, pp. 190). Validity is one of qualitative research strengths because it is based on determining if the findings were accurate from the standpoint of the researcher, the participant, or the readers of an account (Creswell and Miller, 2000). I used triangulation as a strategy to confirm research validity. Triangulation involves verifying data from a variety of sources to gain a more complete understanding for a specific theme or perspective related to the phenomenon. Ashworth (2003) suggested that quantitative studies limited explanations of human behavior, but qualitative research provided a more complex understanding of human behavior by not identifying individuals as problematic. Triangulation is used to ensure the research findings are robust, rich, comprehensive, and well developed.

Transferability refers to the degree to which qualitative research results can be transferred to other contexts, settings, and populations. It is important to note I cannot prove that the research findings will be applicable for other populations with similar characteristics to the study population. To ensure the qualitative research demonstrates credibility, dependability, and validity, I transcribed all the interviews verbatim and provided transcripts to each participant for review and edits before analysis began.

Reliability

I transcribed interviews verbatim to ensure fidelity. I provided participants with a copy of their transcript to review, modify, and approve prior to starting the data analysis process. The process of determining if the findings are reliable entailed three recommended steps that included “checking transcripts, provide clear defining codes, and cross-check codes" (Creswell, 2009, pp. 190). Husserl contended that no assumptions should inform phenomenology inquiry because ultimately, all genuine and all scientific knowledge rests on inner evidence. To understand the reality of a phenomenon is to understand the phenomenon as it is lived by a person (Staiti, 2012). This required me to suspend my own attitudes, beliefs, and assumptions to focus on the participants' experience of the phenomenon and identify the essences of the phenomenon (see Neubauer et al., 2019).

In transcendental DPA, I had to remain neutral and not allow my subjectivity to inform the descriptions offered. I could access the participant's experience of the phenomenon pre-reflectively – without resorting to categorization on conceptualization (Laverty, 2003). To confirm my approach was in line during data collection and analysis, I used bracketing by removing personal views, experiences, previous understanding, past knowledge, and assumptions about the phenomenon of interest. Each participant's experience was considered individually and a complete description of the phenomenon's meaning, and essences was constructed (Moustakas, 1994). Participants' descriptions of their conscious experiences were extracted to a unified summary of the outcomes that created the foundation of study knowledge about the phenomenon, as suggested by Neubauer et al. (2019).

Ethical Procedures

The IRB application included Form C: Ethics Self-Check Application for IRB Approval and the following supporting documents: Research Study Consent Form, Letter to Healthcare/Community Service Agencies, Letter to Participant, Demographic

Survey, Semistructured Interview Questions, and the Confidentiality Agreement- for anyone who reviews the data. Because the partner organization agreed to only share study information with members and were not required to share contact information for potential study participants, they were not required to provide a letter of support with the IRB application. The Letter to Healthcare/Community Service Agencies indicated participants are free to choose whether to participate and can discontinue participation at any time. In addition, the Letter to the Participant reminds all individuals, your decision to (or not to) participate in this study will not impact current relationships with the partner organization. All participants reviewed and signed the consent form.

Individuals were made aware they would receive a copy of their interview transcripts one-two weeks after the interview. They would have no more than three days to review, provide suggested edits, and approve the transcript. All participants provided approval for their interview transcripts. All data was 100% confidential, except for the signed consent forms. To protect the identity of the research participants, they were assigned codes. The codes consisted of one letter of the alphabet and two numbers (e.g., A34). Codes were randomly selected and were not related to the participant. Data is stored in a locked file cabinet in my home office. Electronic files are stored on my password-protected computer and backed up on a password-protected hard drive. All interview audio tape recordings were destroyed immediately after transcription.

Risks and Benefits

The participant consent form listed the potential benefit and risks for participating in this study. The potential benefit of participating in this study could come in the form of providing more comprehensive support services for women diagnosed with breast cancer. All were made aware their decision to participate would not negatively affect relationships with me, the current or future relationships with their healthcare/community-service agency or support networks, or access to services. Individuals understood their participation in the study was strictly voluntary. They were free to withdraw from the study at any time. The following items were listed as potential risks of being in the study:

- Privacy risk: Since the interviews were held via phone, there was a substantial risk the research participant would not be alone while completing the interview. To reduce this possibility, all participants were asked to hold the interview in a setting that allowed them to be alone and free from distractions.
- Psychological risks: Because the interview included very personal and sensitive subjects, unpleasant emotions could resurface while reflecting on experiences. To prevent participants from having to disclose the need for assistance to deal with these emotions, all participants received a list of two local resources (i.e., counseling services).
- Relationship risks: It was likely the interview would resurface difficult emotions pertaining to how the participant’s social support network (e.g., family, friends) responded to their diagnosis of breast cancer.
- Physical risks: While most interviews were 45 – 90 minutes, all participants were made aware the interview could take up to two hours. To ease participant physical discomfort during the interview, the researcher inserted a

prescheduled break to ask the participant, “How are you doing?”, “Do you need a break?”, and “Is it ok to continue or do you prefer we reschedule another time to compete the interview?” All participants were made aware they could terminate (or end) the interview at any time. They also had the ability to refuse to answer any questions they considered invasive or stressful.

Lastly, because I am a member of the partner organization through work affiliations, the following statement was included on the consent form, “you might already know me as a member of the partner organization, but this study is separate from that role.”

Summary

This qualitative study explored the lived experiences of African American women with breast cancer and the use of social support and applied coping strategies during diagnosis and treatment while living in various rural communities of Northeastern North Carolina. DPA was the qualitative method guiding this study. The use of phenomenology examined the lived experiences individually wherein my goal was to reach transcendental subjectivity - removed previous understandings, past knowledge, and assumptions about the phenomenon of interest (Neubauer et al., (2019). This chapter described the study methodology, the role of the primary investigator, the participant selection, recruitment, and participation procedures; ethical considerations that ensured the study would protect the human subject’s personal identifying information appropriately, and lastly, how the data was collected, managed, and analyzed.

The study included seven women who experienced a diagnosis of breast cancer during 2009-2019 and lived in various rural communities in Northeastern North Carolina. The study explored the extent these women developed, possessed, or used various coping skills in managing the disease. All participants agreed to participate in the study by reading and signing the consent form and completing the demographic survey. Participants were provided with my direct contact information to ask questions if they had concerns or were unclear of the information provided. I conducted semistructured interviews that included open-ended questions to understand their interpretations surrounding social support and applied coping mechanisms. All data were transcribed and uploaded into NVivo to support data management and analysis. Lastly, I used bracketing extensively to ensure personal bias was not included in the research. Chapter 4 describes the analysis and study findings.

Chapter 4: Results

Introduction

The purpose of this study was to examine the lived experiences of African American women within Northeastern North Carolina who were diagnosed with breast cancer during the years 2009-2019. This chapter presents the findings from in-depth interviews with seven African American women diagnosed with breast cancer regarding their lived experiences and the development of coping strategies to manage the emotional, physical, financial, and social issues associated with the diagnosis and treatment. This chapter will display information on the participant setting, participant demographics, data collection and analysis process, evidence the study is trustworthy, and the themes produced through qualitative data analysis. The written and transcribed responses to the interviews became the data analyzed for this study.

Several studies have identified the significance of social support and applied coping strategies when challenged with a chronic and life changing illness (Black et al., 2018; Galvan et al., 2018; Imm et al., 2017; Johansson et al., 2016). However, many of these studies presented data from Caucasian and African American survivors living in urban areas (Caldwell et al, 2016; Hayes-Maslow et al., 2016). Limited information presented on the breast cancer experience of African American women with descriptions of their challenges and preferences for coping. Although some studies acknowledged prayer and family support as vital roles, some confessed the support from family and friends were not always helpful (Alicia et al, 2015; Best et al., 2015). However, little is known about African American women who were diagnosed with breast cancer and how they coped. Therefore, this study sought to describe their interpretations of social support, the applied coping strategies, and its role to their survival. Understanding and supporting their perceptions of effective and ineffective coping methods could allow for increased survival rates among the broader population.

