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Pepperdine University
Graduate School of Education and Psychology

THE JOURNEY OF FEMALE CANCER PATIENTS OR SURVIVORS WHILE STRIVING
FOR PERSONAL WORK-LIFE BALANCE

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Education in Organizational Leadership

by

Stacy Rothberg

December, 2014

Margaret Weber, Ph.D. – Dissertation Chairperson

This dissertation, written by

Stacy Rothberg

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

Doctoral Committee:

Margaret Weber, Ph.D., Chairperson

Maire Mullins, Ph.D.

Judge John Tobin, J.D.

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DEDICATION

This dissertation is entirely possible because of God's love, faithfulness, and provisions. I am dedicating this research to my Grandma Bobbie and women who wrestled with cancer and work-life balance. I am deeply grateful to my family, West LA 2010 cohort, and friends who encouraged and supported me during this doctoral journey. My family is an incredible blessing. Their love and support means the world to me. My mom's love, prayers, and her guidance continue to be an inspiration. My grandparents (Grandpa Bruce, Grandma Bobbie, Grandpa Gordy, and Grandma Janet) provided wise, grounding advice and constant support. My immediate family (Mom, Dad, Aaron, Jason, and Suzie) rallied around me, along with my Aunt Sue, cousins, and their families.

These friends especially inspired me to embark on this journey: Dr. Jacob Diaz, Dr. Kerri Heath, Dr. Craig Johnson, Dr. Michael Zoll, Dr. Mark Davis, Ilaria Pesco, Jim "JB" Brock, Denise Taylor, and Tabatha Jones. Amy Dellar, Allison Jerome, Chasidy Murphy, Kirsten Vassie, and Deborah Miller cheered me on when it was challenging. While my cohort made the journey more fulfilling and memorable, three friends were a true gift: Dr. Hughie Barnes, Dr. Renee Dorn, and Jeany Choi.

My pastor and faith community, Bethel Christian Fellowship, has been a source of strength and encouragement. My Semester At Sea friends provided motivation and support. Finally, the Pepperdine community was accommodating, helpful, and understanding as I navigated work-life balance during my doctoral pursuits. The Pepperdine support and encouragement made it possible, especially with the late nights of studying and writing. For all of the love, prayers, and support that I received, I want to extend my deep heartfelt gratitude.

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It takes a village to complete a doctorate. I am grateful to my mentor and chair, Dr. Margaret Weber. Her expertise, guidance, and constant support were invaluable. Dr. Maire Mullins and Dr./Judge John Tobin were wise and caring committee members. Their knowledge, feedback, and encouragement were inspiring. Dr. Janet Giele led the way with her pioneering research on women and work-life balance. Her motivational advice and theoretical framework caused this study come to life.

The Digital Women's Project research team members were excellent role models and guiding resources. Our research team cultivated mentors and advisors throughout the key steps of the dissertation process. Dr. Kerri Heath, Dr. Crystal Jensen, and Dr. Sudonna Moss were especially helpful in critical moments.

A special thank you to Christie Dailo who always answered my questions and guided me through the administrative processes. Stuart Robertson was a NVivo "Jedi". Michelle McMahon, Tom McMahon, Dr. Hughie Barnes, Dr. Renee Dorn, and Ilaria Pesco were excellent editors during my writing journey.

This doctoral journey was fueled by prayer, especially during statistics, Comps, and the dissertation writing process. My pastor, Dr. Craig Johnson, has provided a timely word and prayers when desperately needed. My mom prays without ceasing, and it sustained me in more ways than I can imagine. Dr. Hughie Barnes, Dr. Renee Dorn, Angela Robinson, Jeany Choi, Lolly Kudryashov, and Ilaria Pesco were friends that were available to pray with me throughout the doctoral challenges and celebrations. Finally, I am deeply grateful to Dr. Mark Davis for his prayers, support, and accommodating work environment during my four-year doctoral journey.

VITA

Stacy Rothberg*Education*

Doctor of Education, Organizational Leadership Pepperdine University, Malibu, California Dissertation: The Journey of Female Cancer Patients or Survivors While Striving For Personal Work-Life Balance	May 2014
Master of Arts, Educational Counseling, Summa Cum Laude University of Redlands, Redlands, California	May 1995
Bachelor of Arts, Communication Studies Westmont College, Santa Barbara, California	May 1992

Professional Experience

ASSOCIATE DEAN OF STUDENTS Student Affairs, Pepperdine University, Malibu, California	August 2009 – Present
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Significant Accomplishments:

- Cultivated new campus traditions to promote student engagement with the university and broader community, including Pepperdine's first Christmas tree lighting in the town square and facilitating annual Relay for Life
- Provided leadership for meal plan changes and new food service hours of operation by facilitating focus groups and incorporating feedback into executive-level decisions
- Improved the transfer student experience by identifying unique needs and making programmatic changes for upcoming academic years

General Responsibilities:

- Improve student satisfaction with dining services by leading monthly food committee meetings; organizing theme dinners; and addressing student, parent and departmental concerns
- Serve on the student of concern committee, which provides additional support and resources for student success
- Responsible for the safety and well-being of commuter students
- Provide on-site emergency response coordination for relocation efforts, focusing on coordination of emergency food preparation
- Serve on the dean's council to address the following initiatives: strategic planning, reallocation, policy review and staff morale/development
- Advise student-led Colleges Against Cancer club and oversee their educational and programmatic endeavors, including Pepperdine's annual Relay For Life

DEAN OF STUDENTS**January 2014 – May 2014****Semester At Sea, Institute for Shipboard Education, University of Virginia, MV Explorer, Spring 2014 Voyage**

- Supervised 7-person student life team comprised of resident directors and assistant dean of student life, while closely partnering with psychologists and medical team
- Coordinated care for the safety and well-being for 550 students
- Served on administrative leadership team and duty dean for multiple 24-hour rotations while in port at 12 different countries
- Initiated new leadership endeavors and program initiatives, including a celebration for the 50th Anniversary of Semester at Sea
- Cultivated a respectful, engaging learning community in partnership with faculty and administrative team

DEAN OF STUDENTS**June 2009 – August 2009****Semester At Sea, Institute for Shipboard Education, University of Virginia, MV Explorer, Summer 2009 Voyage**

- Supervised a 14-person living learning team comprised of living learning coordinators, counselors, dependent child coordinator, security officer, and life long learners coordinator
- Served on the administrative team and as duty dean for multiple 24-hour rotations while in port at ten different countries
- Coordinated care for the safety and well-being for 740 students
- Cultivated a respectful, engaging learning community in partnership with faculty and the administrative team
- Initiated new leadership structure and program initiatives for the living learning team

ASSOCIATE DEAN OF STUDENTS**July 2002 – June 2009****Housing and Community Living, Pepperdine University, Malibu, California****Significant Accomplishments:**

- Revitalized the residence life program and integrated the spiritual life advisor program into community living
- Improved collaboration and response for emergencies and critical incidents in the residential community
- Enhanced student satisfaction level with housing and residential life's services
- Led the development of new departmental name, mission, and vision for housing and community living beginning in 2002
- Provided leadership, support, and direction during significant staff transition and changes from 2008-2009

General Responsibilities:

- Oversaw 15 staff members and the operation of department offices
- Administered an operating budget of over \$18 million
- Responsible for the safety and well-being of 2,100 students living in residential community
- Supervised the director of housing and director of community living and led organizational goals

- Provided leadership on the student affairs dean's council for the following issues: staff morale and development, strategic planning, budgetary review, program and policy review, consultation on judicial processes, administrative details and on-going pertinent issues
- Coordinated the Residential Emergency Response Team, provided on-site emergency response coordination and served as point of contact for emergency calls from HCL, public safety and dean of student affairs
- Developed and maintained a strategic plan and assessment program
- Trained the international program resident advisors for the academic years of 2002-2004
- Assisted student evacuees of Hurricane Katrina with their transition to Pepperdine and led Seaver College Katrina relief efforts
- Coordinated Pepperdine's annual "Locks of Love" event during the spring semesters of 2003-2009
- Initiated Pepperdine's Relay For Life in 2008 and continued the endeavor annually

DIRECTOR OF RESIDENCE LIFE

September 2000 – June 2002

Housing and Residence Life, Tulane University, New Orleans, Louisiana

Significant Accomplishments:

- Initiated and cultivated the Louisiana alumni chapter for Semester at Sea (2001 – 2002)
- Implemented the newly created Leadership Foundation Experience, a collaborative project in student affairs focusing on a common development experience for all students interested in leadership
- Collaborated extensively with student affairs colleagues, university faculty and staff members on diversity initiatives, implementation of new alcohol policies, first-year experience program and current Tulane interdisciplinary experience project
- Redesigned programming requirements to emphasize campus engagement, community involvement, safety and personal welfare of residential community
- Created the Residence Hall Association Finance Board, a student-led programming board with an annual budget of \$10,000

General Responsibilities:

- Coordinated staff selection and training for seven area directors, 12 senior staff members, 115 resident advisors and two graduate students
- Supervised seven area directors in all of residence life
- Administered an operating budget of over \$300,000
- Provided leadership for residence life functions, including crisis management, community development, student development, counseling, involvement and leadership opportunities, and general administration
- Oversaw all programming and administration of policies and procedures in 15 residence halls housing 3,400 diverse students
- Developed department-wide initiatives and strategic plans with the central staff management team
- Planned departmental community service and weekend alternative programs
- Conducted successful recruitment, selection and hiring of six area directors for spring 2001

RESIDENT STAFF **June 2000 – August 2000**
Semester at Sea, Institute for Shipboard Education, University of Pittsburgh, Summer 2000
Voyage

Significant Accomplishments:

- Coordinated social events for the entire shipboard community, including special student-faculty interaction activities
- Selected as trip leader for a four-day comprehensive tour of Israel for 150 students

General Responsibilities:

- Ensured the safety and well-being of 60 students who lived on my "sea"
- Performed administrative tasks, including debarkation, embarkation, duty rotations, documentation and follow-up with students
- Assisted contracted tour guides with expeditions in Spain, Norway, Russia and Belgium
- Provided alcohol-free entertainment for students as an alternative to the ship's "Taverna"
- Planned the closing appreciation event for faculty, crew and staff members of the shipboard community

AREA DIRECTOR **January 2000 - May 2000**
Housing and Residence Life, Tulane University, New Orleans, Louisiana

Significant Accomplishments:

- Provided leadership, support and continuity for student staff after a mid-year supervisory change
- Assisted staff in navigating departmental change during leadership restructuring

General Responsibilities:

- Operated a four-building complex that housed approximately 650 residents and implemented educational programs and policies for staff, residents and facilities
- Supervised a staff of 20 resident advisors, 15 desk service coordinators, two assistant resident directors and an administrative assistant
- Assisted in the selection of new resident advisors and coordination of staff retreat and training
- Facilitated all judicial affairs related to policy violations and community concerns
- Counseled residents and staff regarding issues of alcohol, depression, roommate conflicts and academics

DIRECTOR OF HOUSING AND RESIDENCE LIFE **June 1997 - December 1999**
Tropicana Gardens, Santa Barbara, California

Significant Accomplishments:

- Administered an operating and residential program budget of \$3.5 million, which included responsibility for both income and expenses
- Led a comprehensive management team consisting of the assistant director, facility director, contracts manager and front desk supervisor
- Oversaw the design, construction and installation of the internet connection system
- Provided excellent service to the Michael Jordan Flight School and Nike Basketball Camp during the summers

