

ORIGINAL RESEARCH

'My husband would not help me, so I was driving over there': older rural women experiencing breast cancer with a non-supportive intimate partner

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ABSTRACT

Introduction: This article describes the experiences of older rural women diagnosed with breast cancer while in a non-supportive, and sometimes abusive, intimate relationship. Breast cancer is primarily a disease of older women, and in the USA, a higher percentage of rural women are more than 65 years of age compared with other geographical areas. Many women identify their intimate partner as an important source of support during cancer diagnosis and recovery, but little is known about how women deal with breast cancer while in a relationship self-described as difficult.

Methods: Semi-structured qualitative interviews were conducted with a convenience sample of nine rural women from community settings in western Virginia and West Virginia. Participants ranged in age from 55 to 84 years at the time of interview (mean 69 years). Age at diagnosis ranged from 53 to 71 years (mean 59.2). Relationship length ranged from 1 to 55 years (mean 28.5). Time between interview and diagnosis ranged from 1 to 31 years (mean 9.8). All were in heterosexual relationships. Breast cancer stage ranged from I to III. Data were analyzed using hermeneutic phenomenological analysis.

Results: Several themes emerged related to the experience of breast cancer with a non-supportive intimate partner in a rural setting. The themes were: driving, gossip, rural location as therapeutic, and community support.

Conclusions: Older rural women operating without the support of their intimate partner present to oncology treatment with unique challenges, particularly related to distance, financial stress, and sometimes heightened relationship stress. Rural women also



reported rural strengths that aided them in their recovery. These findings indicate a need for complete assessments of social network and quality of intimate partner support in the rural oncology care setting.

Key words: breast cancer, psychosocial aspects cancer, older people, primary partner relationships, vulnerable populations, women's health.

Introduction

In the USA, an estimated 17% of the total population lives in a rural area¹. Approximately one in eight women (12.5%) will develop invasive breast cancer during their lifetime^{2,3}. Breast cancer is primarily a disease of older women, and the majority of women diagnosed with breast cancer are at least 60 years of age⁴, the median age at diagnosis being 61 years⁵. Older women are under-represented in breast cancer research^{5,6}.

Many women of all ages identify their intimate partner as their most important source of support as they navigate breast cancer diagnosis and treatment^{7,8}. Not all partners, however, are supportive. Examples of non-supportive partner responses range from criticism or insensitivity to intimate partner abuse (IPA) at the extreme end of the non-supportive partner behavior continuum. The purpose of this article is to examine the experiences of rural women aged 55 years and older, who dealt with their breast cancer diagnosis with a non-supportive intimate partner. For the purposes of this study, older women were defined as women who were either post-menopausal prior to their breast cancer diagnosis or at least 55 years, the outer limit of the average age range for menopause onset⁹.

Rural women and breast cancer

Rural women have a different breast cancer experience from their urban counterparts. This begins early with breast cancer screening and mammography. Rural women have lower mammography screening rates than urban women, due to a combination of lack of access and financial problems^{10,11}, because a higher percentage of rural Americans live in

poverty than urban Americans¹², and a higher percentage of rural women are 65 years and older¹³. Rural women are more likely to be diagnosed with later-stage breast cancer¹¹.

Rural women may have decreased access to their primary care practitioner because there are less healthcare providers in rural areas, translating to a lower rate of clinical breast examinations^{14,15}. Rural women are also at a disadvantage because there are less options of times and locations at which to receive screening¹⁶.

There is a shortage of recent studies comparing rural with urban treatment. The definition of rurality varies from place to place, so it is difficult to make comparisons¹⁷. Rural women reportedly encounter more barriers in the treatment phase than do urban women, regardless of age. Rural women have decreased access to state-of-the-art treatment, with less access to breast-conserving treatment; the rates of access decrease as women become more rural^{15,18,19}. Rural women wait more days between surgery and beginning chemotherapy¹⁵. They are more likely to receive a mastectomy, and have higher rates of chemotherapy and lower rates of radiation and lumpectomy than urban women^{20,21}.

Rural women travel further for treatment, creating increased stress and financial burden¹⁵. They also may encounter disturbances in work due to distance to treatment¹⁴. The distance between home and place of medical care can also create problems with social roles, such as caregiving¹⁵.

Rural women report making decisions with family members' convenience in mind, such as choosing mastectomy over lumpectomy and reconstruction, or deliberately isolating themselves to avoid being the topic of gossip¹⁴. This may be



in response to reports from rural women that there is a minimized sense of confidentiality and privacy in rural areas²². Some researchers have found that rural women are more likely to leave treatment decisions up to their physician²¹, even though research suggests that participation in treatment decisions can create an increased sense of control and a better cancer experience^{15,21}.