The qualitative data were collected by in-depth phone interviews of seven African American women during the months of June and July 2020. As described in Chapter 3, potential participants were screened to comply to study criteria. To keep data collection and analysis credible, I constantly assessed the ability to remove all thoughts associated with my experiences, understanding, and knowledge of the phenomenon so I could allow the participants' descriptions to be their sole lived experience. Doing so was important so that the personal experience with my mother having breast cancer would not bias data collection, analysis, and interpretations. This study aimed to answer the overarching question below:

What are the lived experiences of rural, African American women diagnosed with breast cancer in the development of coping strategies to manage the emotional, physical, financial, and social issues associated with the diagnosis and treatment?

The following research questions are answered in this section:

- What is the experience of being an African American woman with breast cancer?
- How did you cope with the diagnosis and treatment of breast cancer?
- What ways did your family and friends provide support during the diagnosis and treatment?

- What role did spirituality play in your life as you coped with breast cancer?
- What would you like to see offered to other African Americans diagnosed with breast cancer?

Setting

The global COVID-19 pandemic limited face-to-face interviews; therefore, the way the researcher facilitated interviews were modified and explained on the IRB application. Once I received approval by Walden University's IRB to proceed with the study, I began recruiting in Northeastern North Carolina. Each woman who agreed to participate and met the eligibility criteria contacted me by phone and/or email to express interest. This time allowed me to answer additional questions, review next steps (e.g., review/sign the consent form and complete the demographic survey), and to remind them we would schedule the interview once they returned the signed consent form and completed demographic survey. In addition, each participant was reminded that the study was voluntary, they could withdraw at any time, and all participants who completed the interview would receive a $15 gift card by mail.

Demographics

All women lived in various rural communities in Northeastern North Carolina, self-identified as African American, and were diagnosed with breast cancer between 2009-2019. To protect the names and confidentiality of the participants, each was provided a code for and throughout the study.

F24 is a 61-year-old married woman with a bachelor's degree. She was diagnosed with Stage IV metastatic breast cancer in July of 2015 during a routine asymptomatic mammogram. She received the news of her diagnosis over the phone. She admitted to requesting a return call the next day because she was involved in her work responsibilities when they called. F24 loved her career. She loved being a hospice nurse and she never viewed this role as a job. She has always felt like God chose her for this role. For this reason, she believed it was her purpose in life. She admitted to receiving the mammogram 6 months later than the recommended period. Through her experiences as a hospice nurse and her husband being a head/neck cancer survivor, she was fully aware of the potential impacts' cancer can produce on an individual and family. At the time of the study, she was pleased to share that her recent scans did not show evidence of active disease and was considered stable. She is currently not working. She is a mother and grandmother who openly expressed that her circle of support changed dramatically after the diagnosis. In addition, at the time of her diagnosis she had just started a new job. Unfortunately, she lost her job and health insurance, but this did not break her will power. She knew she was in the fight for her life because around the same time of her diagnosis, her daughter was going through an exceedingly difficult pregnancy. She was determined to live long enough to see her grandson being born – and she did.

B56 is a 63-year-old married woman with a bachelor's degree and no family history of cancer. She has one son who she lovingly calls "a mama's boy." She is employed with a community college. She was diagnosed with an aggressive form of cancer. Her initial treatment only consisted of 80% removal of the breast tissue, which left her breast malformed. Due to a radiologist's keen eye, she received a second opinion that included additional treatment options. Her second opinion resulted to identifying additional cancer cells in the breast tissue. B56's treatment quickly changed to a mastectomy, chemotherapy treatments, and radiation. She believes that if she had not advocated for a second opinion, she would likely be dead. Her support circle expressed fear and concern because she displayed calmness throughout the process. She had to learn how to stop trying to take care of everyone and accept others helping to take care of her.

A10 is a 53-year-old widowed woman with a high school diploma who had a grandmother and husband to experience breast cancer. She has two adult children and grandchildren. She is employed in hotel management. She received the news of her diagnosis over the phone, on her birthday, and while spending time with a close girlfriend. The experience was semitraumatic for her because when she heard the word, "cancer" she immediately hung up the phone on the nurse. The nurse called back to make sure A10 was ok and to offer words of encouragement. A10 admitted she was late receiving the annual screening because she kept putting it off. She reported that her circle of support was incredible, as some relationships with family members improved. Her treatment consisted of a lumpectomy, radiation, and 3 years of oral chemotherapy medicine. A few years after her cancer experience her husband was diagnosed with Stage IV metastatic breast cancer. She expressed concern for those without support when dealing with a life changing diagnosis, such as breast cancer. She further confessed that her experience would have been drastically different if she had not had the community networks to identify necessary supportive resources.

W36 is a 62-year-old single woman with an associate degree and a two-time breast cancer survivor (total of 25 years). She is employed with county government administration. She has two adult daughters. She acknowledged the first diagnosis excluded her family and friends, but realized she was dealing with depression and a desire to not receive pity from others. She was also pregnant with her youngest daughter. She confessed not knowing how she coped with the first diagnosis. However, during her second diagnosis, W36 chose to include her family and friends. The experience revealed the actions from others allowed her to focus on coping with the surgery, chemotherapy, and radiation treatments. She confessed to requesting a third medical opinion from the insurance company to confirm the second diagnosis. The reason was that she felt embarrassed because the cancer was in the same breast, as the first diagnosis, and questioned if things would have been different had she elected to have a mastectomy when she was diagnosed in 1995. She credits her faith in God for providing her with the courage to share her story. She believes God saved her life so she can share her experiences with others and provide support to others with breast cancer (e.g., provide transportation; go to medical appointments, etc.).

K82 is a 65-year-old single woman with a master’s degree, no children (if you do not consider her two dogs), and a two-time breast cancer survivor (total of 26 years). K82 has traveled extensively while employed. She is currently enjoying retirement and living off a lake. Both cancers were slow growing and very isolated. Both treatments consisted of surgery. Her first surgery was a total mastectomy of the left breast and reconstructive surgery. The second surgery was a lumpectomy on the right breast. She did not realize a family history of breast cancer was being formed until after her second diagnosis. Her oldest maternal aunt, father’s oldest sister, and father’s oldest niece all were diagnosed with breast cancer. She is her father’s oldest daughter. She received her diagnosis over the phone. Although it was her second diagnosis, she admitted the experience was still devastating because of the loss of control. She credits the radiologist for recommending additional tests to perform a comparison. She realized this is the reason she was diagnosed with early-stage breast cancer. She also acknowledged that her support circle was better during her first diagnosis but realized it was likely because she was living near her family. However, with the second diagnosis, she did not have the same support because she lives in a different state than her family. In addition, she realized she should have assessed the community more in terms of community health resources (health care facilities), transportation services, etc., prior to moving. While these things are now concerning, she admitted to loving every day in her home off the lake because it makes her incredibly happy.

H61 is a 55-year-old single woman with a bachelor’s degree and no children. Her mother lives with her and she is employed with a community health center. She has some family members that have experienced cancer, but none has experienced breast cancer. She was diagnosed during a regular annual mammogram after it became apparent, she needed additional tests (ultrasound). She admitted to feeling some discomfort before the mammogram but attributed the sensation to carrying a heavy bag. She was diagnosed with triple negative breast cancer. The cancer was on the inner side of one breast and near her chest bones. Her treatment included surgery, chemotherapy, and radiation. She credits her faith in God to be healed, staying positive throughout the journey, and the support she received from her family and friends for her ability to not be defeated even when she did not feel well.

E43 is a 58-year-old single woman with an associate degree and no children. She is currently employed as a hospice nurse. She has no family history of cancer. She loves her job because it allows her to take care of her patients and provide some comfort to the family. She was very shocked when she received the diagnosis over the phone, although she acknowledged having experienced some challenges with her breasts and health in the past. She confessed it took her a while to be able to say the words, “I have breast cancer” without crying. She admits it was due to the fear of uncertainty. E43 expressed not being completely over the fear. Things have improved, but she still experiences anxiety. In addition, she expressed being angry for having frequent occurrences of being sick. E43 had recently moved from another state to take care of her father. However, when she was diagnosed, she was still grieving the recent death of her father. To add to the sorrow, her father was the one who provided her with support each time she became ill. However, she realized through this experience, she does not know how to allow others to take care of her. She does credit her nephew’s children, specifically, the oldest daughter, for being her “saving grace.” Even though she does not have children, she refers to her nephew’s children as her grandchildren. E43 expressed that she cried a lot throughout the journey because she did not have intimate support. Overall, the experience taught her a lot about herself.