General Responsibilities:

- Directed all aspects of contract management, including marketing, retention, application process, room allocation, payment and collection procedures
- Responsible for production and implementation of comprehensive marketing plan in pursuit of maintaining 100% occupancy
- Managed the daily operations of a privately owned, university affiliated, apartment style residence hall housing 450 residents in 108 units
- Orchestrated all operations of summer conferences, including staff selection, supervision, training, contract negotiations; and served as liaison with camp directors, food services and custodial operations
- Developed and implemented policies and judicial processes, including educational sanctions, probation and eviction
- Counseled and advised students regarding academics, relationships, health issues and financial matters
- Consulted daily with Bon Appetit to ensure quality and consistency in the food program for residents
- Worked cooperatively with support services at the University of California, Santa Barbara to assist to students

RESIDENT DIRECTOR**August 1995 - June 1997****Housing and Residence Life, Tulane University, New Orleans, Louisiana****Significant Accomplishments:**

- Managed an expense budget of \$870,000
- Directed programming for the following special interest floors: world issues, pre-law, pre-med, healthy lifestyles and creative arts
- Planned fall and spring training with the director of residence life for 115 residence advisors
- Coordinated English as a Second Language (ESL) and freshman overflow housing programs at neighboring Loyola University

General Responsibilities:

- Supervised a residence hall housing 500 coed, first-year students facing college adjustment issues
- Selected, trained and supervised 21 resident advisors, 17 desk service coordinators, two assistant resident directors and an administrative assistant
- Adjudicated infractions of code of student conduct and served as an advisor to students who faced suspension or expulsion from the university
- Advised Monroe Hall Council and social programming efforts
- Served as public safety liaison and residence hall association advisor

COMPLEX DIRECTOR**September 1994 - June 1995****Student Life, University of Redlands, Redlands, California**

- Supervised two coed residence halls with 275 first-year and upper-class students
- Selected, trained, supervised and evaluated the assistant resident director and ten resident advisors
- Assisted and advised students with academic, social and personal concerns

- Promoted educational and social programming
- Developed and presented in-service training for hall staff, student government leaders and intervention team
- Served as on-duty professional staff member to provide emergency assistance and crisis intervention

RESIDENT DIRECTOR

September 1993 - June 1994

Student Life, University of Redlands, Redlands, California

- Developed and promoted compliance with community standards in coed residence hall with 160 first-year and second-year students
- Supervised and evaluated six resident advisors
- Created educational and social programming to increase student engagement and community development
- Raised over \$1,500 for hall programming through activities involving students and staff

Professional Memberships and Leadership

Planning Committee, Celebrate Women's Wisdom: Life Journeys Conference, Pepperdine University (2013)

Committee Member, Digital Women's Project and Research Team, Pepperdine University (2012-2013)

National Association of Student Personnel Administrators (NASPA)

- Volunteer Committee, Western Regional Conference (2011)
- Program Committee, National Annual Conference (2009)
- Professional Development Committee, Region 6 (Southern California) (2004-2007)

Committee Member, Leanne Knot Violence Against Women Council (2001-2002)

Committee Member, Louisiana Collegiate Leadership Conference (2002)

Advisor, Southwestern Association of College and University Residence Halls Conference (2001, 2002)

Western Training Institute (WIT) Conference

- Co-Chair (1999)
- Committee Member (1998)

Host Committee, Western Association of College and University Housing Officers Conference (1998)

Host Committee, Association of Conference and Events Directors International Risk Management Conference (1997)

Host Committee, Association of College and University Housing Officers International Marketing Workshop (1996)

Presentations

Rothberg, S. (2011, March). *Creating the Space Where Faith Cultivates Passion and Purpose*. Presentation delivered at NASPA Annual Conference, Philadelphia, PA.

Rothberg, S. (2010, March). *How Faith Based Institutions Live Out Their Legacy*. Presentation delivered at NASPA Annual Conference, Chicago, IL.

- Rothberg, S. (2007, 2008, April). *My Experience in Student Affairs*, Lecture presented at California Lutheran University Higher Education Class, Thousand Oaks, CA.
- Rothberg, S. (2007, October). *Developing the Skill of Intergroup Dialogue Through Interpersonal Relations, Oral Communication, Active Listening and Multicultural Competency*. Two-day workshop facilitated at NASPA Western Regional: New Professional/Graduate Student Institute, Las Vegas, NV.
- Rothberg, S. (2006, April). *Facebook and MySpace: Navigation of On-line Communities and Exploring Institutional Responses*. Presentation delivered at NASPA Drive-In Conference, Malibu, CA.
- Rothberg, S. (2006, February). *A Strengths Based Approach to Help Students Discover a Sense of Calling*. Presentation delivered at the Institute on College Student Values, Tallahassee, FL.
- Rothberg, S. (2005, 2006, 2007, February). *What Are Employers Looking For?* Presentation delivered at NASPA Drive-In Conference, Orange, CA.
- Rothberg, S. (2005, April). *Assessment Process and Learning Outcomes*. Coordinated conference at NASPA Drive-In Conference, Malibu, CA.

Honors and Awards

- Student Affairs Staff Member of the Month, Pepperdine University (July 2012)
- Student Affairs Recognition of Service Excellence (ROSE) award recipient, Pepperdine University (December 2008)
- Student Affairs Recognition of Service Excellence (ROSE) award recipient, Pepperdine University (October 2002)
- Outstanding Graduate Student in Counseling, University of Redlands (1995)

Training and Certifications

- Certified Strengths Performance Coach, Clifton StrengthsFinder, Gallup Organization (2006)
- Strengths Training Workshop, Gallup Organization, Pepperdine University (2004)
- Multi-Cultural Communication Training, Lillian Roybal-Rose Three Day Workshop (1997-1999)
- Certified Women's Self Defense Instructor, Rape Aggression Defense Model (1996-1997)
- Certified in CPR, First Aid; Disasters and Shelter Operations Training (1996-1997)

ABSTRACT

This phenomenological study explored how cancer impacted female patients or survivors while striving for personal work-life balance. Since female cancer patients and survivors encounter unique stressors, challenges, and experiences related to their cancer journey, this study examined the narratives of 10 women identified as having cancer and a comparison group matched on age via random sample for the birth year. The 20 narratives were a subset of the larger Weber (2011) sample collected by Digital Women's Project research team. The foundational theoretical framework is provided by Giele's (2008) life story method, which analyzed narratives through the lenses of identity, relationship style, drive and motivation, and adaptive styles of women.

However, this study focused on the following two themes: drive and motivation and adaptive style. The personal experiences of the ten diverse women, who received a cancer diagnosis (Group A), described ways that cancer changed their lives. The comparative sample of women without cancer diagnoses (Group B) were also analyzed along these themes. The findings reveal the differences between Group A and B with their outlook, lifestyles, and how work-life balance was navigated. Successful strategies of navigating work-life balance for the two groups were explored: faith, support systems, healthy lifestyle, resources, therapy, and hobbies.

Chapter 1: Introduction of the Study

This dissertation explored the challenge to maintain work-life balance faced by employed women diagnosed with cancer and cancer survivors who returned to work. It illuminated the ways in which women balanced their health challenges with their personal work-lives. It identified how supervisors and employers could better support female employees with cancer. Since cancer treatments have improved, the number of cancer survivors has increased internationally, which has resulted in more employees living with cancer. This study offered solutions that could be utilized by employers to better meet the needs of those employees. Additionally, strategies were offered for family members to provide better support, including creating a more encouraging home environment.

Background of the Problem

Women's reality of work-life balance proved to be multifaceted and involved juggling competing priorities. It required women to find equilibrium between work and non-work roles (Rothbard, Philips, & Dumas, 2005). As of 2010, women made up half of the workforce (Savitsky, 2010). When demographics changed the American workplace, women found themselves in the roles of providing for their families. "Today, around four out of every ten families depend on an unmarried woman's earnings as primary support" (p. 175). As women were bearing the burden of primary support, work-life balance became even more difficult. This was evidenced by Strategy One's survey where 89% viewed work-life balance as a challenge and 54% struggled significantly with it (PR Newswire, "Amid Economic Woes, Americans Still Seriously Concerned About Work/Life Balance").

The prevalence of cancer, along with early detection and improved treatments, resulted in an increased number of cancer survivors. With more effective treatment interventions, many

cancer patients resumed their normal activities. As a result, more cancer patients worked during and after treatment.

Besides employment earnings and benefits being necessary for a woman's financial livelihood, work was also a significant part of her identity and a place where social interaction occurred. For those struggling with cancer, resuming work helped them regain feelings of control and normalcy. For others, it was a distraction from adjusting to having a serious, life-threatening illness (Nowrouzi, Lightfoot, Cote, and Watson, 2009).

Statement of the Problem

Female cancer patients and survivors encountered unique identity challenges, stressors, and specific experiences while trying to balance their health needs and work-life issues. This study explored, through narratives of women with cancer or cancer survivors, how they navigated the impact of cancer while trying to achieve personal work-life balance. Through personal accounts, strategies were identified for families and employers to provide a more supportive environment during that journey.

For female employees living with cancer, there were specific identity issues and challenges that arose. Some of their fears, concerns, and health considerations were related to how cancer affected relationships and caused feelings of inadequacy. They also experienced concerns about becoming the subject of gossip or having their work capacity questioned (Tiedtke, de Rijik, de Casterie, Christiaens, and Donceel, 2009). Women also dealt with feeling out of control related to “coping with fears about the future, negotiating medical treatments, dealing with emotional ups and downs, shifts in self identity, and role changes at work and home” (Blow et al., 2011, p. 1316).

Along with the emotional challenges, there was a "balancing act" of negotiating the needs of others while caring for self. During that time, women also navigated physical distress, which included fatigue, any physical changes, disfigurement, pain, and decreased cognitive functioning (Nowrouzi et al., 2009). This also included the possibility of accepting any changes with physical appearance and hair loss (Tiedtke et al., 2009). However, the biggest challenge for most women was asking for help, setting boundaries, and learning how to accept help (Sulik, 2007).

As a result of cancer's prevalence, economic necessity of employment, and ability for people to manage cancer more effectively, more cancer patients worked during and after treatment. As described, women experienced cancer uniquely and should be provided essential support related to their societal, cultural, and work roles. Due to these factors, there were definite implications for work environment and practices related to how support could be provided to female employees with cancer.

Dickerson (2004) recognized the demands of juggling multiple roles increased women's emotional and mental stress. Many women struggled with identity issues and believed they were "not doing it right, being good enough or being heard or understood" (p. 338). With the additional burden of being a cancer survivor, the pressure intensified. As a result of the pressures and increased expectations, self-doubt, poor self-image, and feeling like a failure often transpired.

In addition to addressing the identity stressors, the dominant societal scripts and family expectations needed to be managed. In order for cancer survivors to successfully balance the competing priorities, there needed to be a resocialization of dominant cultural scripts as well as strategies to manage uncertainties and caring for self (Sulik, 2007). This study addressed the

problems of identity challenges, stressors, and specific experiences that female cancer survivors encountered when they balanced their health and work-life issues.

Statement of the Purpose

The purpose of this phenomenological study explored how having cancer impacted female cancer patients or survivors' ability to achieve balance in their personal and professional lives. Creswell (2007) described phenomenological study as "the meaning for several individuals of their lived experience of a concept or a phenomenon" (p. 57). The women who had cancer shared their experiences as they related to having cancer and navigating work-life balance. This research was important because it provided insights, effective strategies, and practical advice for female cancer survivors attempting to navigate and achieve work-life balance. By exploring narratives and Giele's life course method (2008), a broader approach was gained in understanding the competing needs and priorities of female cancer survivors striving to achieve work-life balance. The interviews illuminated additional factors involved in work-life balance when someone's health was compromised and the future was unknown.

