

Research Article

Living with Advanced Breast Cancer among Ghanaian Women: Emotional and Psychosocial Experiences

Adwoa Bemah Bonsu,¹ Lydia Aziato,² and Joe Nat A. Clegg-Lamptey³

¹ Department of Nursing, Garden City University College, P.O. Box 12775, Kumasi, Ghana

² School of Nursing, College of Health Sciences, University of Ghana, P.O. Box LG 43, Legon, Accra, Ghana

³ Department of Surgery, University of Ghana Medical School, P.O. Box 4236, Accra, Ghana

Correspondence should be addressed to Adwoa Bemah Bonsu; bemahc2000@yahoo.com

Received 3 April 2014; Revised 2 June 2014; Accepted 7 June 2014; Published 25 June 2014

Academic Editor: Franco Toscani

Copyright © 2014 Adwoa Bemah Bonsu et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

The purpose of this study was to explore the emotional and psychosocial experiences of Ghanaian women living with advanced breast cancer in the Kumasi metropolis. The study employed a qualitative exploratory descriptive design. Purposive sampling approach was used and data was saturated with 10 participants aged between 32 and 65 years. All interviews were audio-taped and transcribed. Data was analyzed concurrently based on the techniques of content analysis. Anonymity and confidentiality were ensured. Women experienced emotional reactions such as sadness, fear, and anxiety. Pain was severe and led to suicidal ideations. Women experienced lost hopes regarding their marriage, parenting, and work. They received support from their families, spouses, colleagues, health professionals, and spiritual leaders. Women coped by accepting the disease and surrendering to God and having the will to live. Five major themes described were emotional reactions, pain, lost hope, support, and coping. It was recommended that health care providers involved in breast cancer management should be trained to enhance effective and holistic care of women and their families. Also, patients with advanced disease should be given effective pain management and a multidisciplinary palliative care team should be instituted to care for the women.

1. Introduction

Breast cancer is a devastating disease among women and it is known to be associated with severe emotional and psychosocial consequences. The emotional and psychosocial experiences of breast cancer patients are well documented in many countries [1]. Early diagnosis of breast cancer leads to a better chance of cure. However, late diagnosis of the disease provides avenue for palliative care because of minimal chances of cure [2]. In many developing countries including Ghana, breast cancer is diagnosed at an advanced stage due to late reporting [3]. Factors that contribute to late reporting include fear of death associated with removal of the breast (mastectomy), seeking alternative treatment, and inadequate knowledge of breast cancer [4]. Research on breast cancer in Ghana confirms that the majority of breast cancer patients (47%–75%) report at the late stage of disease [3, 5] and this implies that many women have advanced breast cancer

(ABC). However, previous research on breast cancer in Ghana [3, 4, 6, 7] has not explored the experiences of women with advanced breast cancer although the incidence is high. It is observed that the majority of women find the diagnosis of advanced disease more stressful than that of early stage breast cancer [8]. The prognosis of advanced disease is, in general, poor [9], so sufferers live with the fear of impending death [8]. Treatments such as chemotherapy and radiotherapy are used to control symptoms, improve quality of life, and prolong survival; however, these can bring about perceived disfigurements and debilitating side effects such as loss of hair and vomiting [10].

Studies that focus exclusively on ABC have explored differences in quality of life when different medical treatments are used [11], rather than on how advanced disease affects women's emotional and psychosocial life. Report from these studies indicates that women with the disease are prone to psychiatric morbidity and issues related to body image and

uncertainty about the future [1, 12]. The breast is an important organ of femininity and emotional responses to the loss of the breast include sadness [4].

Consistent with findings from the Korle-Bu Teaching Hospital, the Oncology Department of Komfo Anokye Teaching Hospital (KATH) also reported that about 51.4% of women presented with stage IV breast cancer from 2004 to 2008 (KATH Records, 2009). The authors of this study observed in their clinical work that ABC presents emotional and psychosocial problems for women in Ghana and these require a systematic exploration. Most people believe that patients with ABC die soon after diagnosis and do not therefore find it worthwhile exploring their experiences. However, women with the disease could live for a number of years [13], and thus their experiences are worth exploring. This study explored the experiences of women with advanced disease in the Kumasi metropolis with a focus on the emotional and psychosocial experiences.

2. Methods

2.1. Design. The study employed a qualitative exploratory descriptive design to answer the research question: What are the emotional and psychosocial experiences of women with ABC? This design was used to explore, understand, and describe the emotional and psychosocial experiences of women diagnosed with advanced breast cancer [14, 15]. The design was also useful since little is known in the area of study: experiences of women with advanced breast cancer in Ghana [16].