Table 1

Participants' Demographic and Survivorship Characteristics

Variable	*n*	Percent (%)
Marital Status		
Single	4	57.1%
Married	2	28.5%
Separated	0	0
Divorced	0	0
Widowed	1	14.2%
No response	0	0
Education		
<High school	0	0
High school diploma	1	14.2%
Associate degree	2	28.5%
Bachelor's degree	3	42.8%
Master's degree	1	14.2%
Doctoral degree	0	0
No response	0	0
Annual Income		
<9,999	0	0
10,000-19,999	0	0
20,000-29,999	0	0
20,000-39,999	0	0
40,000-49,999	2	28.5%
50,000-59,999	1	14.2%
>60,000	2	28.5%
No response	2	28.5%
Employed		
Yes	5	71.4%
No	2	28.5%
No response		
Insurance Status		
Private insurance	6 [a]	85.7%
Medicare	1 [a]	14.2%
Medicaid	0	0
No insurance	0	0
No response	0	0
# of years as a survivor		
>1 year	0	0
1-5	3	42.8%
6-10	2	28.5%
11-15	0	0
>16 years	2	28.5%

Note. *N* = 7.

[a] One participant has private insurance and Medicare insurance.

Data Collection

The qualitative data were collected by seven in-depth semistructured phone interviews with African American women who were diagnosed with breast cancer during 2009-2019. All interviews were audio tape-recorded. All seven women completed the demographic surveys prior to the interview. Demographic data were analyzed by descriptive statistics (frequency, means, and percentages) in the format of a table (see Table 1). I transcribed all seven interviews and uploaded the data into NVivo for analysis.

Data Analysis

I used the qualitative software NVivo. I transcribed the audio files into a word document. Prior to reading the transcriptions, I used the process of bracketing. Bracketing required me to suspend all assumptions, beliefs, attitudes, and past knowledge about the phenomenon of interest, so it does not influence the object of the study. Once I reached a clear mind, I began to read each transcription individually a minimum of five times to develop understanding of the phenomenon from each participant.

Next, I coded each transcript individually based on the participant's responses to the interview questions. I used inductive coding approach. Inductive coding refers to a data analysis process whereby the researcher reads and interprets raw textual data to develop concepts, themes or a process model through interpretations based on data for familiarity, coding, and identification of common themes (Strauss & Corbin, 1990). Phenomenological research uses the analysis of significant statements, the generation of meaning units, and the development of what Moustakas (1994) calls an essence of description. Creswell (2009) identified a seven-step process:

1. Organize and prepare the raw data for analysis, where the researcher transcribes the audio tape recordings into similar formats.
2. The researcher reads the transcripts to obtain a general sense of the information and to reflect on its overall meaning.
3. Cluster together similar topics into chunks or segments.
4. Create descriptive categories next to the topics.
5. Organize the topics to see if new descriptive categories emerged.
6. Modify codes with the same meaning or recode texts, as needed.
7. Develop the categories (themes) and within each category identify subcategories. The researcher used a combination of predetermined and emerging codes.

The initial coding categories were predetermined based on the five research questions. The categories had multiple iterations due to participant responses. When a new code was identified or removed, this researcher went back to each transcript to re-read the data and made necessary changes. I organized the categories and subcategories under each of the five research questions. This allowed me to differentiate between each participant's responses about how they viewed social support and applied coping strategies to manage their diagnosis and treatment.

I identified overarching descriptive themes and illustrative quotes. Data was categorized based on information described by the participants. These expressions represent the emotions and actions concerning how the participant experienced the phenomenon. The connections from all women are clustered to provide a shared experience of the phenomenon.

Evidence of Trustworthiness

To keep the data collection and analysis credible, I constantly evaluated my ability to remove all thoughts associated with my experiences, understanding, and knowledge of the phenomenon so I could allow the participants' descriptions be the facts of the lived experience. Using direct quotes from participant's transcripts regarding the lived experiences captured through the interviews was one method of member checking for limiting bias. The emerging themes provided a more descriptive understanding of the participant's perceptions of their conscious experiences and behaviors toward the meaning of social support and applied coping practices and the social implications.

Results

Content analysis revealed commonalities with all seven interviews even though these women lived in various locations throughout Northeastern North Carolina and had different life experiences and socioeconomic backgrounds. The recurring subjects included but were not limited to cancer, family/friends, women, depression, and care. In Table 2, a summary listing the themes that emerged from the data analysis is provided for each participant. The themes were examined for personification and language that resonated with interpersonal interdependence. The themes listed in table 2 emerged from the data analysis for each participant. Following the table is a description of each theme. All quotations within this section have been taken directly from the transcripts of the participant's interviews.

Table 2

Emergent Themes

Themes	Participants
Theme 1: A difficult reality	F24, B56, A10, W36, K82, H61, E43
Theme 2: The meaning of social support	F24, B56, A10, W36, K82, H61, E43
Theme 3: Rural health narrative	F24, B56, A10, W36, K82, H61, E43
Theme 4: Learning how to cope in the face of uncertainty	F24, B56, A10, W36, K82, H61, E43
Theme 5: A desire to serve and future aspirations	F24, B56, A10, W36, K82, H61, E43

Theme 1: A Difficult Reality

The diagnosis of a chronic and life-changing illness can create a multitude of emotions and alter the life of the individual and their circle of support. The women in this study reflected on their initial diagnosis of breast cancer. Most described this experience as “shocking” or “traumatic”. However, two of the participants indicated they did not have a meltdown from the diagnosis and that stimulated concern from family and friends.

F24 described the diagnosis as “shocking, unexpected, it derailed my whole life.” She was surprised by the news because she did not have any symptoms and it was during a normal mammogram. Although, the mammogram was six-months later than intended. F24 received the news by phone and expressed it was “at an inopportune moment in my life and time of my day, so I asked for a call back the next day.” She did share the news with her children and husband. “Initially, it was like I had breast cancer that is all I know.

We will deal with it and go on." She recognized the initial diagnosis was difficult for everybody, but her. While the news was much unexpected, she said, "I didn't break down and cry, scream, and holler, why God, why me?" F24 was diagnosed with Stage IV metastatic breast cancer. She admitted she might not have done this when she was first diagnosed, but she did have this type of breakdown when "I could not work two years ago…that was a time I was emotionally spent." She expressed her circle of support "makes fun of me because cancer kind of interrupted my life, so I had to get my work schedule done then I could do my treatment stuff so it wouldn't interrupt my life. You have to know me to understand." She continued with,

> I love having fun don't get me wrong, but I love my job. My job that I had wasn't a job it was a calling. God chose me to be a hospice nurse…to be invited into someone's house to take care of somebody that is dying; at a tough time…when you go into their home, it's all about them. It wasn't about me. I worked; I worked and worked until two years ago…I couldn't work anymore.

B56 indicated the news was "surprising being that there is no family history of breast cancer or had not been at that time." She is a wife and mother to one son. She recalled "discussing the home situation to my son was probably the most difficult part…he is an only child…a mama's boy." Initially, B56's treatment plan consisted of breast surgery to remove "80% of breast tissue and…around 3-5 lymph nodes" followed by radiation treatments. However, when she went to see the Radiologist, they asked, "Who butchered you like this? Why didn't they just do a mastectomy? I'm not sure how to proceed with this." She felt differently than the Radiologist, "because I'm alive. My breast had cancer in it, and it was removed." The Radiologist conveyed to B56, "let's get together and make a plan and let me go back to the surgeon and we are going to talk about this." B56 admitted that she is "not keen on progressing without…let me get a second opinion." Therefore, she asked her provider,

> To give me a recommendation for a second opinion. They said, "Well that's going to take forever." Her response, "Well, let's just see. And within three days they had me an appointment…They did an evaluation…reexamined the biopsy and found cancer cells in my lymph nodes because some…were merged together…They immediately put me on chemo…I was like…I ain't doing no chemo."