The goal of this study was to identify effective strategies which provided support for female cancer survivors balancing personal and professional demands. Additionally, the wisdom and lessons learned from cancer survivors were utilized to create practical resource tips for women newly diagnosed with cancer. Such resources could be utilized for support groups and decision making in regards to feasibility of work-life balance. Through these findings, resources could be created to provide support to female cancer patients or survivors balancing competing priorities. This information could be used to help organizations better understand female cancer patients or survivors' needs as employees balancing personal and professional demands.

If employers had a better understanding regarding the needs of women with cancer navigating work-life balance, this would offer a work environment with more sensitivity and better support. It was found important for supervisors and employers to be aware of the effects of cancer and the treatments on the employee (Nowrouzi et al., 2009). Recognition of female employees' unique needs, related to having cancer, required knowledge of mental and physical considerations for employees with cancer, better employment resources, and improved practices.

If supervisors and employers were able to provide a more sensitive work environment, specifically in regards to interactions with the employee with cancer, and encouraging coworkers' improved understanding and sensitivity, this would go a long way in recognizing the unique needs of these employees. It was recognized that "particular points of attention are appearance and uncertainty about work ability after treatment" (Tiedtke et al., 2009, p. 683). Tiedtke et. al., suggested that human resources, employers, and insurance companies be mindful of appropriate communication and consider being active in a supportive role. As a result of education including awareness of sensitivity issues, employers were able to more effectively accommodate a female employee with cancer. Examples of effective employer strategies during treatment and the re-integration process were modified hours, flexibility with duties, and allowing women with cancer to stay professionally active, which provided needed personal and emotional support.

It was helpful if organizations provided practical employee support, including flexible schedules for medical appointments and sick days as needed. If there was access to special paid time for necessary medical leave (surgery, recovery, etc.), then that provided relief from some of the financial stressors. Also, when women with cancer returned to work, there were sometimes necessary accommodations related to job duties, working hours, and flexibility needed for doctor

appointments and health. It was also beneficial for employers to be aware of problems related to work incapacity and work-place integration (Tiedtke et al., 2009). The purpose of this study was to demonstrate effective ways of supporting employees while they navigated and adjusted to living with cancer.

Significant Prior Research

Theoretical framework. A foundational element for this specific study was provided by Giele's (2008) theoretical framework, which used the narrative and life story method. Giele's research focused on women's experiences through the lenses of identity, relationship style, drive and motivation, and adaptive style. These experiences shaped women's life course methods and the decisions they made regarding work-life balance. However, this study utilized motivation and goals, along with adaptive style, to the research questions guiding this study.

Research Approach and Methodology

Research. Weber (2011) replicated Giele's (2008) study, which focused on identity and work-life balance with four sets of questions related to childhood, young adulthood, current adulthood, and future adulthood. The research consisted of individual interviews with each subject following the four general themes from the Giele (2008) study, a set of socio-demographic questions, strategies for balancing life activities, and specific questions exploring the impact of being a cancer patient or survivor. This methodology, utilizing interviews, allowed for data collection where themes could be identified. The themes from the interviews were analyzed to see specifically how they applied to female cancer patients or survivors and how they applied to their personal work-life balance. It also focused on effective strategies and resources for women who were navigating cancer while balancing work-life.

Research questions. Here are the research questions which guided this study:

1. How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance?
2. What sociodemographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions?
3. What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance?
4. What effective strategies or resources help navigate the work-life "balancing act" when diagnosed with cancer?

Significance of Topic

Since the number of women in the workforce has increased and the prevalence of cancer has also increased, female cancer patients or cancer survivors' experience of achieving balance in their personal and professional lives needed to be further studied. The results of this study contributed to educating female cancer patients and survivors regarding having positive mental health, improved identity, and more effective strategies for the "balancing act." This study provided insight and practical advice for female cancer survivors attempting to achieve work-life balance.

Since cancer patients and cancer survivors navigated similar paths of constraints and opportunities, this study revealed the challenges of work-life balance while dealing with the additional health challenges. Through the findings of this study, resources can be created to provide support to female cancer patients or cancer survivors balancing competing priorities. Furthermore, this study provided information that can help organizations better understand female cancer survivors' needs as employees balancing personal and professional demands, and improve their policies to better accommodate female cancer patients or survivors.

Key Definitions

Below are definitions for the life story method created by Giele (2008) included in this dissertation:

Adaptive: innovative versus traditional, which is how a person responds to life's changes and transitions.

Identity: different versus being conventional, which is related to a person's location in time, space, and culture.

Motivation: achievement versus nurturance, which reflects a person's goals and motivation.

Human agency: relating the human being as an actor on the larger stage of society within the world.

Relationship: egalitarian versus deferent, which is shaped by loyalties and social networks.

Key Assumptions

If families or employers did not understand the needs of a cancer patient or survivor, then they were not as effective in helping her navigate her work-life balance while she had cancer. With better understanding, there was more empathy, resulting in more effective strategies for supporting female employees with cancer or cancer survivors.

It was assumed that through the narratives of female employees living with cancer or cancer survivors, there would be important lessons learned from hearing about their experiences of seeking to achieve work-life balance while struggling with health challenges. It was also assumed that female employees who were newly diagnosed would appreciate knowing what

worked for women in similar situations. The hope was that this knowledge and awareness would benefit other female employees with cancer and make their journeys more manageable.

Limitations of this Study

While the preference was to focus solely on cancer survivors, this depended on the number of women in the study who had or have had cancer. If the sample was not large enough, then the study needed to be switched to life-threatening illnesses, or more time needed to be spent interviewing working women with cancer. Since each cancer journey was unique, it was challenging to find strategies effective for every female employee cancer patient or cancer survivor. Blow et al. shared a range of emotions that cancer caused: “anxiety, upheaval, feeling chaotic inside, anger, anguish, dread, terror, and fear” (p.1321). Having cancer was an emotional road and unique to each person’s journey, so it was challenging to tailor effective, personalized support to employees with cancer.

This study focused on female employees having cancer. Since the study did not include men, it focused only on women’s health issues. In order to best assess women’s needs and see their strengths in navigating cancer and work-life balance, the study was designed around women. The sample size made a difference in regard to life perspective, navigating work-life balance, and determining effective strategies for supportive environments.

Summary

This study explored the narratives of female employees with cancer or cancer survivors and how they achieved their own personal work-life balance. It identified strategies for family members and employers regarding better support and fostering supportive environments. It was important to identify resources and strategies for supervisors and employers to help them when they discovered that female employees have cancer. Since women faced identity issues related

to living with cancer along with juggling work-life demands, it proved a challenging experience; however, it was found that the journey did not need to be an isolating or a negative experience. With various strategies of support and a accommodating work environment, it could offer a meaningful experience that fostered personal reflection, learning, and clarity about what was important.

Several cancer types, as indicated in Appendix A, continued to rise in women including: lung, bronchus, and pancreas. Ovarian cancer continued to be a consistent concern (American Cancer Society, n.d., *Cancer Facts & Figures 2011*). It was found important to identify more effective ways for organizations to provide professional and personal support to this growing population. More awareness and knowledge about what is involved, for an employee who has cancer while working, would allow an informed perspective and educated responses. Sensitivity training for supervisors and co-workers would also be beneficial to providing a more supportive work environment. The Women's Project findings illuminated insights, effective strategies, and practical advice for female employees with cancer or cancer survivors seeking to effectively navigate work-life balance.

As a cancer survivor of neuroblastoma and thyroid cancer, this study had personal significance for me. The narratives of the women with cancer were compelling. However, personally knowing the emotional journey of fears, doubts, and anxiety, my empathy and understanding were deeper than someone who has never experienced cancer. This experience also challenged me to present the findings without my personal influences or opinions. Strengthened by my personal journey to achieve work-life balance, the strategies described in this dissertation offer insights to help employers better understand and identify more effective ways to meet the needs of female employees with cancer.

Chapter 2: Review of Literature

Defining Cancer

The National Cancer Institute (NCI) defined cancer as, “a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. Cancer cells can spread to other parts of the body through the blood and lymph systems” (National Cancer Institute, n.d., *What Is Cancer?*). Cancer has been used to describe many diseases; over 100 types of cancer have been identified. Each type of cancer was typically described in name and place of origin. For example, if a woman was diagnosed with breast cancer, then the cancer originated in her breast and the name also described the type of cancer.

Cancer has typically been classified by five main categories: carcinoma, sarcoma, leukemia, lymphoma and myeloma, and central nervous system cancers. Carcinoma cancer started in the skin or tissues insulating an internal organ. Sarcoma is cancer that initiated in fat, cartilage, bone, muscle, or other connective tissue. Leukemia is cancer that began in blood-forming tissues, which produced a large number of abnormal blood cells and entered into the blood stream. Lymphoma and myeloma described cancers that originated in the cells of a person’s immune system. Central nervous system cancers started in the brain tissue and spinal cord (National Cancer Institute, n.d.).

According to World Cancer Research Fund International’s website (n.d.), there were an estimated 12.7 million cases of cancer internationally in 2008. There were approximately 6 million women with cancer and 6.6 million men with cancer. The three leading types of cancer for men and women were lung cancer (12.7%), breast cancer (10.9%), and colorectal cancer (9.8%). For women, breast cancer (23%) was the most common cancer worldwide, with colorectal cancer the second most common (9.4%), and cervical cancer third most common

(8.8%). Breast, colorectal, and cervical cancers comprised more than 40% of all cancers internationally, which did not include non-melanoma skin cancer. Lung and stomach cancers were also common for women and contributed 5% worldwide (“*Cancer Facts and Figures: Worldwide Data*” section, n.d.).

Ganz (2003) described why it is important to study the fate of cancer survivors. With the growing number of cancer survivors, their sub-clinical complaints and/or more serious health issues must be addressed. He believed that researchers should study the high-risk survivor groups and focus on preventive interventions. In striving to be mindful of the cancer survivor’s journey, care does not end after the primary treatment has occurred. As Hewitt et al. (2006) noted, quality cancer treatment should involve a multidisciplinary team method that allowed cancer survivors expert care before, during, and after treatment (Davis, Darby, Likes, & Bell, 2009). Ideally, cancer centers would be established “to monitor the late effects of cancer treatment, as well as provide care and advance our knowledge” (Ganz, 2003, p. 2140).

Women with Cancer in the United States

This study focused on women with cancer living in the United States, although several international studies were reviewed for relevance. According to the Cancer Journal for Clinicians, cancer was attributed to 1 in 4 deaths in the United States. Siegal, Naishadam, and Jemal (2013) shared, “A total of 1,660,290 new cancer cases and 580,350 cancer deaths are projected to occur in the United States in 2013” (p. 11). The 5-year data from 2005-2009 indicated that cancer rates decreased by 1.5% for women. The data identified a 38% lifetime probability of women being diagnosed with an invasive cancer.