2.2. Setting. The study was conducted at KATH in the Kumasi metropolis. The hospital serves patients from across the country and has a bed capacity of about 1,000. It has several departments, including the Oncology Department which was the recruitment outlet. The participants were drawn from the Kumasi metropolis, the second biggest city in Ghana with an estimated population of 1,690,488 [17].

2.3. Inclusion and Exclusion Criteria. Women living in the Kumasi metropolis who have been diagnosed with ABC were included in this study. Participants were purposively recruited to include women diagnosed with ABC who could express themselves in the “Twi” dialect or English (languages the first author could speak fluently) and consented to participate. Women at the terminal stages who found it difficult to communicate were excluded from the study. Also, women with obvious psychiatric disorder were excluded from the study. Obvious psychiatric disorder was identified from the behavior of potential participants, such as mannerisms and inappropriate answers, history from the family, and the healthcare team’s records documented in the women medical folder. This was part of the recruitment screening by the first author. Purposive sampling ensured that women who met the inclusion criteria were recruited.

2.4. Sample Size and Sampling Technique. The sample size of the study was 10. This was determined after the 10th participant was interviewed. The data reached saturation by the 10th

interview as successive participants gave similar responses and no new themes or subthemes were generated. The study employed purposive sampling technique; this allowed sufficient recruitment of participants who met the inclusion criteria for the study. Thus, the first author purposively recruited participants she believed could provide more in-depth information on lived experiences of advanced breast cancer [18]. The oncology unit of the Komfo Anokye Teaching Hospital was the outlet of recruitment. Women diagnosed with advanced breast cancer that came for review at the oncology unit or were referred to the unit and met the inclusion criteria were recruited.

The authors sought formal permission with an introductory letter stating the purpose of the study and gave a copy of the ethical approval to the head of the oncology unit. Two nurses at the oncology unit helped to recruit the participants (recruitment links). The “link nurses” were asked by the authors to give the study’s information sheets to the potential participants. In cases where potential participants could not read and understand the information sheet, the link nurses read and explained the content of the information sheet to them. The authors had a preinterview interaction with the “link nurses” to specify the purpose of the study and the inclusion and exclusion criteria. They were provided with a reminder sheet which spelt out the purpose of the study and inclusion and exclusion criteria and an information sheet (recruitment tool) to give them full information about the study. This helped the nurses to assist in recruiting appropriate participants. The first author’s contact number was made available to the nurses and they alerted the first author when a potential participant was identified. The first author subsequently screened potential participants to confirm their suitability for the study while maintaining confidentiality.

2.5. Data Collection Tool and Procedure. The first author collected the data through face-to-face interviews using a semistructured interview guide. Responses were probed or redirected where necessary to ensure full understanding of the participants’ emotional and psychosocial experiences and also to ensure that interviewees responded within the study objectives. The interview guide was made up of stem questions with probes.

Interview Guide

Main Question. Please can you share with me your story after you were diagnosed with breast cancer?

Subquestions (Probe as Needed)

- (1) Please tell me how you felt when you discovered that you had breast cancer.

Probe:

- (i) So what happened next?
- (ii) So what did the doctors or nurses tell you?

- (2) Please tell me about the treatment you have gone through so far.

Probe:

- (i) After the treatment, what happened?
- (ii) Side effects.
- (iii) Complications.

- (3) Please share with me how you have been managing your life after the diagnosis.

Probe:

- (i) Work.
- (ii) Family support.
- (iii) Marriage.
- (iv) Financial issues.

- (4) Please can you share with me a typical day of your life after the diagnosis?

- (5) Is there anything else you would like to tell me?

All interviews were transcribed from “Twi” (local dialect) to English based on the meaning of the respondents’ comments. The authors discussed the transcription with a person competent in “Twi” and English to ensure accuracy of translation while maintaining confidentiality. Interviews were scheduled at participants’ convenience. All participants preferred to be interviewed in “Twi.” Field notes were written after each interview to include nonverbal cues and researcher’s reflections during the interviews as well as key concerns of the participants.

2.6. Data Analysis. Data was analyzed concurrently with data collection, applying the techniques of content analysis [19]. Transcripts were read several times to make meaning of participants’ responses, and data was managed manually. Initial themes were followed in subsequent interviews and corroborated with field notes to fully develop themes. Validation of individual responses was done by summarizing the key elements in participants’ stories at the end of each interview and confirming the accuracy from the participant. The first author conducted an initial analysis of the data, and the second and the third authors verified findings to ensure that participants’ realities were adequately represented.