The apparent focus to remove the breast tissue, the lack of information on surgical options provided by the initial treating physician, and the immediate tone to begin a different treatment approach are factors that contributed to her inability to process and cope with the circumstances at that moment.

A10 indicated her initial diagnosis experience was "semi-traumatic." In addition, "it would have been pretty traumatic if I didn't have someone here with me at the time." She received the news over the phone; it was her birthday and her first mammogram. A10 admits, "I was late getting it done…I keep putting it off because something always keeps coming up…I would not have gotten it then." A10 expressed appreciation for her primary care physician because, "she said, you have to have your mammogram…she made my appointment for me…I went." When A10 received the news of her diagnosis, she softly stated, “I burst out on the phone crying and hung up the phone. The nurse called back to make sure I was ok…I was hysterical.”

W36 indicated her initial reaction to the diagnosis was, “oh no, this can’t be cancer…its fatty tissue so go ahead and take a closer look.” W36 is a two-time breast cancer survivor (total of 25 years). She asked for a third opinion. She said,

> The second opinion agreed with the first opinion, and I wasn’t satisfied with that…so I called my insurance company and asked them would they please, please consider letting me have a third opinion even if I had to pay for it.

W36 received the third opinion and acknowledged the diagnosis by saying, “if I got it, ok, what are my options so I can get this fixed and move on with my life.” She acknowledged, “because it was the second time, it was almost like I was a little embarrassed…I got it again…like one big disease just walking around here.”

K82 is a two-time breast cancer survivor (total of 26 years) and admitted the experience for both diagnoses were not different. She recalled, “I think it was basically devastating.” K82 was thirty-nine years old the first time. She credits the second diagnosis to

> The tenacity of the Radiologist…looking back at my scans since I was a breast cancer survivor.” They were meticulous in looking at everything and they noticed there was a difference between my last scan and the scan last year. So, if it had not been for that Radiologist being tenacious, God knows.

Although she is a two-time breast cancer survivor, she admitted, “It’s devastating when you hear the word.” She confessed she asked the staff to call her with the results since this was not her first experience and she did not want to return to the office. She softly recalled the experience, “it still took my breathe away, you feel like you can’t breathe.”

H61 indicated her initial diagnosis did not create the ‘initial cry’ that most experience. She said, “I was always the positive minded person.” Although she admits to not having the initial cry, she “did cry” later. She said,

> The shock of hearing that you did have cancer. Everyone that I know has that cry, but after that…there was nothing for me to be even sad about because I knew I was going to be healed. I had that faith that I would be healed.

H61 is single and enjoys time she spends with her mother, who lives with her. She expressed having a close bond with her family and friends. She did admit when she shared the news with her inner circle, “they were shocked” and would tell her, “I’m going to let you go and get your cry out.” She gently laughed and said, I told them, “I’m going to be ok.” She credits the support of her family and friends and her faith for getting her through a difficult time.

E43 indicated the initial diagnosis was “unfreaking believable” because she did not have a family history. She is a single and employed as a hospice nurse and described the diagnosis was during a routine mammogram. She confessed, “I was having some trouble with my left breast, but it turned out that I had the cancer in my right breast.” E43 received the news of her diagnosis over the phone. She is from a large family. She is the youngest of ten. When asked how she shared the news with her family, she acknowledged, “It took me awhile before I could even say the words.” When asked the reason for this, she stated, “Fear…I don’t know if I’ve gotten over it. I really don’t. It is a little easier to say…because I can say it now without crying." She realizes her job allows her to focus on someone else's story, but "this time the story was about me." E43 has dealt with past health issues that has made her feel like, "I'm always sick…I don't like to put that out there to the universe, but I'm kind of sickly." She concluded, "I'm still very angry about it."

Theme 2: The Meaning of Social Support

When asked, "How would you describe the response of your family and friends after your diagnosis?" The women had similar responses; however, one of them made it quite clear they were forced to remove some individuals out of their lives due to conveying negativity. Others experienced a conspicuous absence from select family members. We all have different meanings of social support and the role of social support. The women in the study described their meaning and experience of social support as follows.

F24 spoke candidly about her experience with her circle of friends who were and were not in the medical field. She started the conversation by admitting, "My circle changed quite a bit." She realized it was because "I didn't want nobody to be negative around me and I didn't want anybody to say, "Oh, I'm sorry for you" or pity me." For these reasons, early on in her diagnosis F24 made the decision that "If you were going to be negative or have bad things to say then I was going to have to axe you out of my life"…and she did! She said these were her close friends she had known for a long time. She shared an example,

> I had a good friend that brought up a conversation that we had about taking care of a patient that was really sick…we both agreed at that time that we would never do chemotherapy, ever.

F24 remembers the day vividly. She continued, “So, I was diagnosed, and I had to make that decision and choose to take chemo, but my friend kept reminding me you said, “You would never do it.” Her response to this friend was,

> If God had sent me an email, a text message, called me…six months prior to my diagnosis and I could have looked up alternative treatments, but he didn’t. I was in the fight for my life at that time.” When asked, “How would you describe the role of social support?

F24 stated, “I’ve been told to go outside of my comfort zone to do things, try new things.” Because of this, F24 realized the experience “has opened many doors, I mean many doors…my social network has expanded greatly. It has opened up doors with things I would have never thought for me.” For these reasons, she mentioned, “My private support group is even more active.” She concluded, “What they are working on may not help me, but maybe it will help the woman or man after me, and that’s important.”

B56 indicated “they were a little bit fearful…just at the name of cancer…they were very supportive.” However, B56 acknowledged, “They thought that because I didn’t have a meltdown reaction to it…I was taking it a little bit lightly. So, they were a little concerned with me of being too calm.” When she was receiving treatment, B56 remembers, “They would always say to me, “You have been getting chemo, you don’t look like a cancer patient.” B56 continued, “Just to see my spirit to fight and…not be frail and to not present to them that they would think is a frail, sick person…I think that kind of helped them remove that view of a “death sentence”, it gave them hope.” Through the conversation, B56 specified, “I’m glad that it wasn’t a situation where I had to be like ok, I’ll cut you out of my network.”

A10 experienced positivity from family and friends throughout her journey with breast cancer. She realized this is important because “some of them don’t know what to say and they told me after the fact, but just being there…is all I need.” A10 reflected on others that may not have support with a sympathetic tone, “I look at what if people didn’t have somebody to take care of them…what did they do, they are going through this alone…you just got to have help.” A10 shared she experienced several breakdowns during her diagnosis and when she was caring for her husband after his diagnosis. She said, “I’m like…what’s going to happen. At the time, I didn’t know what was going to happen.”

W36 decided that during her first diagnosis of breast cancer she would take the journey alone because “I didn’t want pity or people feeling sorry for me. I just wanted to do what I needed to do...get on with my life the best way I could.” The second diagnosis was different, as W36 allowed family and friends to be on the journey with her. She realized it was helpful when individuals “would step up to the plate and really just handled things.” She said this helped with making sure she had her medications, a ride to medical appointments, and support after surgeries. W36 realized the first time around, ‘I probably didn’t make the best decision” as it relates to taking the journey alone because the second time “my aunt and boyfriend…made sure I stayed motivated…and friends made sure I would stay active.” She continued, “I never really involved other people…I think I was dealing with some sort of depression which I never got help for it.”

K82 expressed different types of support was provided for each of her diagnoses. She recommends someone be with you at medical appointments because “once a doctor started talking, I went someplace else. My brain went someplace else. I wouldn’t hear ten percent of what he said. So, you really need somebody to go with you.” Since K82 is a two-time breast cancer survivor, she acknowledged her support was quite different both times. For instance, the first experience her family provided a great deal of support. However, the second time she confessed, “I was totally alone because all of my sisters still live in another state…nobody came here, nobody came, and nobody offered, which I thought was interesting.” K82 continued, “To come help me…go to the surgery. Matter of fact that was probably the worst experience.” While K82 acknowledges she did not have the same support from her family during the second diagnosis, she does indicate, “I have some wonderful neighbors…unfortunately, they don’t look like me…I would not want to involve them, although, you know if it really got bad, I know I could call them. But I just don’t want to be…the subject of conversation.”