Rural women report that their breast cancer information is more likely to come from general healthcare providers rather than from oncology-specific healthcare providers^{14,15}. In focus groups, rural women wanted better communication between their urban-based cancer specialist and their local family doctor to provide greater continuity of care¹⁴.

Rural women may be socially isolated from other women with breast cancer²³⁻²⁵. This can lead to decreased ability to cope, decreased ability to deal with cancer related fears, a lower quality of life, and an increase in depression and self-image concerns. Some rural women report feeling stigmatized in public, especially if they have had a mastectomy¹⁵. They sometimes feel a sense of abandonment after returning to their rural home community from an urban area where they are more likely to meet other cancer survivors and patients, access support groups²³, and cancer information¹⁵. Conversely, they can feel isolated when traveling a long distance to an urban community to receive their treatment.

Living in rural areas has positive aspects. Australian women with breast cancer noted that the natural setting can be in itself therapeutic and can make up for treatment disadvantages to assist in recovery²². Rural women are often able to access a large informal support network of community, family and friends^{14,22,26}. Some rural women are empowered by their personal belief that being rural makes one stronger – and thus better equipped to handle their cancer experience²². Rural women report being very pleased with their care quality, especially when their care was local¹⁵.

Breast cancer and social support

Rural women in focus groups report that social support is extremely important²³. The women stated that they want to be asked by their healthcare providers about their social support networks²⁵. Support from a confidant decreases depression after a stressful life event²³.

Many women turn to intimate partners for support, and the quality of partner support can predict how a woman copes with breast cancer^{7,27}. The presence of a supportive partner is often assumed when a woman enters cancer treatment²⁸. Many women are not satisfied with the help that they received from their partner while dealing with breast cancer²⁷. Non-supportive partner behavior can be even more powerful than positive support⁸, leading to emotional distress and maladaptive coping²⁹. Women with no emotional support from their partner experienced an increase in the perceived threat of the cancer³⁰.

Intimate partner abuse lies at the extreme end of the non-supportive partner continuum. Little is known about how IPA impacts a women's ability to deal with her breast cancer diagnosis. Emotional and psychological abuse seems to increase with age^{31,32}. Researchers estimate that 11.1% of older women in any given year experience some form of IPA^{31,33}.

Methods

Overall approaches and rationale

This article describes the experiences of nine rural women who simultaneously dealt with breast cancer and a non-supportive partner. These were participants in a study of women 55 years and older who were in a 'difficult' intimate partner relationship while being diagnosed with and/or treated for breast cancer. After analysis, the rural sample were isolated from a convenience sample of 19 because themes emerged that were unique to the rural women. These themes were not mentioned by any of the urban and



suburban women in the study. The rural experience of was not in and of itself a specific aim of the study, and the researcher did not directly ask questions about being rural. A hermeneutic phenomenological strategy of inquiry was used. The University of Virginia Institutional Review Board approved the study. There was no prior relationship between the researcher and any of the participants.

Participant sample and setting

Rurality was determined by participants' responses to the Rural Survey, as developed by the Rural Health Care Research Center at the University of Virginia School of Nursing, and based on the MSU Rurality Index³⁴. The survey was used to gather demographic data about participants' ages, race, education, and insurance sources, as well as data such as distance to medical care and descriptions of where participants live.

Rurality is generally defined by a combination of measures of population, population density, and proximity to metropolitan areas, generally defined as areas of 50 000 or more people³⁵. In this study, rurality was confirmed by matching participants' zip codes with statistics on rurality from the Virginia Department of Health, the US Census Bureau, and the United States Department of Agriculture (USDA). The USDA defines rural areas by Rural/Urban Continuum codes on a scale of 1–9, with 9 being the most rural. The areas represented by zip code in this sample ranged from 4 to 9 Rural-Urban Continuum Codes³⁶.

All women were from rural counties in western Virginia or West Virginia. Some, but not all, were from medically underserved areas, defined by the Virginia Department of Health as having too few primary care providers, high infant mortality rates, high poverty and/or high elderly population³⁷. All women read and signed an informed consent.

Recruitment procedure

Participants were recruited in a variety of ways, all approved by the University of Virginia Institutional Review Board.