2.7. Rigor. Trustworthiness of the study was ensured by the following criteria: credibility, dependability, confirmability, transferability, and authenticity [20]. Member checks at the end of each interview facilitated full understanding and correct presentation of respondent’s stories. Also, detailed description of the research setting, design, methodology, and background of participants ensured potential applicability of the findings in other similar settings and replication of the study by other researchers. Writing detailed field notes helped to ensure the auditability of the study.

2.8. Ethical Approval. Ethical approval was obtained from the Institutional Review Board at the Noguchi Memorial Institute for Medical Research, University of Ghana. Permission was sought from the oncology unit of the Komfo Anokye Teaching Hospital, Kumasi, with an introductory letter and a copy of the ethical approval. The purpose, objectives, and any potential benefits and risks were explained to participants in the language of their choice (Twi) a week before data collection. This allowed participants enough time to consider their participation. Respondents who met the inclusion criteria and understood and agreed to be part of the study were asked to give their consent by signing or thumb printing a consent form. Respondents were informed that they could decline to take part in the study or withdraw from the study even after they had signed the consent form without any consequences. Only the authors had access to the raw data.

Anonymity was ensured by assigning numbers (001 to 010) to each participant during recruitment. Pseudonyms were used later to replace the numbers when quoting verbatim expressions of the participants. The authors arranged with the hospital counsellor to assist the participants who may need counselling after expressing their experiences of living with advanced breast cancer at no cost to them. No participant was referred to the counsellor because the participants regained control over their emotions after sharing their experiences. The participants were assured of anonymity during publications of aspects of this study.

3. Results

3.1. Sample Description. Ten women aged between 32 and 65 participated in the study. Two of the participants were divorced and the rest were married. Table 1 describes other characteristics such as religion, number of years with ABC, number of children, and occupation.

Women in this study described their emotional and psychosocial experiences with ABC. The major themes revealed were emotional reactions, pain, lost hope, support, and coping. The major themes also had subthemes as shown in Table 2.

3.2. Emotional Reactions. Women with ABC experienced emotional reactions such as sadness, fear, and anxiety. They cried for various reasons such as cost of treatment and were afraid of death.

Sadness, Fear, and Anxiety. The majority of the respondents said they cried on hearing that their cancer was advanced. Some lamented the cost of treatment and the suffering that accompanied the disease:

“The drugs are expensive, how do I get such money? This was what made me sad and I cried a lot” (Maame).

The women feared dying from the disease. News about the death of friends and remembering the death of a family member with the disease therefore caused anxiety:

TABLE 1: Demographic characteristics.

Pseudoname	Age	Education background	Religion	Marital status	Number of children	Occupation	Family history of breast cancer	Number of years diagnosed
Afiba	45	Tertiary	Christian	Married	1	Nurse	No	3
Maame	53	Primary	Muslim	Married	1	Trader	Yes	1
Nyamekye	66	None	Christian	Divorced	5	Farmer	Yes	3
Dzifa	65	None	Christian	Married	7	Cleaner	No	1
Asaaba	51	None	Christian	Married	12	Farmer	Yes	1 ^{1/2}
Yaa	58	Primary	Christian	Married	4	Trader	No	2
Ama	31	Tertiary	Christian	Married	None	Teacher	No	3
Aku	58	Middle	Christian	Divorced	2	Trader	No	2
Yaayaa	46	Primary	Christian	Married	4	Cleaner	Yes	2
Mansa	57	Tertiary	Christian	Married	5	Trader	No	1

TABLE 2: Themes and subthemes generated.

Themes	Subthemes
Emotional reactions	Sadness, fear, and anxiety
Pain	Pain characteristics Pain effects Pain management
Lost hope	Marriage and parenting Work
Support	Family and spousal support Workplace support Support of health professionals Spiritual support
Coping	Acceptance The will to live

"Any time I come to the hospital and see or hear about the death of other patients, I know that it will one day be my turn and I am afraid and anxious" (Dzifa).

Family history of breast cancer related death also caused fear of death and anxiety among participants:

"I have the fear that I may die; my aunties died from the same condition. Sometimes I am anxious about what will happen to me. I saw my two aunties suffering before they died" (Asaaba).

3.3. Pain. All the women in this study experienced severe pain. Some of the women stated that others needed to experience "their pain" to understand what they went through and they wished to die. Subthemes of pain characteristics and effects are described.

Pain Characteristics. The women described the characteristics of pain as piercing and burning and did not stop:

"The pain does not stop; even with medication. The pain feels like a burning knife is being used to pierce my breast. It is really painful" (Maame).