H61 experienced a supportive network. She stated, “They never let me be down, never thought negative, they kept me positive.” H61 did remember a time when she was most vulnerable while receiving treatments. She shared, “I had zero energy, couldn’t even feed myself. My mom had to feed me.” H61 further shared,

> I will encourage others to have support. It's not easy going through it alone because some people going through it alone may be depressed and that may worsen the situation. It's always good to have a good support system.

E43 indicated her circle of support (family and friends) expressed shock when she was diagnosed. Although, they were surprised of the diagnosis, E43 articulated, "Everybody wanted to know what they could do. I don't know if I handled it well to be honest." When asked why she thinks she did not, E43 admitted she loves taking care of others, but it's hard to allow people to take care of her. E43 openly shared, "…a lot of it was me not letting people in. And it was my fault." While E43 did not receive direct negative feedback from her support, she did note, "Everybody just think I can take anything and I'm ok. They sometimes don't realize I am human."

Theme 3: Rural Health Narrative

The study investigated the characteristics of the seven women and the environment in which she lived to determine if both could positively affect survivorship. Each woman expressed different involvements pertaining to the 'rural' aspects of the community. Some women were adamant about receiving medical care outside of the community they live while others acknowledged the ability to identify necessary care to meet their health care needs.

F24 indicated with passion some concerns she has experienced in her rural community. She said,

> You don't really know who or what in this area because everyone is so closed mouth and I think a lot has to do with the community itself. Because our history

> in African American history when it comes to health you don’t take those problems outside the home…It’s a family thing and you deal with it internally, per se.

F24 admits her treatment was not within the community she lives. However, she is passionate about sharing information through various outlets (groups) regarding resources to assist people with breast cancer. She further stated, “That’s when I found out you have to literally, in my community, you literally have to drop the funds, without the leg work into the lap of the person.” F24 was a hospice nurse and at the time of her diagnosis, she lost her new job and insurance. During this period, she expressed frustration because, “in having resources, there are none…if you are dirt poor and have nothing to your name you can get help. If you were trying to struggle to get out of a hole, your own your own.” When F24 reached out to the department of social services, she was told, “I can’t help you, but if you lived in a tent under the bridge there would be a lot of resources for you.” This response stimulated motivation in F24 to figure things out by reminding herself, “I’m going to keep my home, I’m going to keep my car and my husband is going to keep his and we are going to eat in my house…we will do what we have to do.”

When asked, “Did living in a rural community have an impact on your ability to manage your diagnosis and treatment?” B56 expressed, “I did. I honestly did. Not to discredit any of the health care providers.” Initially, B56 was advised to remove 80% of the breast tissue and three-five lymph nodes impacted by cancer. Following the surgery, she had planned to receive radiation treatments. However, her journey quickly changed when she met with another provider who recommended additional tests prior to moving forward with the initial doctor's treatment plans. B54 stated, "They reexamined the biopsy and found other cancer cells in my lymph nodes..." Her treatment plan changed. Because B54 dealt with an aggressive form of cancer, she said,

> They immediately put me on chemo…I had sixteen sessions of chemo…then I had a mastectomy. So, I guess this is where it comes to being in the rural, not saying that the providers were not capable, but there was just not the educational piece…it was kind of this is what we are going to do kind of thing.

B54 also expressed this in terms of African Americans in rural settings, "I don't think we will get a second opinion on average. Because we trust the healthcare providers because this is what we have access to." Before concluding this part of the conversation, B54 warmly stated, "If I had not gotten a second opinion…I would have come out of remission probably within six months…it would have run a really fast course."

A10 realized her situation would have been different had she not been connected to individuals and organizations within the community. She said, "When I found out, my connections…came to mind. I immediately called them to ask for information and suggestions. They were very helpful. It was the best thing because I love my Oncologist." A10's Oncologist was not within her community. She chose to drive one hour to see her Oncologist. Because A10 had health insurance, transportation, and was able to receive care outside her community, she did not experience any rural health challenges.

W36 indicated her first experience with breast cancer helped her identify necessary medical providers. She said,

> I went back to the same doctor because he did such a fantastic job the first time around…I got to a point where I really didn't care for him so I asked the surgeon if he could put me in touch with another Oncologist, which they did. I got blessed because…rather than drive a two-hour drive…it was a forty-minute drive.

W36 expressed concern, "I'm dealing with a lady now that I've been talking too…who got a biopsy done three months ago…and will receive her results soon." She said, "I ask her every year, "Did you go for your mammogram?" W36 continued by saying, "she hasn't been going. She could not remember the last time she had a mammogram. I was like so disappointed with her." W36 indicated she was transporting this woman to her medical appointments. During the conversation, she provided the following information, "she has been refusing service when going to medical appointments." W36 concluded with

> I keep telling her you need to find out now because the chances of the stage changes play a role. She was just hoping it would go away…I told her it maybe and it may not be related to breast cancer, but she has to get it checked out. I think her actions are out of fear.

K82 acknowledged, "My socioeconomic status is not…equivalent to the majority of black women who you may find here or live here. I was fortunate enough to be able to drive to get the best treatment I can find." She admitted,

> I should have been looking at things in this community regarding infrastructure and medical care because I don't think it's the best, neither one…I started thinking maybe I should not have come to this community. I love every day in

> this house. Some days I sit here all day and look out at the water. I'm enamored by the lake…it makes me happy.

She continued by reflecting on an experience that was challenging because of where she lives. She said, "I did reach out to someone to see if there was some type of transportation…I was told there was none. That's why people may go as far as fifteen-thirty minutes to see a provider, but not over an hour where you really have a good selection of doctors."

H61 indicated, "I didn't find it difficult" to identify necessary medical care and treatment in my community "because my team…that I was assigned to…explained it to me very well." She continued, "He talked me through it the whole entire time. Plus, I had read up on the type that I had…I did research on my own." H61 did not experience any challenges concerning rural health challenges by not having adequate health professionals to serve the needs of the community.

E43 indicated, "It was hard in the beginning because I wanted to know who was the best doctor." So, she talked to different doctors. She continued,

> So, my primary during the time was the one who actually found it. You know I was complaining about my left breast and she did an exam, and she was like, "No, I kind of feel something in your right and she was a breast cancer survivor.

When asked how she was able to identify an Oncologist, E43 said,

> I did my own research, and I was pleased with what I had found. One doctor who's now retired was African American, she did not have breast cancer, but she cared about her breast cancer patients. She talked to me about my lifestyle, my

> eating habits, about my skin care…She promised me she would find a doctor who was almost as good as her…I have my first appointment with them next week…she handpicked the new doctor.

E43 acknowledged, “I was kind of leery because I could not find a good Oncologist” in her area but relied on her professional network. She reached out to her network and asked, “Hey, who would you recommend?” Where many people in my community are not doing that, and they are not questioning the doctor, which is so unfortunate. I try to teach people to be an advocate for themselves and they don’t and it’s very disappointing. They don’t know how to be an advocate for themselves, unfortunately.”

Theme 4: Learning How to Cope in The Face of Uncertainty

There is evidence that coping mechanisms can produce positive and negative influences. However, the key is identifying what works best for you when dealing with a life-altering chronic illness. These women shared how they coped with breast cancer while living in a “resource stricken” community.

F24 affectionately expressed her grandson, who she refers to as “Mimi’s boy” helped her to cope through her diagnosis and treatment. She added,

> My family, friends, and being able to work. I’m thankful that I was diagnosed in 2015 and stopped working in 2018. I had three years to do what I love doing and still live a “healthy, normal” life.

F24 continued by reflecting on an experience,

> I’ve had to learn to share the true side and the true emotions and the true feelings. I’m slowly getting to the point where I can show that to people and they

> understand. At first, I was afraid, and I thought if I was afraid to show all those true emotions and everything, people would shy away from me. I think the people that love me the most and care about me the most know that I have a hard time. I try to remain positive. A really tough time feeling isolated due to COVID-19.

Research indicates that often women will not express true emotions to their love ones to protect them. F24 confirmed this with her next remarks.