The Center for Disease Control and Prevention’s website (n.d.) featured “*The United States Cancer Statistics: 2009 Incidence and Mortality Report (USCS)*”, which was the 11th

time both the Centers for Disease Control's National Program for Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) combined their cancer data to produce federal statistics in cancer incidence. The three most common cancers in the United States among women were: breast, lung, and colorectal cancer. Breast cancer was the most common cancer among all women of all races, including Hispanic populations. Lung cancer was the second most common among Caucasian, African American, and American Indian/Alaska Native women. However, lung cancer was third most common among Hispanic and Asian/Pacific Islander women. Colorectal cancer was the third most common cancer among Caucasian, African American, and American Indian/Alaska Native women. However, colorectal cancer was the second most common among Hispanic and Asian/Pacific Islander women ("United States Cancer Statistics (USCS)").

Women's Cancers: Breast and Gynecological

Breast cancer has been identified as the most frequent female cancer in the world, with the majority of women diagnosed during working age. Due to improved breast cancer survival and the female workforce increasing in many countries, there was a need to study women, cancer, and their work participation (Hauglann, Benth, Fossa & Dahl, 2012). In looking at breast cancer, there was a need to study younger women and older women more closely.

While many studies focused on women with breast cancer, there were few that concentrated on the effects of breast cancer and the recovery process for women under 50. One particular study looked at four Australian women under 50, and sought to capture insight into their experiences (Elmir, Jackson, Beale, & Schmied, 2010). While the reasons were not clear, younger women with breast cancer seemed to have more advanced stages of cancer and worse prognoses than older women with cancer.

Since younger women needed to take more aggressive steps towards fighting cancer, their treatments often resulted in mastectomy or double mastectomy. When this occurred, younger women had challenges and stressors related to perceptions of lost femininity, concerns about fertility, struggles with sexual relationships, and experienced negative body image issues due to disfigurement. As a result of the effects of breast cancer, many women also withdrew socially (Elmir et al., 2010).

Themes from the four younger Australian women included having breast cancer consumed them, and they were completely overwhelmed balancing their personal and work responsibilities while facing breast cancer. Since there was a possibility of recurrence in each woman's case, this caused fear and uncertainty. The uncertainty resulted from having to make life changes due to having breast cancer and created fear about not being desirable or attractive post-surgery. However, all four women shared that the experience of having breast cancer made them stronger personally. The experiences cultivated strength through friends, loved ones, and health professionals (Elmir et al., 2010).

Even though a cancer diagnosis created a stressful and emotional journey, each woman regarded it as a life-changing experience. As Sammarco (2001) described, younger women also coped with multiple roles, which included working, cleaning, and cooking. This created added pressure while they had to deal with the realities and demands of having cancer. Thewes et al. (2004) shared that younger women experienced challenges related to their recovery while trying to work and continue with domestic chores. However, the overall experience resulted in these four having optimistic attitudes towards life (Elmir et al., 2010).

Younger women with breast cancer had multiple contexts in their lives that determined whether or not they sought rehabilitative care (Elmir et al., 2010). In Miedma and Easley's study

(2012), 35 young women from four Atlantic Canadian provinces were interviewed twice during their journey with breast cancer. Even though many of the women in this study were experiencing physical or psychological symptoms related to breast cancer, over half of the women chose not to seek assistance. It was revealing to see the reasons why young women did not utilize rehabilitative services: too busy, cost of services, lack of available services, issues related to travel, and lack of specific support related to young breast cancer survivors. Personal decisions were also related to these factors: time constraints, family/household responsibilities, acceptance of new reality/personal limitations, personally tired, and appointment fatigue. It was observed that some women did not want to burden the system, so they chose not to access support (Miedma & Easley, 2012).

The Miedma study revealed that time constraints were not the main reason for young breast cancer survivors not accessing rehabilitative support. Rather, the rehabilitation decision was based on intensity of the treatment, along with personal factors such as work status, financial condition, psychological impacts, and type of support network. This information could help young cancer survivors understand the significance of rehabilitation support rather than sacrificing “to get back to normal” for their loved ones (Miedma & Easley, 2012). Bloom, Stewart, Oakley-Girvan, Banks, and Shema (2012) discovered in their Quality of Life interviews with young breast cancer survivors that positive changes were fewer sexual problems and work problems due to cancer. However, there were still negative concerns related to women leaving the workforce and those who reported being sexually inactive as a result of recovering from cancer.

Older breast cancer survivors faced different challenges than younger cancer survivors. Older breast cancer patients had challenges differentiating symptoms related to cancer and those

due to aging. In this study, Leventhal's Common Sense Model (CSM) was utilized with 61 women who had breast cancer and were navigating multiple symptoms. The findings concluded that 41 women believed that their symptoms were related to another chronic health issue. Twenty-one women believed their symptoms were due to a cancer recurrence or were a result of their cancer treatment. Five women believed their symptoms were related to aging, and there was a woman who thought that radiation caused her arm pain (Royer, Phelan, & Heidrich, 2009).

Over 90% of the women with breast cancer identified strategies that were self-directed for symptoms; 67% utilized healthcare provider strategies. Most women were using at least six strategies to manage their symptoms. Unfortunately, 61% reported that one or more of their strategies were unsuccessful.

Several barriers were described by the breast cancer patients: communication challenges with healthcare providers, not having necessary resources, difficult symptom management, psychological distress or physical restrictions, concerns with medications, and fears of surgical or diagnostic procedures (Royer et al., 2009).

Interestingly, most women in this study attributed their symptoms to aging. Since participating women reported at least 4.6 chronic health conditions, and 67% of the respondents believed their symptoms were related to another chronic issue, more coordinated care between healthcare providers could be helpful. Also, this study revealed that more should be done to address women's beliefs (i.e. these symptoms are incurable or uncontrollable) and improve communication with healthcare providers (Royer et al., 2009).

Regardless of age, breast cancer impacted rates of returning to work. In the Netherlands, a study was facilitated by utilizing sick leave data from ArboNed's Occupational Health Services to study sickness absence and return to work rates for women with breast cancer. In the years

2001-2005, there were 2,259 women who had 2,361 documented absences related to having breast cancer. The types of companies represented were: health care (28%), administration (18%), retail stores/shops (15%), economic sectors (10%), manufacturing (10%), catering (7%), and education (7%). The average duration of absence related to breast cancer was 349 days, which is close to a year away from work (Roelen, Koopmans, de Graaf, Balak, & Groothoff, 2009).

Roelen et al. (2009) described, “1,733 episodes were longer than 6 months, 950 episodes lasted longer than 12 months, and 425 episodes longer than 18 months. In 240 cases, there was no return to work within 2 years after diagnosis... Ultimately, 19% of absences among women aged 25-34 years lasted longer than 2 years as compared to 11% of the older women” (p. 544).

In 2006, Verbek discussed the International Classification of Functioning, Disability, and Health known as the ICF model, which described a disease/disorder as a condition that limited activities, impaired body functions, and restricted involvement in societal roles such as work (Roelen et al., 2009).

Three opportunities for healthcare providers using the ICF model were: 1) better treatment by including new skills or learning towards the plan in returning to work; 2) adapting the work environment to be cognizant of less manual/physical work for a more accommodating environment, along with being mindful of support from supervisor/colleagues; and 3) utilizing rehabilitation to help navigate having cancer and the transition back to work. If women with breast cancer received better support from their work environments, this could help reduce the duration of sick leave because the women would be provided with a more understanding, accommodating work environment. As Amir et al. (2007) described, 20% of cancer patients

experienced deterioration at work related to their motivation and professional prospects. The ICF model presented an approach to help address such concerns (Roelen et al., 2009).

Breast cancer has been found to impact survivors' health and stamina. In Helgeson and Tomich's 2005 study, they focused on the quality of life of 267 disease-free breast cancer survivors and 187 similarly aged healthy women from the local neighborhood. The research examined how breast cancer impacted the 267 survivors. While there were many similarities, the breast cancer survivors, without education intervention, reported challenges with physical functioning and mental fatigue related to breast cancer treatment. The education intervention offered information and coping skills about how to navigate breast cancer. The breast cancer survivors with understanding from the intervention indicated that they had more faith than the control group from the neighborhood. In regards to the women who had a recurrence of breast cancer, their quality of life was impacted in several areas, including feeling fatigued. However, there were not differences in the survivors in the areas of work, spirituality, and marriage (Helgeson & Tomich, 2005).

In regards to women's cancers, more attention has been focused on gynecological cancers, which includes uterine, ovarian, and cervical cancers. In 2013, Rowlands et al. shared the results of a longitudinal study for Australian women with endometrial cancer. There were 632 women who participated in Australian National Endometrial Cancer study (ANECs) from 2005-2007 and the ANECs follow-up Quality of Life study. In this study, women with lower levels of education, along with poor mental and physical health experienced the greatest amount of emotional distress. However, women who had cancer previously and those with lower education levels also demonstrated resiliency and for many, it resulted in positive change. It depended on the coping style for each individual.

In 2001, Chan et al. facilitated a longitudinal study of 74 predominantly Chinese gynecologic cancer survivors who were studied to see what the challenges were for psychosocial recovery. Some of the recognized challenges of gynecologic cancer were impaired fertility, menopausal state caused by the treatment, decreased sexual desire/response, and relationship insecurities related to gynecologic cancers. While 5.7% of the women reported struggles with depression, the majority of the women had a similar self-esteem and did not fall into a depressive state. This was especially true if they had a job and good social and familial support. Psychosocial challenges arose in women who were treated surgically, not well-educated, and did not have any religious beliefs. Those treated surgically had perceptions that their femininity was compromised. For those with lower education levels, processing all of the clinical information presented frustrations and anxieties. Those who indicated having religious beliefs seemed to have more hope than those without any faith or spiritual beliefs. “As such, religion is a powerful force for shaping a person’s understanding of breast cancer and the options they perceive they have to be able to respond to the experience” (Swinton, Bain, Ingram & Heys, 2011).

Corwin, Wall, and Koopman (2012) proposed that incorporating psychotherapy with spirituality would improve mood, quality of life, and psychological, physical, and spiritual needs. They studied how Psycho-Spiritual Integrative Therapy (PSIT) was incorporated with women who had breast cancer. The cognitive behavioral therapy, passage meditation, and mindfulness provided an intervention that focused on spiritual and psychological needs. While PSIT needs to be researched further for effectiveness, researchers believed that these strategies have the potential to help minorities and those who are practice spirituality.

Each year, there have been over a million new cases of gynecological cancer worldwide. Three of the major gynecological cancers were endometrial, cervical, and ovarian. With

improved survival outcomes, returning to work became a realistic possibility. In this study, 55 gynecological cancer survivors were interviewed after they returned to work, and 36 provided a follow-up after 12 months. It resulted in three emerging themes of *Meaning of Work*, *Disclosure of Cancer Diagnosis*, and *Readjustment* (Grunfield & Cooper, 2012, p. 82).

Several of the long-term side effects of survivors of gynecological cancers who experienced chemotherapy were: high levels of fatigue, hot flashes, nausea, vomiting, constipation, and poor concentration. “Up to 50% of these patients may experience chronic radiation enteritis with symptoms including diarrhea, incontinence, abdominal bloating, and discomfort” (Grunfield & Cooper, 2010, p. 83). There are also psycho-social impairment related to accepting the reality of receiving chemotherapy, dealing with pain and discomfort, and dealing with the side effects of chemotherapy (Buick et al., 2000). Besides the physical challenges, women also experienced reduced confidence about returning to work (Grunfield & Cooper, 2012).