Cancer pain was described as "real pain" and was compared to labour pain as follows:

"...maybe you need to go through pain to understand what I mean. When I compare to my labour pains eight years ago, I can say that cancer pain is real pain" (Afiba).

Some of the women could not find appropriate words to describe their excruciating pain:

"I do not even know how to describe the pain for you to understand. It is very painful, intense, and unbearable and it causes me to scream, I am dying" (Asaaba).

Pain Effects. Severe pain prevented the women from eating, sleeping, thinking, or praying. Some participants cried throughout the night because of pain and could not sleep, eat, or pray:

"I cry throughout the night and cannot sleep. I cannot even eat. I cannot think, pray nor do anything because of the pain. My entire mind is always on the pain" (Asaaba).

The intense pain led to suicidal thoughts and most of them wished to die:

"As for me, I prefer to die and end it than to suffer like this" (Asaaba); "I wish to die instead of suffering" (Maame).

Pain Management. The women used prescribed syrup morphine for their pain. However, some did not experience total pain relief after using the syrup morphine and resorted to alternative therapies such as opening of windows to improve ventilation and prayers to cope with pain:

"My doctor gave me syrup morphine when I reported my pain to her. The drug reduces the

severity of my pain but I do not get complete pain relief so I prayed and sometimes open my windows to help me deal with the pain” (Asaaba).

Some employed sleeping on the floor and praying with the rosary:

“I slept on the cold floor and used my rosary to pray when in pain and it sometimes helps” (Dzifa).

3.4. Lost Hopes. A psychosocial implication of ABC included worry over losses related to marriage, parenting, and work. The women described these as “lost hopes” which could not be achieved.

Marriage and Parenting. Three of the married respondents had lost hope in relation to their marriages. Their current status did not attract their husbands’ affection:

“My husband does not show interest in me anymore. My current state does not attract him. He comes home late and sleeps off. What can I do?” (Maame).

Parenting was also an important issue for the women who had children. The women were concerned about the future and the up-bringing of their children since they were not actively involved in nurturing their children:

“My children are young and there is no one to take care of them. The future of my children will be disorganized. If I die; there will be no mother to guide them” (Dzifa).

Work. Some of the women who were self-employed regretted their inability to maintain their businesses because of weakness and side effects of treatment. The businesses were collapsed at the time of the study:

“I do not want to even think about my business because it is one of my biggest worries. That was my only source of income but today it is destroyed by this disease. I do not even have any hope that I will one day restart. Where is the money...?” (Ama).

3.5. Support. The debilitating effect of ABC called for various forms of support for women in this study. All the women received support from spouses, family, friends, workplace, healthcare professionals, and spiritual support. The support helped them to cope with the disease physically, emotionally, psychologically, and socially.

Family and Spousal Support. All participants received physical, emotional, financial, and social support from their families during the diagnosis and treatment of their disease:

“My sisters pay for my treatment. When they visit me, they cry when they see me in pain and they give me emotional support” (Maame).

Some felt their family support was genuine and has helped them cope:

“My sister is really supporting me from her heart and I know that I have been able to cope with this difficulty because of the support she gives me” (Asaaba).

Some of the women had good support from their spouses and this helped them to cope with the disease:

“I am very grateful to God for my husband. He has really helped me; in fact, he does everything for me. I wouldn’t have survived without him and he has helped me to cope with the disease” (Ama).

Some of the husbands gave their wives emotional support:

“My husband’s behaviour has not changed towards me. He advises me when I am sad. He also encourages me to have a positive attitude” (Dzifa).

However, a few did not receive adequate spousal support:

“My husband buys food but he does not have time for me. No affection, attention and care” (Maame).

Workplace Support. Some of the women had support from their bosses and colleagues and were receiving salary at the time of study although they could not work for almost a year of absence:

“My boss told me to rest at home till I feel strong enough to come to work. My monthly salary comes in full and I use it for my treatment and personal needs... sometimes my colleagues at work visit me to help with my grocery shopping” (Afiba).

Support from Health Professionals. The women had adequate support from health care professionals. Some of the women commended the nurses and doctors for teaching and assisting them when they were emotionally disturbed:

“The doctor and the nurse were very supportive. They allowed me to cry and they were standing around me rubbing my back. I was shocked to see the nurse shedding tears. She was empathetic” (Maame).

A participant also reported a negative health professional attitude regarding inadequate pain management:

“The doctors were wicked to me. It was as if they knew I was dying so they did not bother to give me any medications to control my pain. I even said, ‘even if I will die, do I have to die with suffering and pain?’ (Aku).