> I have to watch it because my husband feeds off my emotions. If he sees me up, going, and bubbly and everything, life is grand. We are moving right along. The moment he starts to see me down or feel sad…he begins to think something is wrong. I have to watch that. Or as all of my doctors say, "She fakes it to make it." Sometimes I do. If I say it enough, maybe, I'll believe it.

B56 said, "Reading was the most important thing for me because I didn't have anybody in my family…information out there on the type of breast cancer I had. You know I knew none of those terminologies, so it helped me to learn more…so that when I did talk to the doctors…it would be familiar. And to also be able to communicate that to others." B56 also shared other ways she coped. She said,

> Walking a lot, praying, and meditating. Holding on true to my faith and the word of God. I stayed connected to my friends; I continued to work until my immune system began to break down. I stayed in constant communication with other people.

She shared, "I didn't have a lot of discouragement or low moments during the treatment or during the cancer, but the healing process, afterwards was more of a continuous fight."

She concluded, “I developed lymphedema…so I wear a compression sleeve…I have to wear it all the time. And sometimes…even six years after, people don’t know what it is. It’s like a stigma…even with being cancer-free. The scars and the thoughts of what if it comes back. There’s still always that thought. If you don’t hold onto your faith and being that a lot of people in the rural area are very private and very modest…they may suffer alone.”

A10 said, “Staying busy…with work…helped. It kept my mind off of it. She also expressed the ability to openly communicate with her family about her diagnosis and treatment options helped her to cope. She reflected on an experience when she was considering a mastectomy. She said, “Me and my husband we talked about it. I asked him, “What would you think of me? What about the physical attraction?” He said, “He would love me regardless.” A10 said, “even though he said that it still played in my mind.” She said her reason for the consideration was, “I’m afraid it may come back.” She also shared, “I didn’t tell my family until we were all in the consultation together. A10 said the following things helped her to cope during this period. She said, “I talked to people. I talked to my family. It helped because…it was a strain knowing that I had breast cancer. I had a nurse navigator. That helped.”

W36 acknowledged the differences between her two experiences with breast cancer. As mentioned, she chose not to include her family or friends with her first journey. However, the second time she realized her support network allowed her to better cope by only focusing on her health since her day-to-day activities were being handled. She also mentioned her provider relationships helped her to cope. She said, “The medical staff was just awesome. They treated me like they would have treated their mother…they were so compassionate…they cared, and they listened.” She concluded with,

> I didn’t attend any support groups or anything. I kind of used my aunt and boyfriend for support and they made sure I stayed motivated. My friends made sure I would stay active and kept my mind active…and I was doing things to enjoy myself.

K82 acknowledged the first and second experiences were quite different regarding coping processes because the second time she had to rely more on herself for support. She did share activities that were effective. She said, “Exercise, walking, just getting out and trying to do more.” She further noted “being still, being depressed, and fighting the depression…just feeling like I wasn’t in control.” During this time, she realized she still have things to do, but she said, “My get up, and go just got up and went. I eventually just said, ok you got to kind of get back into a routine, life is going on. So, I just started trying to get out more and do more things. She concluded with,

> I would say, probably one of the best things I think is to talk about it, but it is very dangerous to try to discuss it with people because some people don’t want to face that reality for joining you in your reality. I think you have to really, really understand that. It’s a different journey for people. The patient needs to get used to the idea, used to being able to cope with it without worrying about what someone else is talking about or what someone else is thinking or worrying about someone else’s motives.

H61 indicated there was not anything specific that helped her to cope. She said, "It was just my family. Being around me. I was always positive. There was nothing for me to be even sad about because I knew I was going to be healed. I had the faith that I would be healed." She further expressed one of the challenges was, I had zero energy…I couldn't even feed myself. It was difficult to even get out of bed. My mom had to feed me." H61 concluded, "After I went through it…it seems more people were diagnosed with breast cancer and I helped them cope with my experiences…this is rewarding to me."

E43 expressed the ways of coping with the diagnosis and treatment as, "I cried a lot…I prayed, I talked to my mom and dad." She continued with dear emotions by stating,

> I have a nephew that thinks I'm his mother and he has a tendency to follow me…no matter where I live. Him and his wife had a baby three months before my dad passed. And she has been my saving grace. She's like my grandbaby. She took me through my breast cancer. I don't know where I would be if she wasn't present in my life at that time. She has just taken over my life. She saved me during that period.

E43 also acknowledges her family came through for her as well. She said, "They took shifts during my radiation…after my surgery, two of them came down then a few days later then another one came down…that did help." E43 concluded by sharing a funny experience with one of her sisters she recently remembered, "She was following me around the house. I could not even go into the bathroom. I was like, "Where are you going?" She was like, "I'm just going to sit right here to make sure you're ok." Though our conversation, you could tell E43 was beaming as she was sharing the story. She said, "I would think about stuff like that and it would make me laugh."

Theme #5: A Desire to Serve and Future Aspirations

Resilience comes in many forms. Data expressed African American women have the highest mortality rate for breast cancer compared to other racial/ethnic groups. While the seven women have similar processes for coping, they all expressed a desire to serve in their communities by sharing messages of hope to others impacted with breast cancer.

F24 reiterated the impact of this experience, "I'm a very big advocate now for metastatic breast cancer, especially African American women in rural areas. I just do what I can in the community so someone else will have a better experience going through this." One of her main concerns and desires was for every woman to be assigned a nurse navigator. She said,

> I never had a clinical navigator or nurse navigator. I didn't realize that was an option…I was told the reason I didn't get a nurse navigator was because I'm a nurse. It was very unjust. It was horrible. So now I make sure that when I talk to people, I ask, "Do you have a clinical navigator?" If you don't, I will be yours. I will help you. And I have done that. I have gone to doctor appointments with women and I've asked those questions they didn't know to ask.

She continued by saying, "I am an open book. There is nothing that is off limits. Because I feel like if I tell you everything, one little sentence or word will help somebody to do better or get help.” F24 said her advice to other women that are impacted by breast cancer is simply, “You are not alone. All you have to do is ask.”

B56 said the community connections are important. She said, “Once I connected with the breast cancer…support groups and all, I learned that there were others in the community who had breast cancer.” She learned all women do not share experiences the same. She said, “Some will only share negative views of cancer…but it just showed me that you’ve got to respect individual’s privacy, especially if they choose to or not to discuss it.” She found, “The way to really talk about it was to talk about myself and the positive experience, but most of all talk about the resources that are available.” B56 advice to others is simply, “Explore your options…communicate with your provider, your thoughts, your fears, and your concerns.”

A10 candidly expressed her concern for individuals without support. Because she recognizes the challenges, she said, “I would…support them. I would let them know if there was anything, I could do for you to let me know.” A10 reiterated she would not like for anyone to have to deal with breast cancer alone. She said her advice to others is, “go to your appointments, listen to your doctor and continue to get your mammogram every year.” For persons needing emotional assistance, she expressed, “be sure to talk to someone…if you are feeling any type of way…there is just too many resources out there where you can talk to people. It doesn’t even have to be face-to-face. Because talking does help. It’s a big relief.”

W36 said, “You know we get through it and then you know, the end result is absolutely amazing because people would never know, what you’ve been through if you don't tell them." She reiterated this being the main reason she participates in different community education programs. She expressed,

> I can share my story and talk to people and let them know that no disease has to be a death sentence. And you have to be an advocate for yourself. You've got to want to live and just do the best you can do for you.

W36's advice to other women impacted by breast cancer is, "Stay positive, that's the biggest part of your healing. Don't hesitate to ask questions. Advocate for yourself. Don't assume anything. Follow doctor's orders." She concluded by saying,

> The outreach that I do for breast cancer awareness is very rewarding because if I don't do anything but touch one person's life…then I've accomplished my goal and mission. I try to be a resource to people to let them know if they need assistance with where to go for what and if I need to travel with them or if I need to get to transportation or anything for them, I'm that person they can reach out to…It makes me feel good to help. I'm committed to this.

K82 said one of her favorite points in life is, "Reason, season, and lifetime." This is how she views various experiences in her life and relationships. She expressed one rewarding aspect for the two-time experience is simply, "Learning how to live in the present and making the most out of every day, as you possible can." She continued by sharing her advice to others impacted by breast cancer is, "It is not a death sentence…block out anything that's not causing you peace…and to have one thing you can do every day that brings you a smile." K82 will continue to participate in programs in her community focused on breast cancer awareness. She hopes others will remember, "It takes the patient awhile to get use to their new reality" before they feel comfortable sharing the diagnosis with others.