Recruitment lasted for 6 months. The investigator ran classified ads in several newspapers and gave presentations about breast cancer in retirement communities. Staff from a local cancer center sent letters to women in their database who were currently 55 years and over and not currently in treatment. Potential participants then contacted the investigator by phone, and were called back to establish eligibility. Eligibility criteria were: (i) ability to speak English; (ii) at least age 55 years at the time of the interview; (iii) self-described as having been in a 'difficult' intimate partner relationship at the time of breast cancer diagnosis and/or treatment; (iv) a score of at least 23 on the Mini-Mental State Exam³⁸. Following eligibility, the participants signed the consent form and then completed the Rural Survey. After the interview, the participants completed the Women's Experience With Battering (WEB) Scale to determine the nature of the difficult intimate partner relationship. The WEB scores of these women ranged from 10 to 48 (mean 25.4, median 23).

The WEB measures the psychological vulnerability that abused women experience, especially in the areas of mental health, anxiety, and depression³⁹⁻⁴¹. The WEB is a 10 item scale, with scores ranging from 10 to 60. A score of 19 or above is definitive of emotional abuse as derived from a sensitivity and specificity analysis, resulting in a sensitivity of 94.6% and a specificity of 96.1%³⁹.

Interview

Interviews were conducted in-person and were digitally recorded. Interviews were transcribed either by the author or a *Health Insurance Portability and Accountability Act* (HIPAA) 1996 certified transcriptionist. Transcription files were double-checked against the recordings for accuracy. The interviews lasted between 1 and 2 hours and were open-ended but guided by probes and closed questions. Sample interview questions are provided (Fig1). Interviews took place in a participant-determined confidential location or by telephone.



- Can you tell me a little about your partner and your relationship?
- Tell me about the breast cancer.
- How did you learn about the cancer?
- What kinds of treatments have you had?
- How did you tell your partner about the initial diagnosis?
- What was his/her response?
- How did you tell your partner about the treatments?
- Have you had a lot of side-effects from the treatment?
- Do you think that the breast cancer has changed your relationship with your partner in any way? If so, how?
- Is there anything you wanted or needed from your partner that you did not get?
- How did your partner interact with you when you were not feeling well?
- What comments has your partner made related to the illness, if any?
- What was your menopausal status at the time of diagnosis?
- How do you describe your partner's role in your treatment and recovery?
- Describe how you dealt with your cancer.

Figure 1: Sample interview questions (based on the Partner Responses to Cancer Inventory²⁹)

Analysis

Interview data were analyzed using a hermeneutic phenomenological approach presented by Cohen, Kahn, and Steeves in which the aim was to describe older women's experiences of breast cancer with a non-supportive intimate partner⁴². In this article, themes unique to the rural participants are highlighted.

In hermeneutic phenomenology, the researcher analyzes and interprets the narratives of those who have experienced a phenomenon first-hand in order to gain understanding of that lived experience⁴². The data were analyzed and re-analyzed in order to identify themes that characterized the participant experiences. First, natural meaning units were identified in the interviews. The units were then grouped into categories and coded based on perceived similarities. The next stage of analysis involved grouping the categories into themes representing the experiences of the participants and addressing the specific aim. An audit trail was maintained and the author consulted a peer reviewer who is a qualitative expert. The author met regularly with a team of people familiar with the research to discuss data analysis. NVivo software was used to manage the data.

Results

These findings describe the experiences of how nine older rural women in difficult intimate relationships dealt with breast cancer. These were unsolicited depictions about rural life noted in the analysis and were unique to the rural women; they were sufficiently prevalent to indicate their importance as descriptive themes. Themes include driving, gossip, rural location as therapeutic, and community support. Participants' age range at the time of interview was 55–84 years (mean and median 69 years). Age range at diagnosis was 53–71 years (mean 59.2). Relationship length range was 1–55 years (mean 28.5). Time between interview and diagnosis was 1–31 years (mean 9.8, median 4). All were in heterosexual relationships. Breast cancer stage range was I–III. Six of the nine women had had a mastectomy, three of those women had had reconstruction, and three women had had lumpectomies.

Driving as an additional stress on already stressed relationships

The most common theme that emerged related to rurality was distance and the challenges presented by travel to the participants' intimate relationships. Most of the women



received their treatment at an urban medical center that was 80.5–96.6 km (50–60 miles) from their homes. The psychological barrier of the distance to this treatment facility was reflected in the unanimous description of the facility as ‘over at’, ‘across the mountain to’ and ‘down to’ the facility. Driving back and forth was ‘exhausting’ and ‘stressful’ for the participants, and their partners’ obligation to the participants a great distance to treatment put additional stress on relationships that were already difficult.