Spiritual Support. The respondents’ reliance and state of dependency on God were very clear in all the interviews. All the respondents described themselves to be fully dependent on God. Faith, hope, and trust in God and having a relationship with God were the most common experiences; they saw faith as a source of strength. The participants’ relation with God was associated with great optimism and hopefulness:

"Any time I come to the hospital, I pray before I enter. I pray to God to show the doctor my problems and also the drugs that can heal me" (Maame).

Some believed that God can heal them drawing from other miracles in the Bible:

"I have faith in God. He will heal me because He did it for Hannah and Sarah. I know that my healing from cancer is a small thing for God so He will do it for me" (Nyamekye).

Some of the women drew closer to God because of their experience with breast cancer and their pastors also prayed for them:

"Yes, I pray every day. I think this disease has even drawn me closer to God. Now I pray often; . . . it has increased my faith and hope in God. . . sometimes my pastor also visits and prays with me" (Dzifa).

3.6. Coping. The psychological process of grieving ended with the stage of acceptance and some of the women had a strong will to live. These processes helped them to cope with the menace of ABC.

Acceptance. All the women went through the grieving process and were at the acceptance stage at the time of data collection. They all had the "Why me?" stage, were angry, depressed, and accepted; "let His will be done":

"ei! why me? I used to cry everyday, I was angry and sad because of the suffering I was going through. But what can I do? Let the will of God be done" (Maame).

The acceptance of ABC among participants was related to their spiritual beliefs:

"Now it is only God that I look up to; I do not have anything to say, let His will be done" (Nyamekye).

The Will to Live. Some of the women stated that the will to live had kept them strong. They reported consciously suppressing negative thoughts of fear of death:

"I pray positively and I do not entertain negative thoughts. I believe that I will not die but live; this has always been my prayer to God. I am alive today because of this" (Afiba).

4. Discussion

The study revealed some findings that are congruent with the existing literature such as sadness, anxiety, and fear [2, 4]. The breast is an important organ for nurturing and body image for women. It also plays a significant role in intimacy for couples globally. Advanced breast cancer destroys the breast and the woman responds emotionally due to the loss of breast function and the cosmetic effect of ABC [6]. Within the Ghanaian context, late reporting of breast cancer is associated

with influence of spouses who do not allow their wives to undergo breast surgery and seeking spiritual intervention [4]. Women in this study also showed strong reliance on God with some hoping for cure. It can be inferred that religiosity is a significant aspect of the sociocultural context of Ghana and should be acknowledged by health workers [21].

Pain associated with ABC is commonly reported by previous researchers and, in this study, pain was common to all the women. Some of the women experienced pain despite the use of morphine syrup. The women described their pain as severe and intense, not relieved by analgesics. In similar studies, pain expressions by the women were in conformity with this study [2, 22]. A growing body of evidence suggests that the majority of patients with cancer continue to experience pain regardless of pharmacological interventions [23]. There was evidence that pain management was inadequate because of excruciating pain that led to suicidal ideations and sleeplessness in this study. Consistent with these findings, inadequate pain management, lack of support, hopelessness, and other physical symptoms of cancer have been associated with suicidal ideations in other studies [24, 25]. However, within the context of the study, palliative care is not available and women did not benefit from supervised home-care especially for pain management as pertains elsewhere [2]. Health professionals in Ghana do not administer adequate analgesics because of fear of addiction [26]. The nonpharmacological measures adopted by the women should not replace analgesic as these are considered adjuvants for pain management [27]. Lying on the cold floor when in pain should not be encouraged due to possible complications such as hypothermia [28].

The synergistic effects of ABC and the side effects of treatment such as chemotherapy resulted in debilitation, fatigue, and low self-image due to breast wound or loss of breast and metastasis [8]. In view of this, women could not carry out their activities of daily living and perform other roles related to their work, marriage, and mothering. Within the Ghanaian sociocultural context, marriage and childbirth are cherished [29] and women expressed lost hopes because of this sociocultural significance. Also, parenting can be challenging emotionally and physically and the debilitating effect of ABC hindered women's parenting roles as supported by previous researchers [30, 31]. Individuals require good health and energy to work effectively. In this instance, the effect of treatment and disease on women led to their inability to work and those who were self-employed could not sustain their businesses. This shows that women should invest and have alternative sources of income, insure their businesses, or have joint ventures so that their businesses can be maintained during illness. Previous authors argue that having a gainful employment significantly improves quality of life [32, 33]. Several studies from high income countries observed poor health as a factor that compromised cancer patients' ability to work [34, 35]. The feeling of lost hopes, maladaptation, and suicidal ideations could be a result of inadequate support for women in this study.