H61 expressed the most rewarding aspect of the whole process was, "I got through it. I survived it and I can help…someone else get through it." H61 participates in several breast cancer awareness events throughout her community. When asked what advice she would give to others, she said with emotion, "It's a life experience…get that cry out because it's a shock. But after that…you stay positive. I can't say that everyone is strong, but it's good to have someone around you that is strong…to be there when you have those low moments."

E43 indicated the most rewarding aspect of the journey was, "It just opened up a whole world of people that are good people. That I like talking to. It's like a sisterhood." She said her advice to others is, "To breathe…and to journal." E43 shared an emotional experience when she was contemplating sharing her raw emotions with others. She said,

> I remember telling myself a few times, you know this opens you up to help somebody else…I went back and forth on whether to post something. I never did. I said by not saying anything it could be somebody out there that needs to hear it. And know my heart and know they can count on me.

She continued by sharing one of the hardest things to grapple with is, "To be ok knowing that everybody is not going to be ok…I'm a people pleaser." E43 indicated she was in the middle of reading a book entitled, Calm My Anxious Heart. She said, "It teaches you how to be kind of content in the way things are. It doesn't ask you to give up your hopes and dreams, but to find peace where you are."

Summary

The purpose of this study was to examine the lived experiences of African American women in Northeastern North Carolina who were diagnosed with breast cancer. Chapter 4 described an overview of the procedures used to collect, manage, and analyze data collected from seven participants and the use of social support and activities for coping with the diagnosis and treatment of breast cancer. Participants were selected based on purposeful convenience and criterion sampling techniques, all participants were informed of their rights, and signed informed consent forms prior to beginning the interview process.

Responses from in-depth interviews examined how African American women managed their health using social support and coping strategies to effectively handle the diagnosis and treatment. All participants expressed understanding for the need of support and the importance and meaning for finding ways to cope. Some participants felt prayer and the connection to higher power was required to survive their diagnosis. All women shared after the initial shock of the diagnosis, they had to identify ways that would ensure survival or ways to be able to move on with their life, irrespective of the outcome. All women expressed a desire to help other African American women impacted by breast cancer. The women of this study identified the use of social support and meaning of social support almost immediately after the diagnosis of their breast cancer; although, two experienced a lack of support.

The last section in this chapter identified evidence of quality. One way to ensure quality was a process for credibility. To ensure credibility, I used data triangulation.

Another way to ensure quality was confirmability. I used rich accounts from the study participants. Lastly, to ensure quality was dependability. I used audio-recordings to capture verbatim what each study participant said during the interview. Chapter 5 will offer an interpretation of the study findings, limitations of the study, recommendations, social change implications, and concluding remarks.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to examine the lived experiences of African American women in Northeastern North Carolina who were diagnosed with breast cancer and the role of social support and their ability to cope with the emotional, physical, financial, and social issues. Chapter 5 provides a thorough discussion of the results of the study, its limitations, recommendations for future research, and social change implications. Five themes emerged from the data: (a) a difficult reality-initial diagnosis, (b) the meaning of social support—pros and cons, (c) rural health narrative—does it exist, (d) learning how to cope in the face of uncertainty, and (e) a desire to serve and future aspirations. These themes were closely examined based on current research and the participants' experience.

African American women have higher mortality rates for breast cancer compared to other ethnic groups. According to the ACS (2019), the United States estimated 202,260 new cases of breast cancer. In addition, the ACS expected 73,030 deaths among African Americans in 2019. North Carolina was projected to experience 10,946 new cases of breast cancer and 1,467 expected deaths in 2019 (NCCCR, 2019). African Americans in rural areas have higher mortality rates in different cancers compared with Caucasian rural dwellers (Tang et al., 2015). Rural populations, specifically rural minorities, experienced greater disparities in health and health care access.

For the past several years, emphasis has been on breast cancer awareness, including education and promotion of mammograms (ACS, 2019; CDC, 2019; Molina et al., 2014). However, little research was available that explored facilitators and barriers of coping mechanisms that is, aspects of the health system, social environment, or physical environment that supported African American breast cancer survivors in obtaining necessary health care (Ustjanauskas et al., 2017). Women in rural areas with limited medical providers face numerous challenges due to limited access to quality health care. Rural Americans are likely to have low income, be uninsured or underinsured, have less education, be older and sicker; and be less likely to receive preventive and necessary medical care (CDC, 2020; USDA, 2019). Reasons for this include distrust among the African American community and the healthcare system (Molina et al., 2014) and lack of engagement in treatment and continuity of care (Ferrera et al., 2016).

In this study, I identified the effects and meaning of social support and the applied coping practices that became sources of comfort and fostered healing. Research suggested that psychological distress and physical symptoms were the most described adverse changes experienced by women with breast cancer (V. P. Henderson et al., 2012). The way breast cancer patients coped shows an impact on the physical and emotional well-being, and long-term quality of life adjustment (Torres et al., 2016).

Interpretation of the Findings

The study results confirmed and supported the suggestions that social support and applied coping practices was meaningful in helping the participants cope with their breast cancer diagnosis and treatment. Although not all participants felt positive about the future, finding meaning and ways to be happy with life did help in dealing with the psychological distress. Due to this life-altering event, identifying how they coped and pursued and received support allows them to understand the importance to having meaningful lives (Sadati et al., 2014). This was almost exactly, what most of the participants in this study felt they experienced. Because most felt supported by family and friends immediately following the initial diagnosis, they were able to recognize the importance of social support. All women identified ways to cope that fostered healing.

Researchers declared that social support was associated with fewer depressive symptoms and decreased levels of emotional anguish (Levine et al., 2015). Research provided multiple types of support: emotional, instrumental, and informational support (Haynes-Maslow et al., 2016; Lazarus, 1966; Lazarus & Folkman, 1984). Most of the women in this study stated how they benefited from meaningful relationships, support, identified, and applied coping activities that helped decrease psychological distress. Building upon previous work, this study unveiled the stress and coping processes and utilities as described by African American women. Lazarus and Folkman (1984) theorized that, when individuals recognized the stress outweighed the resources, they will be engaged in coping strategies. Based on the information available, it is logical to say some of the findings are in alignment with other studies and outcomes. The way that this study extended knowledge was that it acquired data that could be added to the literature about the role of social support and the applied coping mechanisms that were found to be helpful in managing the diagnosis and treatment of breast cancer.

The findings of the study fit the literature review. All women had health insurance, were educated, were or had been employed, and were proactive in receiving preventive screenings and necessary medical care. The findings showed an emphasis on

African American women who have been diagnosed with breast cancer and how these women viewed the role of social support and applied coping practices to effectively manage the diagnosis and treatment. The findings will add to the research by enlightening the unique experiences of women diagnosed with breast cancer and the significance of social support (through family, friends, and community engagement), and the development of meaning for social support can influence. Identification of the processes and coping strategies among African American women can potentially provide optimal survivorship when incorporated after diagnosis.

According to Neubauer et al. (2019), the foundational premise of research is to discover information or to achieve new understanding of the subject. This process often requires understanding the experiences of others, so we can glean new understanding about a particular phenomenon. Husserl (as cited in Neubauer et al., 2019) emphasized the reality is internal to the knower, what appears in their consciousness and labeled as transcendental (descriptive) analysis. With DPA, the researcher must remain biased during the data collection and analysis. Understanding the lived experiences makes phenomenology the philosophy and method that involves studying a small number of subjects through engagement to develop patterns and relationships of meanings (Moustakas, 1994).

I went to great lengths to ensure the credibility, dependability, and validity of the data collected. This included the use of bracketing by removing personal views, experiences, previous understandings, past knowledge, and assumptions about the phenomenon. Each participant’s experience was considered individually and a complete description of the phenomenon’s meaning and essences was constructed (Moustakas, 1994). I used NVivo to support data management and analyze the collected data.