And he was totally stressed out at that time, but so was I. It's hard to co-ordinate your work to get off to go to the hospital when you know you might be there all day. So he was stressed... He ended up having to take me and still come back and do his job.

For the women who were in abusive relationships, the role of partner-as-driver put him into an increased position of power and control. One woman described trying not to rock the boat because, ‘I was dependent on him. In every way. Because he was the one taking me to [urban medical center] all the time’. She went on trying to keep everything kind of normal, ‘to get through it. It was an emotional time’. Another woman’s husband ‘insists’ that she does not drive anymore. When asked if she is able to get where she needs to go, she replied, ‘Well, yes and no’.

The participants viewed whether or not the partner was able to drive them to their treatments as indicative of his supportiveness.

So, see, I was going back and forth. And my husband would not help me, and so I was driving over there and that's probably the worst thing I should have done, because here I was, my brain was fuzzy and I was driving across the mountain, and this was in the wintertime.

This participant felt that having to drive this distance by herself was potentially harmful to her.

Being rural affected the women’s cancer experience in several other ways. One woman could not access cancer-specific marriage therapy due to distance. Another extremely rural woman was limited socially (visiting friends) by low income. Because her husband gave her a small allowance, and gasoline costs were high, she had to limit her car use to shopping for basic necessities and health care. For one woman whose relationship was difficult due to her husband’s terminal illness, distance played a role in the treatment she chose. ‘My husband was ill and could not drive me. So I had no choice but to do my radiation here’.

‘People were telling me’: rurality and gossip

The women did not mention loss of privacy in terms of the breast cancer, but rather in the context of their difficult intimate partner relationships. This had both positive and negative manifestations.

Lack of privacy was an issue for one participant who was living in a rural area with her abusive husband. She described the difficulty of obtaining domestic-violence-related prosecution against her husband in their small town. ‘...Because he had a lot of relatives down there. You know that's a small place - so everybody knows everybody.’ Consequently, she was never able to press charges against him for violent behavior, such as verbal harassment, threats of physical violence, and intimidation. She believes that the abusive relationship caused her to delay her mammogram.

Several women described that they found out about their husbands’ affairs while they were undergoing treatment via hearsay or gossip. They used phrases such as, ‘And then I started hearing things around town’, ‘Then I found out that...’, or ‘People were telling me...’. Finding out about the affairs during treatment affected the women differently. Some women chose to ignore this gossip, so the information about the affair did not overtly affect their cancer treatment. However, for the one woman whose relationship broke up because of his affair, this information created increased difficulty during treatment because she lost her driver.



Participants whose marriages eventually broke up described how this was received in their community. One woman's husband left her for another woman in the midst of her cancer treatment. Gossips and gossip flew, but for her this translated into community support. People she hardly knew would express their feelings about her husband: '[One] woman said "What a slimy thing to do" [for him to leave her while she was dealing with breast cancer]'.

Her husband's behavior was known in the community and communicated to her almost every time she was in a public space. There was public condemnation of his desertion.

And I have women say to me all the time. And I don't know whether they're lying or not but they'll say, 'I ran into him on the street and I couldn't speak to him'. And he's got to know that.

She described a sense of the public watching out for her, 'People all the time ask me, has he moved? I never see him!' She believed that by keeping her informed of her (ex) husband's movements, they were telling her that they were on her side. For this woman, her failing marriage was more important to the public eye than her breast cancer.

'I have to have room between us': rural space and quiet equals recovery

Although the participants did not have the support of their intimate partner, they described the rural location and physical space as an important part of their cancer recovery.

It's therapeutic to be here because that summer after I got through with all my treatments, I just sat on the porch and just listened to the birds and watched them fly; the barn swallows ... get up on these lines and just chatter away. I just love it.

One participant, whose intimate relationship broke up as a result of her breast cancer diagnosis, ended up moving up to a very rural area as part of her recovery. Because of the

cheaper cost of rural living she was able to move, cut back her work to 2 days a week, and still save for her retirement. She describes how thinking about moving to her current rural location helped her get through her treatment:

What I did when I was too icky and fuzzy to get up out of bed or too nauseated, I would draw plans for what I wanted this place to look like and what kind of space I needed. Then when I started on radiation, I was feeling better, I was able to come back here on weekends. The energy that I was able to put into the future while I was in treatment really made up for the fact that the relationship was so awful. I think if I hadn't had something that I could look forward to in the future that I felt I could count on, it would have been much more difficult. It's a peaceful kind of place and it's been a wonderful place to recover.