In the wake of declining ill health, physical strength, and the emotional responses that resulted, women appreciated the support they received from family, spouse, workplace,

and healthcare providers. This need is confirmed by reports from other studies [2, 36]. Forms of support received were physical, emotional, social, financial, and spiritual. Sarpong [22] reported the importance of family network to Ghanaians and the support of family to its members in all aspects of life such as illness, death, birth, education, and marriage. In the current study, women were content with the support they received from their husbands. However, few husbands did not give their wives the required support. This finding means that men should also be educated on breast cancer and encouraged to give their wives the necessary support [4].

Also, financial support from employers was used to defray the cost of treatment for personal needs. Other studies also found similar support from employers and colleagues and women appreciated such support [37, 38]. Within the Ghanaian health system, the national health insurance scheme does not cover all aspects of breast cancer treatment such as chemotherapy. The involvement of coworkers to meet the needs of women points to the need for effective palliative care and integration of cancer care volunteers to help women with ABC.

Health personnel are expected to provide efficient care with empathy. This form of support was satisfactory. However, unsatisfactory care was related to poor pain management. The women received emotional support and teaching on cancer and its treatment from healthcare professionals. In contrast to the present study, Cebeci et al. [39] noted that women in Turkey reported receiving only information on chemotherapy but not psychosocial support from health service providers.

Spiritual support played an important role for the women. They exhibited trust and reliance on God as their ultimate source of healing. All the study participants received regular prayer support from religious ministers and this increased their faith in God and further helped them cope with the challenges of the disease [29]. Women who received adequate support had better coping strategies and hope for the future. "Acceptance" and "the will to live" were the main coping strategies employed by the women in this study. The will to live was demonstrated by the women praying positively and being hopeful for long life despite their suffering. Acceptance in this study implies that the women came to terms with the realities of ABC after an initial shock, denial, anger, and depression which are consistent with the grieving process [40]. The women upon acceptance surrendered their concerns to God and prayed for the will of God to prevail regarding their ABC. Previous authors confirmed that coping measures are important for women with ABC due to the psychological impact on women [2, 41]. A number of studies have explored coping measures and their effect on cancer [39, 41, 42]. These include faith in God, spirituality, acceptance, will to live, seeking for information, and social support. Though support and coping were found to be sources of strength in dealing with debilitating cancer symptoms, some of the participants did not receive adequate financial, physical, and emotional support. They had difficulties coping with the sufferings of advanced breast cancer, leading to depression, lost hope, and a feeling of neglect.

Understanding the lived experiences of women with ABC can help nurses provide appropriate care that meet the needs

of patients. Nurses should be committed to administer analgesics to control cancer pain and educate patients about their disease and its effects. To promote early detection of breast cancer, nurses and other women organizations should be actively involved in breast education and screening programs. Early detection can lead to cure and possible breast preservation. Also, nurses should collaborate effectively with other professionals to provide effective end of life care for women with ABC.

An important limitation of the study is the absence of men among the group studied since 1% of the population of men is at risk of developing breast cancer. It is likely that men diagnosed with ABC in Ghana have different life experiences from women. Also, further investigations could compare the experiences of women with ABC and that of women with early-stage breast cancer. It is also necessary to investigate the knowledge and attitude of nurses on ABC and palliative care in Ghana.

5. Conclusion

Pain was acknowledged as a distressing symptom of advanced breast disease. Inadequate pain management affected women's quality of life and further influenced their will to live. Spirituality was a source of support and it increased the faith and hopes of the women and kept them going despite the sufferings of advanced disease. The participants also received physical, emotional, and financial support from family, spouses, workplace, and health professionals though some conflicts occurred during these interactions. Support was a significant determinant of good coping. On the other hand, women who did not receive the necessary support had difficulties coping with the sufferings of the disease and experienced lost hopes. It is important for women with ABC to receive necessary care and pain management to prevent suicide and also help improve their quality of life. The need for palliative care services is highlighted within the context of this study.

Conflict of Interests

The authors declare that there is no conflict of interests regarding this research and publication.