Limitations of the Study

The delimitations for this study were 6-8 African American women diagnosed with breast cancer between 2009-2019 and living in various rural communities in Northeastern North Carolina. All participants self-identified as African American women. The research participants were in various counties of Northeastern North Carolina: Edgecombe, Halifax, Northampton, and Warren.

The small sample size represented a limitation; however, researchers stated that such a small sample could provide sufficient opportunity to identify and classify themes (Creswell, 2009). A second limitation was that the participants were African American who lived in some rural counties in Northeastern North Carolina, which limited the research applicability only to this ethnicity and this community. Therefore, comparisons could not be made with other racial or ethnic groups and different regions. A third limitation was that the study was about breast cancer, which meant the findings could not be generalized to other types of cancers. A fourth limitation is that I used NVivo to support the data management and analysis process. I acknowledge that if the study were to be replicated and examined with different software, it would not yield the same results. A fifth possible limitation might be of some concern was the difference in participants’ characteristics (i.e., income, education, health insurance, etc.). If the study were conducted in the same methodology and research design, but with different participants, the outcome might slightly change. Since this is a phenomenological study, one could never obtain an undeniable outcome. For that reason, the results of this study could not be statistically measured. A sixth limitation is that women were interviewed only once. Additional individual interviews may have revealed further insights about the participants. A seventh limitation was the way in which the interviews were conducted. Traditionally, these interviews would have been conducted face-to-face, which builds a level of trust between the participant and the researcher. However, due to newly imposed restrictions on in-person interactions for the purposes of research, these interviews were conducted over the telephone. This may have limited the trust and comfort the participants may have felt when discussing such personal experiences.

This study consisted of solid procedures to support recruitment of participants, the research design, and the methodology used. All were completely appropriate to serve the study. The findings were valid within the limitations of the study. Lastly, the limited amount of current literature (in the past 5-7 years) on the topic, which included minorities from medically underserved rural communities with breast cancer, presented a limitation.

Recommendations

Future recommendations would be to conduct the same study with the same delimitations, parameters, methodology, and research design elsewhere in the United States, specifically, a rural community labeled as an HPSAs. This would verify the reliability of the findings and potentially close the gap in research regarding African American women diagnosed with breast cancer, how they view social support and applied coping strategies to foster healing. Some participants expressed concerns regarding changes in communication and support patterns with family members after being diagnosed. Research is needed to explore the impact of breast cancer experience for African American women and their family members so culturally sensitive programs can be designed to address these issues and assist African American families through the experience (Davey et al., 2016; V.P. Henderson et al., 2012).

The diagnosis and treatment of cancer are associated with considerable psychosocial distress for both patients and their families (Davey et al., 2016). This was especially true for this study's participants because they reported worry and fear of the uncertainty and reoccurrence, financial issues, changes in physical appearance, emotional challenges, and changes in roles at home. Another recommendation would be to conduct this same study with the same population, but with a mental health perspective and with individuals who are uninsured or underinsured, have low income, and with less education to see if the results change. I anticipate that the reason for the study results is that the women in this study were all educated about breast cancer, used community resources, received preventive screenings and medical care, and had health insurance to meet their medical needs.

Implications

Positive Social Change

This study was unique because it addressed an underresearched and underserved population (African American women from a rural community) and topic (breast cancer and coping mechanisms). The results of this study sheds light on how social support from family, friends, and community engagement influenced the psychological adjustment of African American women living in various rural communities as they transitioned from the initial shock of being diagnosed with breast cancer to a feeling of being empowered and not defeated. In addition, the findings in this study demonstrate the importance of interventions that promote ways for support systems to be actively engaged with African American women with breast cancer in rural communities. Information gained from this study will add to the existing partial literature on the topic.

Research argued the availability of social support is often overlooked as an essential influence on breast cancer outcomes (Haynes-Maslow et al., 2016). While cancer survivorship can bring a host of additional health and life challenges, research argued that living in rural areas might heighten psychological issues that perpetuated disparities in health care (Caldwell et al., 2016). Based on the research findings, it might be helpful to make behavioral health providers available to screen cancer patients upon intake and periodically during the survivorship phase to determine the needs, concerns, and available resources to support the patient and their social network (family and friends) throughout the continuum of care.

In addition, the clinical staff should assess the meaning of breast cancer from the patient (African American woman) and their support network (family and friends) perspectives to address the psychosocial and educational needs throughout the breast cancer experience (Davey et al., 2016, Watkins et al., 2017). The information will help to develop interventions that are culturally specific to the population. Breast cancer remains the most common type of cancer among African American women in the United States and they have the lowest five-year survival rate (ACS, 2019). Supporting the successful execution of coping methods could allow for increased survival rates among the broader population.

Conclusion

This qualitative study of rural African American women who experienced breast cancer between 2009-2019 highlights common themes and expands our cultural understanding. The African American women in this study spoke candidly and some quite succinct about how they coped with breast cancer with the expectation the information could help other African American women challenged by breast cancer. This study sought to obtain a deeper understanding of the breast cancer experience for African American women by focusing on how they coped with the disease in some rural communities.

The participants described strategies that they used to cope, including, having a positive attitude, prayer and spirituality, learning how to live in the present, using supportive networks (family, friends, community), removing unsupportive people from their networks, having a will to live, and sharing their breast cancer experience with others. Many of the participants expressed a desire to support other African American women impacted with breast cancer. Whether through social support (to provide encouragement), transportation assistance, moral support (at medical appointments), and as a resource by sharing information on available resources. Participants in this study described serving in survivorship support roles were recognized as important ways of improving an African American woman's ability to cope with an illness such as breast cancer, especially in a rural community. Many expressed a sense of gratitude and comfort to be able to serve in these roles. Perhaps medical professionals working with African Americans with breast cancer in rural sectors should consider creating interventions that support survivorship support programs. The findings should help organizations and individuals who dedicate their time to meeting the needs of African American breast cancer patients and survivors in rural settings.

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Appendix A: Demographic Survey

Interviewee Code: _______________ Date: ____________________

Instructions: The survey is designed to capture demographic data on the research participants. All information will be kept strictly confidential. Please place a ‘X’ beside the correct response regarding the questions below.

1. Marital Status
    a. Single ___
    b. Married___
    c. Separated___
    d. Divorced ___
    e. Widowed___
    f. No response___

2. Educational Status
    a. Less than high school___
    b. High school diploma___
    c. Associates degree___
    d. Bachelor’s degree___
    e. Master’s degree___
    f. Doctoral degree___
    g. No response___

3. Annual Income
    a. <$9,999___
    b. $10,000-$19,999___
    c. $20,000-$29,999___
    d. $30,000-$39,999___
    e. $40,000-$49,999___
    f. $50,000-$59,999___
    g. >$60,000___
    h. No response____

4. Employed
    a. Yes____
    b. No___
    c. No response___

5. Insurance Status
    a. Private Insurance (e.g., BCBS, Ambetter, etc.) __
    b. Medicare____
    c. Medicaid___
    d. No Insurance___
    e. No response____

6. Number of years as a breast cancer survivor
    a. >1 year___
    b. 1-5 years____
    c. 6-10 years____
    d. 11-15___
    e. >16 years___
    f. No response__

Appendix B: Semistructured Interview Questions

Interview Protocol

Date: _______________

Interviewee Code: ______

Video Conference and/or Phone Interview

1. Please tell me how you would describe your initial diagnosis of breast cancer?
2. How would you describe the roles of your family after your diagnosis?
3. How would you describe your friends after your diagnosis?
4. What type of activities helped you to cope with your diagnosis of breast cancer?
5. How did you understand the diagnosis and treatment of breast cancer while living in various rural communities of Northeastern North Carolina?

   **prescheduled break: ask participant, “How are you doing? Do you need a break?” “Is it ok to continue or do you prefer we schedule another time to complete the interview?”

1. What weas the most challenging aspect of coping with the diagnosis and treatment of breast cancer?
2. What was the most rewarding aspect of coping with breast cancer while living in various rural communities of Northeastern North Carolina?
3. How do you describe the role of social support (coping) networks when dealing with breast cancer?
4. If employed, how do you or did you manage home and work during breast cancer diagnosis and treatment?
5. What are your experiences when interacting with women in the community who have a diagnosis of cancer?