'I pretty much used up the neighborhood' – rural community support

Community support was an important aspect of support for these rural women, who were experiencing breast cancer without a supportive intimate partner. One woman who did not have children living in her rural area described how her community was able to assist her by driving her to radiation treatments, which were at a facility over a mountain range and 96.6 km (60 miles) away.

When I started the radiation treatments, [husband] said he couldn't stand driving up there back and forth every day and every day and every day. So he would make sure that I had a driver. I could have driven myself when I took the radiation, but he did not want me to be driving by myself because he knew that I was weak. I always had a driver. I pretty much used up the neighborhood, but I always had somebody to take me up there.

Although some participants drove themselves to their long-distance treatment, many, like the woman quoted above,



relied heavily on others, such as community members and extended family, for driving.

Another participant described how she felt supported not only by her own community, but also her son's community, in a neighboring county 72 km (45 miles) away:

People I didn't know would come up to me on the street and say, 'When is your next appointment? I want to take you'. It would be people that I didn't even really know.

This same participant's community also supported this woman emotionally:

And I had women and men! Come up to me and say, 'I know exactly how you're feeling. You know I didn't have a life-threatening disease but I was dumped and I know how it hurts you and how confused you are. If there's anything I can do for you'.

Communities were aware of the financial strain that cancer treatment put on the participants and their families. One woman's church gathered up \$1,100 to pay for the gasoline needed for transportation to cancer treatment. This woman worried that her husband would take the money, because he had expressed an interest in using the money for his truck repair, but 'I put that money in an envelope and I kept it in my purse. And that money stretched all the way through all my treatments, believe it or not'.

Other participants described other support from their neighbors and community such as physical assistance with getting up the stairs and bringing food. Rural participants mentioned their friends as sources of support and encouragement, and felt better prepared for the side-effects of treatment as a result. Rural women also mentioned seeking the support of other women with cancer. One woman stated:

And I knew all this stuff because I had a friend down here who went through the same identical thing only she had ovarian cancer and uterine cancer.

Although no participants mentioned involvement with Internet support groups, several mentioned using the Internet to look up cancer treatment information and information about emotional abuse. The Internet was also a source of family connection.

Participants who obtained treatment locally received support from medical professionals in their rural communities, and this support helped offset lack of intimate partner support. One woman described how her level of comfort with both her surgeon and radiologist, with whom she was on a first-name basis, allowed her to be assertive in her request for an elective bilateral mastectomy.

And he said that he has a whole group of women that still meet and I could join them, and he has performed their mastectomies. I figured that Bob could do as good a job as any, and Bob had our friendship to inspire him, and you don't usually have that.

Sometimes the participant's care providers knew each other, and this provided the women with an extra sense of security in their care. One woman knew the nurse that was with her in the cancer center, 'I happened to know the nurse that was with me. I didn't know that I was going to have her here, but that was nice.' Other participants mentioned knowing their nurses by chance.

Summary

Although these nine older women are a small sample, they described unique experiences with breast cancer. Participants described these rural-related themes as both positive and negative. Because the participants were in difficult intimate partner relationships, their experiences with traveling a distance for treatment, gossip, need for community support, and the comfort that their rural location provided them as



they recovered might be different from rural women experiencing breast cancer with a supportive partner.

Discussion

The participants, because of their difficult intimate partner relationships, highlighted different aspects of their cancer experience as rural women than researchers have previously described in the scant literature about rural women and breast cancer. Some themes were consistent with existing literature. For instance, distance created difficulties such as increased financial stress, which spilled over into general relationships with partners^{15,43}. Unique to these women are the additional complications that being in a non-supportive, sometimes abusive, relationship with an intimate partner placed on the situation. For some women, the need for driving became another way that the partner could manipulate the woman and make her become more dependent. This is consistent with other literature, whereby the way an abusive partner exerts power and control morphs to fit the situation at hand^{44,45}. Asking for help from others is difficult, and could potentially place the woman in the difficult position of having to reveal an abusive relationship.

Financial stressors, increased age, and illnesses such as cancer often exacerbate already stressful relationships²⁸. Breast cancer created additional financial stress due to time lost from work, gasoline prices, and the occasional need for lodging. It is not difficult to see that rural older women with breast cancer who are in already stressful relationships, are put at additional disadvantage by their rural location.