Grunfield’s study (2012) illuminated stigmas associated with people’s perceptions of gynecological cancers. Some women acknowledged that it was an embarrassing cancer due to a perceived stigma of sexual impropriety. Women also recognized that disclosing information about gynecological cancer created vulnerability and disempowerment in the work setting. As previously seen with breast cancer, surgical removal of reproductive organs also created identity issues to personally reconcile. Since many gynecological cancer survivors had residual symptoms or unrealistic expectations about resuming employment, it would have been helpful to have interventions that helped patients be realistic.

In Nachreiner, Ghebre, Vernig, and Shanley’s study (2012), 110 gynecological cancer survivors shared their experiences through the duration of treatments. The results showed that

86% of the women had operations and 74% went through chemotherapy. While 62% of the women changed their work schedules to accommodate their treatments, 9% changed their treatment plans to accommodate their work. Most women (41%) stopped working during their first month, and 32% reduced their hours in the second month. By the sixth month, 8% of women had increased their hours at work. By the seventh month, the majority (67%) continued working or resumed working. Over one-quarter of the gynecological cancer survivors required work accommodations during treatment. This illustrated the need for providing flexibility and support to employees who have cancer.

Since 18% of all female cancers worldwide were gynecologic, it was important to better understand the needs of this group of cancer survivors. Another study focused on 199 gynecologic cancer survivors through a questionnaire to assess supportive care needs and psychosocial outcomes 1-8 years after successful treatment. While 68% reported positive outcomes, there were 29% who were very concerned about a second recurrence and dealing with clinical anxiety or PTSD (Hodgkinson et al., 2007).

Dealing with gynecologic malignancy showed to significantly impact a cancer survivor. As a result, supportive care interventions were needed for women who suffered from clinical anxiety, PTSD, and traumatic responses to their fears or what they negatively experienced. This involved planning for comprehensive counseling and extended support if needed. There was a need for continued investigation into areas requiring more education or resources, and language barriers that need to be overcome (Hodgkinson et al., 2007).

Gynecological cancer survivors faced long-term challenges related to the type of cancer they experienced. In 2004, 802 women participated (56% response rate) in population mail-based survey. It revealed several unmet needs: “fear about the cancer spreading (17%), concern

about the worries of those close to them (15%), uncertainty about the future (14%), lack of energy/tiredness (14%), and not being able to do the things they used to do (14%)” (Beesley et al., 2008, p. 392). Beesley et al. recommended tailoring support groups that provided psychological support provisions to the shared unmet needs (Beesley et al., 2008). In Merckaert et al. (2010) study of 381 patients, they found that women seek counseling support 26% more than men and often it is associated with support for their sexual difficulties due to their female cancer experience.

Sekse, Raheim, Blaka, and Gjengedal (2012) conducted a qualitative study with 16 Norwegian women; the study showed that there were considerable differences in how women process their experience of having cancer. Cancer impacted the lives of the women significantly and nurses and healthcare professionals’ support were vital during treatment. In order to provide fundamental support, these nurses and healthcare professionals listened to their stories, accepted their emotions, and were mindful of communication. If healthcare staff possessed good listening skills and conversational competence, then it would be easier to build personalized follow-up care suited for each patient. Time is a central theme for cancer survivors, healthcare staff were instrumental in helping cancer survivors understand how their time is experienced and navigated. Healthcare staff guided cancer survivors to find ways to most effectively use their time and be mindful of their well-being (Rasmussen & Elverdam, 2007).

Since progress has been made in prolonging the lives of women with ovarian cancer, there was added reason to focus on their quality of life. In the United States, ovarian cancer was documented as the second most common malignant gynecological cancer. Arriba, Fader, Frasure, and von Gruenigen reported in 2010, “It is estimated that more than 21,500 new cases were diagnosed, with approximately 14,600 resulting in deaths” (p. 390). It was more

challenging to have a positive outcome with ovarian cancer when it was diagnosed at an advanced stage.

Arriba's study reviewed the literature on quality of life, measurement tools, and areas to further well-being. While there had been smaller studies conducted, quality of life for those with ovarian cancer needs to be researched on a larger scale. Ferrell et al. surveyed more than 3,000 ovarian cancer patients and shared the biggest reported fears: 56% were concerned about a cancer recurrence and 9% were concerned about dying from ovarian cancer. Mautlonis et al. explored the quality of life for 58 early stage ovarian cancer patients. While many had good physical scores, 90% reported that they had no interest in sex or were not engaging in sexual behavior (Arriba et al., 2010).

When looking at ways to enhance the quality of life and survivorship of ovarian cancer patients, there were three areas of focus: improving nutrition quality, encouraging physical activity, and utilizing support groups and caregivers. It was noted that future research and considerations should include the disruption that ovarian cancer has on women so that researchers and healthcare professionals may develop effective interventions for the diverse ages, stages, and needs of women who have ovarian cancer (Arriba et al., 2010).

Racial and Ethnic Issues Related to Cancer

Race and ethnicity has been identified as a leading cause to cancer; however, cancer incidence and mortality rates vary among different races and ethnic groups. Factors considered by the North American Association of Central Cancer Registries (NAACCR) are: "geographical variations in sociodemographic and life-style factors, medical settings, and cancer screening behaviors" (Jemal et al., 2010, p. 283). Heredity can be a major factor, along with cultural factors related to lifestyle, beliefs, and practices.

Ethnicity was also demonstrated to be a contributing factor in breast cancer survival. Through the World Health Initiative (WHI), African American breast cancer survivors were compared with Caucasian breast cancer survivors. WHI was the largest women's health study, and measured breast cancer survivors' health-related quality of life. In this study, Caucasian breast cancer survivors reported better health and physical functioning than African American breast cancer survivors. This may be related to the more aggressive cancers experienced by African American women, which required chemotherapy and had an impact on overall health and functioning. African American women were diagnosed with more high-grade tumors, resulting in a higher breast cancer mortality rate (Paskett et al., 2008).

In this racial comparison study, African American breast cancer survivors reported limitations related to their physical functioning, general health, and emotional health. The African American breast cancer survivors also experienced more pain and less vitality than Caucasian breast cancer survivors. Some contributing factors to African American breast cancer survivors' experiences were: stressful events faced in life, socioeconomic challenges, and two or more diseases being experienced concurrently. However, this study revealed that African American and Caucasian breast cancer survivors had similar results regarding social functioning and emotional well-being. More research was needed to illuminate the disparities for African American breast cancer survivors and how their physical and psychosocial experiences can be improved (Paskett et al., 2008).

The Center for Disease Control and Prevention website elaborated on the racial disparities between Caucasian women and African American women with breast cancer. African American women had the highest breast cancer death rates in the United States among all ethnic groups; they were 40% more likely to die from breast cancer when compared to Caucasian

women. The factors attributed to higher death rates were: limited economic resources and social support; aggressive cancers which grew fast and were difficult to treat; lack of prompt follow-up on irregular mammograms; and less likely to get high-quality care and treatment (*“Breast cancer: Black women have higher death rates from breast cancer than other women”*, November 2012).

Sometimes, racial disparities included factors such as lack of health insurance, poverty, acculturation barriers to getting proactive screenings, and not being inclined to receive formal services (i.e. counseling). Farone, Fitzpatrick, and Bushfield (2008) noted that 109 elder Latina cancer survivors participated in quantitative analysis regarding the health and well-being of older women of Mexican origin who were diagnosed with cancer and residing in the United States. Two notable findings were that Mexican religion and spirituality increased hope and also helped the women learn to accept their circumstances. Through faith and prayer, it helped to provide a “fighting spirit” toward cancer and more active coping than someone without faith.

However, there are findings that reveal causes for racial inequalities. Wall, Rocha, Salinas-Martinez, Baraniuk, and Day (2010) discovered in their study of working women in Mexico “that socioeconomic inequalities among Mexican women are reflected in differences in knowledge and practice of Pap examinations, and that these differences are associated primarily with level of education” (p. 1267). Mainly, the lower education and lower familial income contributed most towards the disparities.

In Ashing-Giwa, Lim and Gonzalez (2010) research, they found that Latina-Americans received lower quality of care, greater language difficulties in medical settings and challenges accessing state-of-the-art health care. As a result, this contributed to poorer physical outcomes for breast and cervical cancer survivors. In order to improve overall survivorship outcomes for

Latina-Americans, the research showed that healthcare providers should provide navigational services which would help to advocate, provide translation services, and overall assistance.

Racial disparities with breast cancer were also reflected in Mujahid et al.'s (2011) breast cancer and job loss study. Over half of the women with breast cancer, when diagnosed, were still working age, making it important to study employment outcomes for cancer survivors. Since many women juggled family and work responsibilities, it was vital to know more about return to work opportunities for breast cancer survivors. This study explored how racial/ethnic differences influenced work outcomes during breast cancer. Some of the factors may have been related to minorities having more advanced stages of breast cancer requiring more aggressive treatment, along with having other health challenges. Often, Latinas and African American women were represented in lower paying jobs, which tended not to be very supportive work environments. In this study, there were 3,252 women diagnosed with breast cancer in Detroit and Los Angeles who were asked to complete a survey regarding employment, job loss, and any racial/ethnic disparities.

In the findings of Mujahid's study regarding job loss rates, 4.3% quit their jobs and 5.5% lost their jobs due to having breast cancer and going through treatment. This study also explored financial strain and whether or not there was a supportive work environment. This study found that there were substantial differences related to ethnicity/race. Latina women were more likely to lose their jobs during their breast cancer treatment. It was also noted that African American and Latina women were likely to miss more work than Caucasian women during aggressive treatment. This may have been related to African American and Latina women being in unsupportive work environments with no flexible scheduling or paid sick leave. These findings heightened the awareness of clinicians and staff to ethnic differences and unsupportive work

environments while women undergo chemotherapy for breast cancer. An understanding of this reality could help healthcare providers personalize treatment in order to account for job demands, scheduling, and strategies for symptom management, so that women can better balance breast cancer treatment and work (Mujahid et al., 2011).

In Coker, DeSimone, Eggleston, White, and Williams (2009) study regarding ethnic disparities in cervical cancer survival in Texas, it revealed disparities for Hispanic and Black women. There were 5,166 women identified in the Texas Cancer Registry (TCR) during 1998-2002. While Hispanic women seemed to have cervical cancer advantage relative to White women, the Black women in this study were more likely to die of cervical cancer. It appeared that Black women were more reluctant to have surgery, while White and Hispanic women were inclined to have surgical procedures. However, Black and Hispanic women were more likely to have cervical cancer detected at a later stage. The data suggested that Black women may receive less optimal care and more likely to die of cervical cancer among those who receive treatment.

Davis et al (2009) highlighted the research from Siminoff, Graham, & Gordon, (2006) regarding another factor related to racial disparities: “a study examined the relationship between patient characteristics and communication patterns between oncologist and their cancer patients found that physicians were more likely to engage in relationship building with white patients and more educated patients over non-White patients and less educated patients” (Davis et al., 2009, p. 572). Recognizing the bias toward white patients and educated patients, Davis et al. advocated for oncology social workers to have professional skills, training, and values to be a leader in quality care of underserved and minority cancer patients. Support services helped to bridge the gap if they can focus on patient advocacy, especially for those who are vulnerable and may not have the resources.

Cultural Issues Related to Cancer

Cultural disparities showed to impact women with cancer and their families. Due to the lack of resources, American Indians with cancer typically faced challenging roads to navigate. Since American Indian cancer survivors had not been adequately served, researched, or studied, the following was important research that sought to better understand adult Chippewa cancer survivors. The study only had 10 cancer survivors and 10 tribal family members participate; 80% of the participants were female. This voluntary research partnership was helpful in examining any loss of functioning related to cancer; what support helped improve any barriers for health and well-being; what support helped enhance quality of life and personal/professional productivity; and how the cancer survivor and family coped with the treatment, new personal realities, and work situations (Johnson et al., 2011).