References

- [1] S. Aranda, P. Schofield, L. Weih et al., "Mapping the quality of life and unmet needs of urban women with metastatic breast cancer," *European Journal of Cancer Care*, vol. 14, no. 3, pp. 211–222, 2005.
- [2] M. A. A. Doumit, H. Abu-Saad Huijjer, and J. H. Kelley, "The lived experience of Lebanese oncology patients receiving palliative care," *European Journal of Oncology Nursing*, vol. 11, no. 4, pp. 309–319, 2007.
- [3] J. N. A. Clegg-Lamprey and W. M. Hodasi, "A study of breast cancer in Korle-Bu teaching hospital: assessing the impact of health education," *Ghana Medical Journal*, vol. 41, pp. 72–77, 2007.

- [4] L. Aziato and J. N. Clegg-Lamprey, "Breast cancer diagnosis and factors influencing treatment decisions in Ghana," *Health Care for Women International*, 2014.
- [5] M. Ohene-Yeboah and E. Adjei, "Breast cancer in Kumasi, Ghana," *Ghana Medical Journal*, vol. 46, no. 1, pp. 8–13, 2012.
- [6] L. Aziato, "Post-mastectomy experiences of women with breast cancer in the Accra metropolis," *West African Journal of Nursing*, vol. 20, pp. 51–57, 2009.
- [7] . Opoku S, M. Benwell, and J. Yarney, "Knowledge, attitudes, beliefs, behaviour and breast cancer screening practices in Ghana," *European Journal of Cancer Supplements*, vol. 8, article 16, 2010.
- [8] R. P. Vilhauer, "A qualitative study of the experiences of women with metastatic breast cancer," *Palliative & Supportive Care*, vol. 6, no. 3, pp. 249–258, 2008.
- [9] J. E. Price, "Concepts and mechanisms of breast cancer metastasis," in *The Breast: Comprehensive Management of Benign and Malignant Disorders*, K. I. Bland and E. M. Copeland, Eds., Elsevier, St. Louis, Miss, USA, 2004.
- [10] L. Aziato, "Post-mastectomy experiences of women with breast cancer in the Accra metropolis," in *Nursing*, University of Ghana, Accra, Ghana, 2006.
- [11] E. Reed, P. Simmonds, J. Haviland, and J. Corner, "Quality of life and experience of care in women with metastatic breast cancer: a cross-sectional survey," *Journal of Pain and Symptom Management*, vol. 43, no. 4, pp. 747–758, 2012.
- [12] M. Warren, "Uncertainty, lack of control and emotional functioning in women with metastatic breast cancer: a review and secondary analysis of the literature using the critical appraisal technique," *European Journal of Cancer Care*, vol. 19, no. 5, pp. 564–574, 2010.
- [13] A. K. Conlin and A. D. Seidman, "Beyond cytotoxic chemotherapy for the first-line treatment of HER2-negative, hormone-insensitive metastatic breast cancer: current status and future opportunities," *Clinical Breast Cancer*, vol. 8, no. 3, pp. 215–223, 2008.
- [14] M. J. Mayan, *An Introduction to Qualitative Methods: Training Modulation for Students and Professionals*, International Institute for Qualitative Methodology, University of Alberta, Alberta, Canada, 2001.
- [15] M. J. Mayan, *Essentials of Qualitative Inquiry*, Left Coast Press, Walnut Creek, Calif, USA, 2009.
- [16] A. S. de Vos, H. Strydom, C. B. Fouché, and Delpont C. S. L., *Research at Grass Roots: For the Social Sciences and Human Service Professions*, Van Schaik, Pretoria, South Africa, 4th edition, 2011.
- [17] Ghana Health Service, *2011 Population and Housing Census Summary Report of Final Report*, Kumasi, Ghana, 2011.
- [18] D. F. Polit and C. T. Beck, *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, Lippincott Williams & Wilkins, 8th edition, 2008.
- [19] M. B. Miles and A. M. Huberman, *Qualitative Data Analysis: An Expanded Sourcebook*, Sage, Newberg Park, Calif, USA, 2nd edition, 1994.
- [20] E. G. Guba and Y. S. Lincoln, *Effective Evaluation: Improving the Usefulness of Evaluation Results through Responsive and Naturalistic Approaches*, Jossey-Bass, San Francisco, Calif, USA, 1981.
- [21] B. M. Sackey, "Faith healing and women's reproductive health," *Institute of African Studies Research Review*, vol. 18, no. 1, pp. 5–12, 2002.
- [22] P. Sarpong, *Ghana in Retrospect*, Ghana Publishing Corporation, Tema, Ghana, 1975.
- [23] L. R. Gauthier, G. Rodin, C. Zimmermann et al., "Acceptance of pain: a study in patients with advanced cancer," *Pain*, vol. 143, no. 1-2, pp. 147–154, 2009.
- [24] E. J. Shim and B. J. Hahm, "Anxiety, helplessness/hopelessness and 'desire for hastened death' in Korean cancer patients," *European Journal of Cancer Care*, vol. 20, no. 3, pp. 395–402, 2011.
- [25] G. Rodin, C. Zimmermann, A. Rydall et al., "The desire for hastened death in patients with metastatic cancer," *Journal of Pain and Symptom Management*, vol. 33, no. 6, pp. 661–675, 2007.
- [26] L. Aziato and O. Adejumo, "The ghanaian surgical nurse and postoperative pain management: a clinical ethnographic insight," *Pain Management Nursing*, vol. 15, no. 1, pp. 265–272, 2013.
- [27] L. A. Menefee and D. A. Monti, "Nonpharmacologic and complementary approaches to cancer pain management," *The Journal of the American Osteopathic Association*, vol. 105, no. 11, supplement 5, pp. S15–S20, 2005.
- [28] B. Knobel and A. Mikhlin, "Severe accidental hypothermia in an elderly woman," *Harefuah*, vol. 140, no. 11, pp. 1014–1119, 2001.
- [29] G. K. Nukunya, *Tradition and Change: An Introduction to Sociology*, Ghana Universities Press, Accra, Ghana, 2nd edition, 2003.
- [30] C. Fisher and M. O'Connor, "'motherhood' in the context of living with breast cancer," *Cancer Nursing*, vol. 35, no. 2, pp. 157–163, 2012.
- [31] H. J. Campbell-Enns and R. L. Woodgate, "Decision making for mothers with cancer: maintaining the mother-child bond," *European Journal of Oncology Nursing*, vol. 17, no. 3, pp. 261–268, 2013.
- [32] D. M. Rasmussen and B. Elverdam, "The meaning of work and working life after cancer: an interview study," *Psycho-Oncology*, vol. 17, no. 12, pp. 1232–1238, 2008.
- [33] L. M. Frazier, V. A. Miller, D. V. Horbelt, J. E. Delmore, B. E. Miller, and E. P. Averett, "Employment and quality of survivorship among women with cancer: domains not captured by quality of life instruments," *Cancer Control*, vol. 16, no. 1, pp. 57–65, 2009.
- [34] C. J. Bradley, D. Neumark, Z. Luo, and M. Schenk, "Employment and cancer: findings from a longitudinal study of breast and prostate cancer survivors," *Cancer Investigation*, vol. 25, no. 1, pp. 47–54, 2007.
- [35] P. F. Short, J. J. Vasey, and R. BeLue, "Work disability associated with cancer survivorship and other chronic conditions," *Psycho-Oncology*, vol. 17, no. 1, pp. 91–97, 2008.
- [36] J. Julkunen, M. Gustavsson-Lilius, and P. Hietanen, "Anger expression, partner support, and quality of life in cancer patients," *Journal of Psychosomatic Research*, vol. 66, no. 3, pp. 235–244, 2009.
- [37] F. Kennedy, C. Haslam, F. Munir, and J. Pryce, "Returning to work following cancer: a qualitative exploratory study into the experience of returning to work following cancer," *European Journal of Cancer Care*, vol. 16, no. 1, pp. 17–25, 2007.