Although some researchers point to the increased difficulty that rural women have finding support from other cancer patients²³⁻²⁵, these participants did not emphasize this. Rather, they emphasized the positive support they found within their communities. None of the women attended or wished to attend a cancer support group, and they were able to find other woman in their area who had had cancer.

In this study, lack of privacy and confidentiality was never mentioned in relation to the breast cancer, perhaps because few of the women received their treatment in the town where they lived. They did discuss gossip, but its role in the health of these women is still unclear. Generally gossip has negative connotations, but in this context hearsay and gossip were surprisingly positive, a way of keeping intimate partners in line. Bioethicists have suggested that the rural community keeps itself in check by this system of gossip and a community-wide sense of what is right⁴⁶. Some researchers view gossip as the mark of a healthy community⁴⁷, and rural communities, by nature of their small size, are more likely to have gossip. As long as healthcare professionals do not violate confidentiality, gossip is potentially healthy.

Little research documents the positive aspects of rurality⁴³. These women mentioned several aspects of their rural location that were therapeutic: the geography itself, other support, and a good relationship with healthcare professionals (some of whom were already known to the women). These positive themes of rurality echoed the findings of McGrath's and Rogers-Clark's research^{22,43}.

Implications

Although generalization of these descriptive study findings to broad clinical implications is impossible, several clinical practice recommendations can be made. Rural women operating without the complete support of their intimate partner while dealing with breast cancer present for breast cancer treatment with unique needs. First and foremost is the need for a complete social network assessment⁴⁸, community resource assessment, and assessment of intimate partner support. Health professionals should access information packets already used in psychosocial interventional research on rural women with breast cancer, such as the rural focused Workbook-Journal 'One in Eight: Women Speaking to Women'²⁴. These information packets can be placed at community centers or health departments in addition to being distributed to cancer treatment centers and medical offices. Information packets should be developed addressing



more specific individual needs, such as the needs of abused women or women with ill partners.

Several participants accessed the internet as a source of information and communication. Use of the internet could be useful for rural, abused, and/or older women. Referrals to internet sources could be made from doctors' offices and community centers. A specialist breast-cancer nurse could be invaluable for rural breast cancer patients in particular, because this nurse could be a valuable information source, patient advocate, referral source, and link between rural and urban healthcare facilities²².

Limitations

These women were rural, but not remote. All of the women were within 96.6 km (60 miles) of their treatment. Because these women were not recruited specifically from exclusively rural locations, the sample size was extra small. The investigator did not recruit women from rural areas where a more diverse population of rural women live. Future studies should gather data about income level and should incorporate more direct questions related to the rural experience of breast cancer. This study included only women over 55 years, and although none of the themes seem to be directly related to being older, it would be interesting to see if younger women's experiences are similar. Selection bias is a concern, because only women who had successfully navigated this experience participated in the study. There was potential for memory bias in the interviews because of the wide range of years between the diagnosis and time of interview.

Conclusions

This study describes the experiences of older rural women who were navigating their breast cancer experience with negative or absent intimate partner support. Their stories serve as powerful reminders to healthcare providers to view patients in light of their specific contexts, and to thoroughly assess the quality of their social support. Because of stressors

accentuated by distance, these women, who all were experiencing the additional stressors of a non-supportive intimate partner, presented to cancer treatment in a state of heightened vulnerability. However, the women also described the unique strengths that their rural communities offered to them while they were ill – an extensive, creative network of strength and support. Healthcare professionals need to work to uncover rural community strengths in order to modify rural disadvantages.

References

1. United States Department of Agriculture, Economic Research Service. *Rural Population and Migration*. (Online) 2008. Available: <http://www.ers.usda.gov/Briefing/Population/> (Accessed 24 April 2009).
2. Manne SL, Pape SJ, Taylor KL, Dougherty J. Spouse support, coping, and mood among individuals with cancer. *Annals of Behavioral Medicine* 1999; **21(2)**: 111-121.
3. National Cancer Institute. *Probability of Breast Cancer in American Women*. (Online) 2006. Available: <http://www.cancer.gov/cancertopics/factsheet/Detection/probability-breast-cancer> (Accessed 21 April 2009).
4. Ganz PA, Guadagnoli E, Landrum MB, Lash TL, Rakowski W, Silliman RA. Breast cancer in older women: quality of life and psychosocial adjustment in the 15 months after diagnosis. *Journal of Clinical Oncology* 2003; **21(21)**: 4027-4033.
5. Carlson RW, Moench S, Hurria A, Balducci L, Burstein HJ, Goldstein LJ. NCCN Task Force Report: Breast cancer in the older woman. *Journal of the National Comprehensive Cancer Network* 2008; **6(Suppl4)**: S1-S27.
6. Mandelblatt J. Treating breast cancer: the age-old dilemma of old age. *Journal of Clinical Oncology* 2006; **24(27)**: 4369-4370.