In the Johnson (2011) findings, all of the Chippewa cancer survivors experienced health problems, which included fatigue. A third of the cancer survivors reported that they needed counseling and employment accommodations, such as flexibility with their work schedule, along with a supportive supervisor and colleagues. Several of the Chippewa Indian cancer survivors needed more support when faced with having cancer, which was culturally not embraced. The Johnson study recommended a rehabilitative approach to better support Chippewa cancer survivors so that rehabilitation could take place through education, counseling, support, and accommodations to the cancer survivor and family members. Since the family members shared fears related to recurring cancer, how care-giving presented challenging dynamics for the family, and how financial issues were related to the medical bills and treatment, it was helpful to address the Chippewa families' needs as well.

Cultural disparities and beliefs showed to pose obstacles for women faced with a cancer diagnosis. In 2010, the Burhansstipanov et al. study was the first time that 266 American Indians and Alaskan Native Indians shared about physical conditions related to breast cancer survivorship issues; 263 of the respondents were women. One of the reasons for the lack of disclosure was related to access issues, which contributed to discrepancies and lack of reporting. When the women had high blood pressure, diabetes, thyroid problems, arthritis, and/or were overweight, these additional health challenges complicated their breast cancer journeys. The American Indians and Alaskan Native Indians experienced financial burdens, such as a lack of health insurance which prevented them from getting the treatment that was needed. Also, there was a lengthy delay (around 6 months) from the time of diagnosis until treatment was sought. The majority experienced pain, depression, fatigue, weakness, and hair loss. The most troubling reported symptom was unmanaged pain, which may have been related to not having consistent access to the necessary pain medications.

Culturally, hair held a unique significance for American Indians. Hair symbolized spiritual strength and balance. If a woman lost her hair during chemotherapy, then she may have been perceived as a “weakened spiritual being.” In many tribal nations, hair falling out also culturally implied impending death. Either cultural explanation would explain why depression was common in American Indian or Alaskan Native Indian women with cancer (Burhansstipanov et al., 2010).

Cultural issues also arose in regards to hereditary concerns, lifestyle, access to health services, and cultural beliefs. Only 63% of American Indians and Alaskan Native Americans were alive after 5 years of breast cancer, which was the poorest survival rate of any minority or ethnicity represented in the United States. Since there was no detailed accurate survival data for

American Indians and the breast cancer rate continued to escalate, it presented challenges in trying to reduce the cancer rate in this population. As a result, Native American Cancer Education for Survivors (NACES) was developed to improve the quality of life for American Indian and Alaskan Native Americans. NACES was founded as a community-driven research and education project. All participants in their research voluntarily completed a quality of life survey that focused on physical, spiritual, social, and psychosocial components. This study compared the conditions during the first year of diagnosis with conditions during the next four years, and, for those who survived, conditions past five years (Burhansstipanov et al., 2010).

The NACES patient advocates were helpful with tracking personal breast cancer information and physical conditions. As a result of working with the advocates, breast cancer patients accessed web-based resources. Since American Indians have reported lower education attainment, a lack of understanding could have contributed to accessing timely healthcare and treatment. The long-term survivors demonstrated that there is hope. If American Indians newly diagnosed with breast cancer accessed timely treatment, the survival rate for their population could improve (Burhansstipanov et al., 2010).

Culturally, there were several reasons discovered why Filipina women with breast cancer were uniquely impacted: the emphasis on Filipino family, dynamics of support, and the influence of transnational perspective. Filipina women in the United States were found to be an understudied group. In the San Francisco Bay area, a university/community partnership hosted its first Filipina breast cancer support group in 2004. As a result of this group and partnership, the cultural and social contexts of the Filipina women were studied through ethnographic research of observations, individual and small group interviews. The qualitative information

provided ways to identify meanings of support and survivorship, especially in light of many of the women being immigrants (Burke, Villero, & Guerra, 2012).

Filipinos were documented to be the second largest Asian group, after Chinese, in the United States. Filipinas had higher rates of breast cancer than most Asian groups, second only to Japanese women. Maxwell et al. noted that compared to Caucasian women, Filipina women were more likely to be diagnosed with advanced stages of breast cancer and die from it. Chockbur and Deapen; Keegan et al.; and McCracken et al., noted that in California, Filipinas had the highest rates of mortality from breast cancer (Burke et al., 2012).

There were two main philosophies of Filipinas' understanding of breast cancer, which were “surviving” and “passing through” cancer. Dimensions related to “surviving” cancer were: breast cancer was one of many trials; it was not about you, but rather your family; it was a second chance/rebirth, and opportunity to be cancer-free. Dimensions related to “passing through” cancer were: caregiving, family support/dynamics, patients continued as caregivers, transnational nature of support/responsibilities, and religious/spiritual support. The data clearly indicated the necessity for more support and resources in the Filipina community. Because many Filipina women were recent immigrants to the United States, there was a lack of understanding of resources and support available. Understanding the transnational perspective, support dynamics of Filipino families, and survivorship of Filipina women with breast cancer would allow programs to better support and meet the Filipina needs (Burke et al., 2012).

Another cultural group to consider is Arab Americans. According to the Arab American Institute website, an estimated 1.9 million Americans of Arab descent are living in the United States (“Demographics”, n.d.). The Azaiza and Cohen study revealed cultural insights into the Arab community. In a study of 51 Arab women in five focus groups of representative

communities in Israel, the attitudes of Arab women towards breast and cervical cancer screenings were explored. Since breast cancer was diagnosed in more advanced stages and there was a higher mortality rate in minority ethnic groups, it was relevant to study the 18.7% of Arab women living in Israel. The survival rates from breast cancer were 63% for Arab women compared to 71% for Jewish women. This was attributed to Jewish women attending screenings and clinical exams more often (1.2-2 times) than Arab women, which provided an earlier diagnosis and better survival outcomes (Azaiza & Cohen, 2008).

There were barriers for Arab women seeking screenings, which included lack of finances, accessibility, and language challenges. Cultural beliefs and traditional perceptions also presented obstacles, such as the Islamic culture's emphasis on modesty. There were beliefs that the illness was a punishment from God, which limited willingness to participate in breast cancer and cervical screenings. Having cancer presented an inability to fulfill a woman's role and a societal loss. This study illuminated how modern biomedical perceptions interacted with cultural and religious beliefs (Azaiza & Cohen, 2008).

Most of the women in the Aziaza study had knowledge of the breast and cervical cancer screenings. However, there were mixed perceptions; some believed that "cancer equals death," while others believed that modern treatments were a possible cure. Many knew about hereditary and environmental causes such as the modernization of cell phones, high-fat diets, and hormones and chemicals in food as speculative causative agents. There was a cultural myth that cancer was contagious, but it appeared to be receding. There was also a religious perspective (Islamic, Christian and Druze) that breastfeeding your child would reduce the risk of breast and cervical cancer. Others believed that cancer was a test from God or a punishment for sexual impropriety (Azaiza & Cohen, 2008).

Fear of a positive screening was a barrier. A major issue discussed was personal responsibility versus the community health system. Many women felt that health authorities should be more proactive with awareness, accessibility, cultural sensitivities, availability, and personal invitations. In the Islam religion, women displayed indifference to their bodies and were not attentive to personal responsibility. Christian women, or those influenced by modernization, seemed to take more proactive and personal responsibility. However, there were those who still believed cancer was a fate from God (Azaiza & Cohen, 2008).

Another cultural barrier included women not wanting to expose parts of the body during medical tests due to modesty, embarrassment, or a husband opposed to exposure. Many women expressed that they did not want their husbands looking at them differently, viewing them as inferior as a result of cancer. An interesting barrier was fear of being the subject of gossip; this was especially true in the villages. All of the women expressed concerns about a male doctor facilitating the exams and were only comfortable with a female doctor. However, there were also concerns about the doctor if he or she was a friend of the family (Azaiza & Cohen, 2008).

Cultural norms and expectations presented challenges when women had cancer, especially when they were experiencing physical challenges and anxieties. This study on Arab women living in Israel revealed that cultural norms and perceptions influenced women's quality of life and psychological reactions to having breast cancer. For the Azaiza study, 56 Arab women living in Israel with breast cancer shared their perspectives through questionnaires. These women were matched with women, who did not have breast cancer, of similar background, age, and education who responded to the same questionnaire to see how culture influenced breast cancer survivors. The women with breast cancer experienced higher anxiety and manifestation of physical problems related to the emotional distress (headaches, pain, etc.).

However, the women with breast cancer reported more support than what was culturally anticipated. These findings highlighted the importance of cultural understanding and sensitivity in addressing someone who was sick, support and care during that time, and approach to body change through the lens of culture. This also demonstrated the importance of culturally evaluating how to help a woman with breast cancer cope and adjust to having a life-threatening disease (Cohen, Mabjish, & Zidan, 2011).

The Azaiza study presented diversity in attitudes and beliefs, ranging from traditional to modern perceptions. The two different belief systems were integrated in many ways. Future implications from this study included: increased screenings and health promotions in Arab communities, mindfulness of discussions related to cultural sensitivities and religion, and more accessibility to Arab women and health service providers (Azaiza & Cohen, 2008).

The Chinese culture faced obstacles related to available resources, burden of role-related obligations, expectations of significant others, and a need for positive sources of support. In the Ching, Martinson, and Wong study (2012), the focus was on reframing and meaning-making regarding 24 Hong Kong Chinese women and their experiences with breast cancer. Reframing referred to the psychological adjustment, in this case so that Chinese women could find acceptance, sustain their mindsets, and incorporate breast cancer into their realities. Five of the women were followed up with two additional times after the initial interview. Al-Azri, Al-Awisi, & Al-Moundhri (2009) found that breast cancer patients used a variety of coping strategies including yoga, increased religious practices, exercise, social and family support, wishful thinking, cancer acceptance, positive cognitive restructuring, and emotional expression (Ching et al., 2012, p. 251). There were vast resources for Western patients to cope with cancer. In regards to Chinese women utilizing Eastern resources for coping with cancer, this was still

being explored. In recent years, there has been more specific research on the Chinese experience with cancer. He and Liu (2005) and Li and Lambert (2007) described common Chinese coping strategies: positive thinking and reframing, palliative collaborative planning, self-distraction, and self-reliance (Ching et al., 2012).

For the 24 Hong Kong Chinese women involved in the study, they focused on a hopeful mindset that sought a cure while persisting through suffering. This was further described: “A change in global meaning was noted, in this study and others, in striving for a personally meaningful goal, minimizing social disturbance, self-reinforcing courage, and appraising secondary gain so as to be sustained in coping and in all transformational thoughts, including change in the relative importance of things in life” (Ching et al., 2012, p. 257). A common Chinese social disturbance was reducing the burden of role-related obligations and expectations of significant others, and seeking positive sources of support. It also involved understanding the influence of Chinese values and beliefs in order to leverage them for the best outcome while enduring cancer.

Implications included recognizing that counseling and psychological support should be included in routine care by oncology nurses. Nurses encouraged coping through helping the cancer patient know her strengths, limits, and religious/cultural values, along with encouraging her to seek help from loved ones and healthcare professionals. Since personal relationships were meaningful, fostered hope, and provided support for Chinese women, relationships could help them manage cultural role-related expectations while enduring breast cancer. Once the mental adjustment was made along with the sustaining support, then transformation and learning could occur from the cancer experience. Nurses could help each woman seek personal meaning and find effective ways to cope during her journey with cancer (Ching et. al, 2012).