- [38] A. Johnsson, T. Fornander, L. E. Rutqvist, and M. Olsson, "Factors influencing return to work: a narrative study of women treated for breast cancer," *European Journal of Cancer Care*, vol. 19, no. 3, pp. 317–323, 2010.
- [39] F. Cebeci, H. B. Yangin, and A. Tekeli, "Life experiences of women with breast cancer in south western Turkey: a qualitative study," *European Journal of Oncology Nursing*, vol. 16, no. 4, pp. 406–412, 2012.
- [40] F. R. Nedjat-Haiem, K. A. Lorenz, K. Ell, A. Hamilton, and L. Palinkas, "Experiences with advanced cancer among latinass in a public health care system," *Journal of Pain and Symptom Management*, vol. 43, no. 6, pp. 1013–1024, 2012.
- [41] H. Svensson, Y. Brandberg, Z. Einbeigi, T. Hatschek, and K. Ahlberg, "Psychological reactions to progression of metastatic breast cancer—an interview study," *Cancer Nursing*, vol. 32, no. 1, pp. 55–63, 2009.
- [42] M. A. A. Doumit, N. El Saghir, H. Abu-Saad Huijjer, J. H. Kelley, and N. Nassar, "Living with breast cancer, a Lebanese experience," *European Journal of Oncology Nursing*, vol. 14, no. 1, pp. 42–48, 2010.