7. Pistrang N, Barker C. The partner relationship in psychological response to breast cancer. *Social Science and Medicine* 1995; **40(6)**: 789-797.
8. Manne S, Glassman M. perceived control, coping efficacy, and avoidance coping as mediators between spouses' unsupportive behaviors and cancer patients' psychological distress. *Health Psychology* 2000; **19(2)**: 155-164.
9. Stoppler MC, Shiel WC. *Menopause*. (Online) 2008. Available: <http://www.medicinenet.com/menopause/page2.htm> (Accessed 4 August 2009).
10. Lane A, Martin M, Uhler J, Workman L. Enhancing breast health in rural populations: clinical nurse specialist as the key. *Clinical Nurse Specialist* 2003; **17(6)**: 292-297.
11. Bencivenga M, DeRubis S, Leach P, Lotito L, Shoemaker C, Lengerich EJ. Community partnerships, food pantries, and an evidence-based intervention to increase mammography among rural women. *Journal of Rural Health* 2008; **24(1)**: 91-95.
12. USDA Economic Research Service. *Rural Poverty at a Glance*. (Online) 2004. Available: <http://www.ers.usda.gov/publications/rdrr100/> (Accessed 30 March 2009).
13. USDA: Economic Research Service. *Nonmetro America Faces Challenges From an Aging Population*. (Online) 2007. Available: <http://www.ers.usda.gov/Briefing/Population/Challenges.htm> (Accessed 30 March 2009).
14. Gray RE, James P, Manthorne J, Gould J, Fitch MI. A consultation with Canadian rural women with breast cancer. *Health Expectations* 2004; **7**: 40-50.
15. Bettencourt BA, Schlegel RJ, Talley AE, Molix LA. The breast cancer experience of rural women: a literature review. *Psychooncology* 2007; **16(10)**: 875-887.
16. Sparks BT. Breast cancer screening in rural populations: a pilot study. *Journal of Rural Health* 1996; **12(2)**: 120-129.
17. Vanderboom CP, Madigan EA. Federal definitions of rurality and the impact on nursing research. *Research in Nursing and Health* 2007; **30**: 175-184.
18. Answini GA, Woodward WLI, Norton HJ, White RL Jr. Breast conservation: trends in a major metropolitan area compared with surrounding counties. *American Surgeon* 2001; **67(10)**: 994-998.
19. Beaulieu JE, Massey CS, Tucker TC, Schoenberg N, Ross F. Rural-urban variation in breast-conserving surgery in Kentucky. *Kentucky Medical Association Journal* 2003; **101**: 455-459.
20. Tropman SE, Ricketts TC, Paskett E, Hatzell TA, Cooper MR, Aldrich T. Rural breast cancer treatment: evidence from the Reaching Communities for Cancer Care (REACH) project. *Breast Cancer Research and Treatment* 1999; **56**: 59-66.
21. Bettencourt BA, Talley AE, Molix L, Schlegel R, Westgate SJ. Rural and urban breast cancer patients: health locus of control and psychological adjustment. *Psychooncology* 2008; **17**: 932-939.
22. Rogers-Clark C. Living with breast cancer: The influence of rurality on women's suffering and resilience: a postmodern feminist inquiry. *Australian Journal of Advanced Nursing* 2002; **20(2)**: 34-39.
23. Koopman C, Angell K, Turner-Cobb JM, Kreshka MA, Donnelly P, McCoy R et al. Distress, coping, and social support among rural women recently diagnosed with primary breast cancer. *The Breast Journal* 2001; **7(1)**: 25-33.
24. Angell KL, Kreshka MA, McCoy R, Donnelly P, Turner-Cobb JM, Graddy K et al. Psychosocial intervention for rural women with breast cancer. *Journal of General Internal Medicine* 2003; **18**: 499-507.
25. Wilson SE, Andersen MR, Meischke H. Meeting the needs of rural breast cancer survivors: what still needs to be done? *Journal of Women's Health and Gender-Based Medicine* 2000; **9(6)**: 667-677.