It was found that more cultural sensitivity was needed in addressing women with cancer with respect to their heritage. The Uchida et al. (2011) study explored Japanese women with advanced breast cancer and their unmet needs. It was hypothesized that greater unmet needs would be more prevalent in these women, including more psychological distress. A random sample of 87 patients completed the Short-form Supportive Care Needs Survey (SCNS-SF34), which explored the following areas: health system/information, psychological, physical/daily living, patient care/support, and sexuality. It identified their levels of need for help in relation to having advanced breast cancer.

More than 50% of the Japanese patients revealed unmet needs, most of which were psychological or health system/information domain. These unmet needs were associated with the psychological distress that women with breast cancer were experiencing. This study, compared to previous similar Australian and British studies, revealed a higher number of unmet needs. This may have been related to a lack of social support systems in Japan. Also, there was a need for more cultural sensitivity that could be intentionally addressed in each cancer patient's intervention. If there were more interventions to address the specific unmet needs, this would reduce the distress of advanced cancer patients and improve their quality of life. This study recommended case management for each patient to have unmet needs addressed to provide appropriate resources and needed psychological services (Uchida et al., 2011).

In the Korean culture, when a woman was diagnosed with cancer, the traditional family roles and societal expectations of men as the main providers reduced the number of women returning to work. This study focused on Korean breast cancer survivors and factors in determining whether or not they should return to work. It was significant because Korean women were not as actively involved in the workplace and the breast cancer survivors were

younger than Western women who had been previously studied. There were 1,594 Korean women with breast cancer who participated in this study, ranging from ages 20 to 60. These breast cancer survivors were compared with 415 healthy Korean women as the comparison group. All women completed the survey, which focused on the impacts of breast cancer, employment status, and ability to complete housekeeping and occupational tasks (Ahn et al., 2009).

Ahn's study revealed that only 58.9% of Korean women with breast cancer continued working. In studies with Western women, it was revealed that 72-80% continued employment. Several observations with this study were congruent with Western countries. Factors that seemed to influence not returning to work were: the level of the cancer, lower income, and multiple health conditions which complicated the healing or recovery. The findings also revealed that lower household income correlated to lower employment, which may be a cause and result of unemployment. The main difficulties reported were fatigue and physical exhaustion. Many women reported that having cancer, a lower income, and losing their job decreased their quality of life (Ahn et al., 2009).

There were socio-cultural factors specific to the Korean experience with breast cancer. If a woman was living with a spouse, she was more likely to quit working. This may be due to Korea's national healthcare and societal expectations that Korean men are the primary providers. Also, this study identified that breast cancer had more of an impact on Korean women's employment than previously observed in Western women with breast cancer (Ahn et al., 2009).

In the Turkish culture, there were observed to be traditional cultural factors of a patriarchal society and strong Islamic influences that impacted the cancer patient and family. Psychological distress was common in cancer patients. Okamura, Yamawaki, Akechi,

Taniguchi, and Uchitomi, (2005) shared that when patients were diagnosed with cancer, 14-38% reported struggles with depression, hopelessness, and loneliness. These three psychiatric disorders were prevalent when someone was diagnosed with a life-threatening disease. Cancer caused feelings of vulnerability, doubts about the future, and a loss of control ((Pehlivan, Owayolu, Sevine, Camci, and Celattin, 2012).

This study focused on 188 Turkish patients with recent diagnoses of cancer. None of these patients had any known mental health issues. Each one was issued a questionnaire when they transitioned to outpatient status. With an average age of 44, 79.8% were married, and 51.6% were male. The most frequent cancer experienced was gastrointestinal cancer (22.3%); 20.7% had a family history of cancer; and 66.5% received chemotherapy for treatment (Pehlivan et al., 2012).

The findings were that cancer patients who perceived higher social support by loved ones struggle with loneliness or hopelessness. Taskila et al. (2006) noted that social support helped alleviate psychological problems, reduced the progression of an illness, improved physical adaptability, and enhanced quality of life. Culturally, Turkish families were supportive because they valued their family, intimacy, and unity. However, those who perceived lower social supports experienced hopelessness and loneliness (Pehlivan et al., 2012).

The Turkish patients who experienced a longer duration of cancer and had a family history of cancer had lower perceived social support. This study also revealed that there was more hopelessness in women, older patients, those who were illiterate, and those living in rural areas. This study proved the importance of healthcare providers being aware of the traditional cultural factors of a patriarchal society and how it impacted the cancer patient (Pehlivan et al., 2012).

Culturally, African American women tended to be women of faith. The Roff, Simon, Nelson-Gardell, and Pleasants (2009) qualitative study explored the role of faith and spiritual support in the lives of 18 African American women with breast cancer. The women had an average age of 53, and all of them described themselves as Christians. Jemal et al. (2008) reported that African Americans have the highest breast cancer mortality rate in the United States. The Roff, Simon, Nelson-Gardell, & Pleasants (2009) phenomenological study was conducted with private interviews that lasted 2-4 hours as each person shared her “story,” which included 11 interest areas: personal background, health insurance, diagnosis, treatment, satisfaction with doctors/nurses, accessible services, caregiving, support systems, cancer’s impacts, ethnicity, and any memorable moments. The four primary sources of spiritual support were: God, family/friends, faith community, and healthcare personnel. The descriptions of spiritual support and how it was received could be helpful to health care providers seeking to be informed, culturally sensitive, and sensitive in their intervention strategies (Roff, Simon, Nelson-Gardell, & Pleasants, 2009).

Geographical Issues Related to Cancer

In addition to ethnicity and culture, geographic location was a factor in the success of treatment of women with breast cancer. After a month of chemotherapy, 46 women living with breast cancer in rural areas participated in quality of life and psychological surveys (Beck Depression Inventory-Second Edition and Hesitation Scale) to assess if rurality had any effects on their recovery. It was discovered that rural women tended to experience more distress, along with higher levels of hopelessness and depression. In rural areas, there tended to be less mental healthcare available and more stigmas associated with having cancer (Reid-Arndt and Cox, 2010).

The analyses disclosed that after a month of chemotherapy, rural women tended to experience lower physical functioning, lower overall well-being, and were very concerned about breast cancer symptoms. Even though there may have been geographic distance between them and their support systems, many women in the rural areas had close relationships and reliance on faith. This study of women with breast cancer living in rural areas illuminated the importance of seeking social support during chemotherapy and recovery (Reid-Arndt & Cox, 2010).

Paskett et al. (2011) revealed in their study that living in a rural area increased cancer risk and complicated survival rates for cancer patients. There were cancer-related disparities in Appalachia mainly due to the area being an underserved, independent, rural population. Even though the Appalachian region was described as primarily Caucasian, the population has since become more diverse, growing to include a large Hispanic population. Paskett's report shared factors that may have affected the health of its residents: isolated regions, not having insurance or being underinsured, limited public transportation, and fewer healthcare facilities and doctors. As a result, cancer risk was increased due to lack of screenings, limited treatments, and varied survival rates.

The central part of Appalachia had a higher incident and mortality rate, mainly present in cervical, colon/rectum, and lung/bronchus cancer. The National Cancer Institute funded a community partnership to focus on education, awareness, research, and training for the Appalachian region. Remaining challenges were identified: understanding the needs of the communities, recognizing the dynamic aspects with technology, changing demographics, and finding ways to make cancer education/prevention relevant. This report emphasized the importance of a unified commitment to reducing cancer disparities and improving resources for underserved populations (Paskett et al., 2011).

Cancer and Treatment Issues

It has been demonstrated that having cancer creates an emotional journey. Deshields, Tibbs, Fan, and Taylor (2006) explored how depression often occurred after a cancer diagnosis. Once the reality of the diagnosis was accepted, there often followed fears about dying, along with feelings of isolation, loss of control, depression, and hopelessness (Yoo, Aviv, Levine, Ewing, and Au, 2010).

When women experienced cancer and the treatment needed, there were typically results of physical, cognitive, and psychological symptoms. Nausea and vomiting were the most common responses to chemotherapy and created negative impacts on quality of life. Another response was psychological distress that could result in depression or anxiety. Patients' perceived needs or outcome also influenced their quality of life. These findings took place in Nagoya, Japan, where 214 patients were studied at the outpatient oncology unit while undergoing chemotherapy at Nagoya City University Hospital (Akechi et al., 2010).

Cancer proved to reduce cognitive and physical functioning. The most significant results from the Gudbergsson, Fossa, Borgeraas, and Dahl (2006) study indicated that Norwegian cancer survivors (51%) did not have any difference in work hours or full-time jobs from the cancer-free control group; however, the cancer survivors reported significantly less mental work capabilities and poorer physical capacities. The cancer survivors reported more somatic diseases, and male cancer survivors indicated poorer general health. Due to the study's findings regarding impaired physical and mental capabilities, challenges were presented for cancer patients in the long run. An important consideration was to have healthcare professionals focus on such realities in follow-up programs. In the Hodgkinson et al. study regarding gynecological cancers, 29% of

women were dealing with clinical anxiety or PTSD related to concerns about recurrence (Hodgkinson et al., 2007).

Ignorance, or lack of information, exacerbated the experience of breast cancer symptoms. The Helgeson and Tomich (2005) study focused on the quality of life of 267 disease-free breast cancer survivors and 187 similarly aged healthy women from the local neighborhood. The research examined if breast cancer had any negative long-term impacts on their quality of life. While there were many similarities, the breast cancer survivors without education intervention reported challenges with physical functioning and mental fatigue related to breast cancer treatment. The education intervention offered information and coping skills about how to navigate breast cancer. The breast cancer survivors indicated that they had more faith than the control group from the neighborhood. In regards to the women who had a recurrence of breast cancer, their quality of life was impacted in several areas, especially feeling fatigued. However, there were not differences in the survivors in the areas of work, spirituality, and marriage.

Fatigue was a common symptom of cancer survivors post-treatment, creating poorer quality of life and lower overall emotional well-being. Previous studies indicated that 40% of cancer survivors dealt with fatigue, sometimes even years after being diagnosed. The following study focused on which cancer-related factors and work factors were related to fatigue in cancer survivors. The study included 135 cancer patients who returned to work. They participated in a first questionnaire and a 12-month follow-up. The findings revealed four factors were associated with fatigue at 6 months of employment: depression, higher work pressure, lack of workplace accommodations, and physical workload. At 18 months, the only factor related to fatigue was lack of workplace accommodations. This demonstrated that accommodations for cancer

recovery could help reduce depression and fatigue (Taskila, de Boer, van Dijk, & Verbeek, 2011).

Cancer patients had to navigate mental health, emotions, and psychological issues while experiencing cancer. The Elmir et al. study (2010) focused on younger Australian women with breast cancer. Treatment for aggressive breast cancer often resulted in a mastectomy or double mastectomy. When such physically altering operations occurred, there were significant impacts on perceptions of lost femininity, struggles with sexual relationships, concerns about fertility, and negative body image issues due to disfigurement. One of the effects of breast cancer was women sometimes withdrew socially. The possibility of recurrence in each woman's story caused fear and uncertainty. The uncertainty stemmed from having to make life changes due to breast cancer, along with struggles related to fears about not being desirable or attractive post-surgery.