26. Howat A, Veitch C, Cairns W. A descriptive study comparing health attitudes of urban and rural oncology patients. *Rural and Remote Health* **6**:563. (Online) 2006. Available: www.rrh.org.au (Accessed 6 November 2010).
27. Manne S, Ostroff J, Sherman M, Heyman RE, Ross S, Fox K. Couples' support-related communication, psychological distress, and relationship satisfaction among women with early stage breast cancer. *Journal of Counseling and Clinical Psychology* 2004; **72**(4): 660-670.
28. Schmidt NK, Woods TB, Stewart JA. Domestic violence against women with cancer: Examples and review of the literature. *Supportive Oncology* 2006; **4**(1): 24-33.
29. Manne S, Schnoll R. Measuring supportive and unsupportive responses during cancer treatment: A factor analytic assessment of the Partner Response to Cancer Inventory. *Journal of Behavioral Medicine* 2001; **24**(4): 297-321.
30. Fridfinnsdottir EB. Icelandic women's identifications of stressors and social support during the diagnostic phase of breast cancer. *Journal of Advanced Nursing* 1997; **25**(3): 526-531.
31. Zink T, Fisher BS, Regan S, Pabst S. The prevalence and incidence of intimate partner violence on older women in primary care practices. *Journal of General Internal Medicine* 2005; **20**(10): 884-888.
32. Zink T, Jacobson CJ, Pabst S, Regan S, Fisher BS. A lifetime of intimate partner violence: coping strategies of older women. *Journal of Interpersonal Violence* 2006; **21**(7): 634-651.
33. Mouton C, Rodabaugh R, Hunt J, Rovi S, Talamantes M, Brzyski R. Prevalence and 3-year incidence of domestic violence in postmenopausal women. *American Journal of Public Health* 2004; **94**: 605.
34. Weinert C, Boik R. MSU Rurality Index: development and evaluation. *Research in Nursing and Health* 1995; **18**: 453-464.
35. The United States Department of Agriculture, Economic Research Service. *Measuring rurality: What is rural?* (Online) 2007. Available: <http://www.ers.usda.gov/Briefing/Rurality/WhatIsRural/> (Accessed 24 April 2009).
36. United States Department of Agriculture, Economic Research Service. *Measuring Rurality: Rural-Urban Continuum Codes.* (Online) 2004. Available: <http://www.ers.usda.gov/Briefing/Rurality/RuralUrbCon/> (Accessed 24 April 2009).
37. Virginia Department of Health. *Shortage Designations and Maps.* (Online) 2009. Available: <http://www.vdh.state.va.us/healthpolicy/primarycare/shortagedesignations/>. Accessed 4/24, 2009.
38. Folstein M, Folstein SE, McHugh PR. 'Mini-Mental State' a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 1975; **12**(3): 189-198.
39. Smith PH, Earp JA, DeVellis R. Measuring battering: Development of the Women's Experience with Battering (WEB) Scale. *Women's Health: Research on Gender, Behavior, and Policy* 1995; **1**(4): 273-288.
40. Smith PH, Smith JB, Earp JAL. Beyond the measurement trap: a reconstructed conceptualization and measurement of woman battering. *Psychology of Women Quarterly* 1999; **23**(1): 177-193.
41. Smith PH, Tessaro I, Earp JAL. Women's experiences with battering: a conceptualization from qualitative research. *Women's Health Issues* 1995; **5**(4): 173-182.
42. Cohen MZ, Kahn DL, Steeves RH. *Hermeneutic phenomenological research: a practical guide for nurse researchers.* Thousand Oaks, CA: Sage, 2000.
43. McGrath P, Patterson C, Yates P, Treloar S, Oldenburg B, Loos C. A study of postdiagnosis breast cancer concerns for women for women living in rural and remote Queensland. Part II support issues. *Australian Journal of Public Health* 1999; **7**: 43-52.
44. Reitz RR. Batterers' experiences of being violent. *Psychology of Women Quarterly* 1999; **23**: 143-165.



45. Band-Winterstein T, Eisikovits Z. 'Aging out' of violence: the multiple faces of intimate violence over the lifespan. *Qualitative Health Research* 2009; **19(2)**: 164-180.

46. Klugman CM. Vast tracts of land: Rural healthcare culture. *American Journal of Bioethics* 2008; **8(4)**: 57-58.

47. Dunbar RIM. Gossip in evolutionary perspective. *Review of General Psychology* 2004; **8(2)**: 100-110.

48. Kroenke CH, Kubzansky LD, Schernhammer ES, Holmes MD, Kawachi I. Social networks, social support, and survival after breast cancer diagnosis. *Journal of Clinical Oncology* 2006; **24(7)**: 1105-1111.