After a cancer diagnosis, there were mental considerations and preparations needed to resume activities, including work. Since improvements have been made in early detection and treatment for cancer patients in developed countries, more people could return to work. The following study focused on breast cancer survivors' mental preparation and considerations explored regarding returning to work. There were 22 Flemish female employees with an average age of 46, who had breast cancer, surgery, and chemotherapy/irradiation therapy. The cancer survivors shared that before returning to work, careful evaluation and mental preparation took place regarding how to transition from "being ill" to "returning to work" (Tiedtke, de Rijk, Donceel, Christiaens, and de Casterle, 2012).

These women also reported a desire to go back to work, so that a sense of normalcy and feeling recovered would take place. They did not want to be perceived as sick or disabled and

they wanted to continue contributing to society. Another mental preparation was considering if it was worthwhile for all of the effort needed to return to work by evaluating health, possibility of recurrence, and if work was necessary for livelihood (Tiedtke et al., 2012).

Exploring concerns about recovery was also a mental preparation included in reviewing a woman's desire and ability to return to work. Fears about performance and of a cancer recurrence occupied these cancer survivors' minds while considering a return to work. Besides concerns and fears, there were also doubts about acceptance at work. Many wondered if there would be understanding regarding returning to work, especially if 100% capability or performance was not possible. Also, these women felt like they would have to pretend that they were feeling healthier or stronger than they were to fit in at the workplace (Tiedtke et al., 2012).

For these women, the mental preparation needed to return to work was permeated by vulnerability and uncertainty. In regard to vulnerability, they feared recurrence and were cognizant of their mortality. They also experienced uncertainty because they did not know if they could fully contribute in a positive and respected way. The study showed that while women may have wanted to return to work, there were doubts about whether it was physically feasible (Tiedtke et al., 2012). “It is likely that the more extensive disease is associated with more limitations in functional capacities due to a greater negative influence of symptoms, possible greater burden of combined treatment modalities and related side effects, and eventually a more unfavourable prognosis” (Van Muijen et al., 2012, p.157). They also had to navigate how much mental and emotional effort was needed. As a result, these women had to wrestle with mixed feelings while deciding whether or not to resume work (Tiedtke et al., 2012).

Historical Background of Women and Work

Women's rights and opportunities within the United States have blossomed in the last century. There were improvements in women's civil rights and significant legislative changes. Women achieved more political status, resulting in more access, privileges, opportunities, and rights than in previous decades. Additionally, the labor demand created opportunities for women in the workforce. Societal expectations changed along with the United States' economic conditions, which also contributed to there being more women in the workplace (Reeves, 2010).

The United States was one of the first countries to be involved in *first-wave feminism*, which included women gaining the right to vote in 1920. While most women did not work, there were a few occupations women were employed in: teaching elementary school, nursing, bank tellers, and telephone operators. Occasionally, women became lawyers or doctors, but this was rare and usually related to a family business (Reeves, 2010).

World War II encouraged women's participation in the workforce in nearly all professions, but it was primarily because of the war. The various professions included airplane pilots and non-combat military work. The majority of women's labor was needed in manufacturing plants. African American women were also represented in the workforce, mainly in the war-related industries. However, once the war ended, many men came back and resumed their previous roles. At that time, the mindset was that society had a responsibility to provide men and single mothers with jobs (Reeves, 2010).

Second-wave feminism began in the 1950s, when women wanted equal access to professions, responsibilities, and leadership at work. While most women remained at home during the 1950s, the desire for equality continued. The inflation of the 1960s and 1970s motivated some women to enter the workforce to supplement family incomes. During this time,

the civil rights movement progressed and birth control was becoming more readily available, which allowed women to have more civil liberties and sexual rights. The women's movement began focusing on equality with regard to economic opportunities and education (Reeves, 2010).

Third-wave feminism took place in the 1990s and was attributed to the demographic and cultural changes. *Second-wave feminism* was mainly attentive to Caucasian, educated, upper-class women. *Third-wave feminism* was inclusive of minority women, various cultures and social classes, and was not only focused on the job market but also on educational pursuits. From the 1990s until the present, there was an emphasis on legal protections for women in the work environment, ranging from subtle discrimination to penalties for violations related to gender. *Third-wave feminism* gave women a voice and helped improve their pay (Reeves, 2010).

For the past 6 decades, women's employment in America continued to expand in industries. In 1964, 19 million women were non-farming employees. There were five main business sectors that employed women: local government, transportation, trade, utilities, and manufacturing; these accounted for 54% of the female labor force. By 2010, 65 million (53% of) women were working in these main industries: education and health services; transportation, trade, and utilities; and local government. The growth of women working in education and health services was noteworthy (United States Department of Labor, 2011).

In the 1960s, manufacturing had the highest number of women employed. During the 1970s and 1980s, trade, transportation, and utilities were the main industries where women worked. There were more women employed in local government than in education and health services until 1975. In 1976, the number of women working in education and health exceeded the number working in local government. Education and health services ranked first in

employment of women from 1993 to 2010, followed by transportation and utilities, trade, and local government (United States Department of Labor, 2011).

Women continued to seek educational attainment. The National Center for Educational Statistics reported that from 1999-2000 to 2009-2010, the percentage of degrees earned by females was approximately 60-62% of associate's degrees and 57-58% of bachelor's degrees. Women continued to exceed men in graduation rates. The rates for master's degrees earned by women increased from 1999-2000 from 58-60%. In 2009-2010, the rates increased from 45-52% for doctoral degrees (*Fast facts: Degrees conferred by sex and race* "2012).

Women Seeking Leadership

With more women educated and involved in the workforce, more opportunities for leadership became available. Women in leadership faced unique challenges. In Eagly and Carli's (2007) "Women and the Labyrinth of Leadership," workplace barriers for women were identified. Prejudices continued where men earned higher salaries and received faster promotions. In 2005, women earned 81 cents to every dollar that a man earned in the United States. Bias was observable in performance evaluations and promotion opportunities. Men were advantaged where women had higher odds stacked against them, where women needed to overcome discrimination, organizational policies not favorable towards women, and their expectations of domestic responsibilities at home.

Since discriminating attitudes existed, women were prevented from seeking leadership roles. Debebe (2011) described the tension: "The conflict between societal and organizational expectations can reflect tensions between espoused beliefs that women can do men's work and actual concerns that they may not be suitable for it" (p. 682). Since women were often interpersonally sensitive, compassionate, friendly, helpful, soft-spoken, and gentle, they were

viewed as possessing communal qualities. Men were perceived as having agentic qualities, often aggressive, dominant, individualistic, assertive, controlling, confident, and forceful (Eagly & Carli, 2007).

Effective leadership has often been associated with agentic traits. When women focused on being agentic, they were scrutinized for not being communal enough. However, when women were communal, they were criticized for not being assertive or dominant enough. This created an unfortunate bind that female leaders faced when they sought to navigate leadership in a male-dominated culture (Eagly & Carli, 2007).

Women also experienced challenges because their non-verbal behavior, language, style of disagreements, and self-promotion were typically misperceived. While men were usually given the benefit of the doubt, women faced critical attitudes. Male leaders were given more freedom in regards to how they treated people and their communication styles. However, women experienced scrutiny about their motivations, communication styles, and behaviors. Female leaders were analyzed more and had more barriers than male leaders (Eagly & Carli, 2007).

As women strived to be in leadership roles, not all feminine traits were perceived as being as effective as masculine traits. In Catalyst's study of Fortune 1000 female executives, 96% of the female leaders indicated that it was vital to develop "a style with which male managers are comfortable" (as cited in Eagly & Carli, 2007, p. 67). The meta-analysis revealed that female leaders were generally more effective in their approaches, while male leaders were moderately effective, or may have even been a hindrance. An additional meta-analysis showed female leaders were usually more collaborative and participative than most men preferred.

Most female leaders had additional expectations and responsibilities of caring for their families: domestic work, childcare, caregiving, or other family responsibilities. As a result,

women often made sacrifices in their careers for their loved ones. Women's sacrifices were scrutinized in environments where social capital was a necessity. Most women would skip networking when time was limited. It also became a challenge if the male activities and networking excluded women. For example, there was a gender discrimination lawsuit against Walmart due to male-dominated activities such as hunting, fishing, and venturing to strip clubs (Eagly & Carli, 2007).

Strategies presented for reducing employment barriers for female leaders included: changing the norm of expected long hours, reducing the gender subjectivity in performance evaluations, increasing awareness of the ingrained bias towards women, enhancing personnel practices for recruiting, ensuring critical mass of female leaders in executive roles, being intentional for women's social capital opportunities, avoiding having a token female on a team, and bringing women into line management. Additionally, it was important for female leaders to have opportunities for promotions even if more time was needed. If family circumstances required a personal leave, companies should allow women the opportunity to return. These strategies identified ways to help women navigate the barriers which have prevented equality. If female leaders could make more informed choices and their managers had better understanding of the challenges women faced, gender balanced leadership could be achieved. The study illustrated that women need to continue to be vigilant in activism regarding continued social change (Eagly & Carli, 2007).

Women with Cancer and Work

Due to cancer's prevalence, the economic necessity of working, and ability for people to manage cancer more effectively, more cancer patients worked during and after treatment. With more effective treatment interventions, many cancer patients were able to resume their normal

activities, including work. Since women experienced cancer uniquely, they required essential support related to their societal, cultural, and work roles (Nowrouzi et al., 2009).

In 2009, Nowrouzi et al. (2009) surveyed 225 human resource personnel in Ontario, Canada, to discover how employers were accommodating employees who had cancer. They reviewed the companies' accommodations regarding return to work, flexibility with hours and scheduling, and paid time for medical appointments. The findings revealed that larger organizations and public sector jobs typically provided better assistance to employees with cancer, possibly due to greater access to resources. Smaller businesses did not seem to be able to offer the flexibility and benefits, such as a return to work meeting, reduction in work hours, and paid time for doctor's appointments. Nowrouzi sought to increase employer awareness and understanding towards employees with cancer because their mental, physical, and cognitive abilities were affected. It was also noted that employers should provide resources and services that are essential for employees recovering from cancer (Nowrouzi et al., 2009).

If employers were mindful of how to assist employees navigating cancer during the return to work process, their actions could assist the recovery process. Hauglann et al. (2012) surveyed 1,548 Norwegian women diagnosed with breast cancer. The study included women ranging in age from 45 to 54, in all stages of cancer. The majority of women were diagnosed during working age, which was 67 and younger in Norway. There were also 1,548 cancer-free women involved in this national Norway register-based controlled cohort study.

The results of the Hauglann study (2012) showed that women with breast cancer had an increased risk of permanent reduced work ability of up to 14 years compared to similarly aged women without cancer. This work ability depended on the individual's psychological, physical, and social resources. Women with more advanced stages of cancer and mastectomies were

more likely to pursue disability pensions. For women who remained in the workforce after cancer treatments, there was a negative impact on employment income, but it was recovered over time. This study confirmed that employment for cancer patients was not only good for the survivor's well-being, but also important for their social interactions and overall experiences. The study demonstrated it was wise for employers to be mindful of rehabilitation interventions and workplace adjustments to assist employees navigating cancer during the return to work process.

The importance of returning to work was even more significant for female employees with cancer. In a European qualitative study of 16 women who had breast cancer, the psychological pathway to health included a sense of belonging by returning to work and feeling reconnected with a normal life. This sense of well-being gave each woman an opportunity to prove that they were conquering cancer and maintaining an ordinary life. For the women involved in this study, it was more important to belong than actually be working (Johnsson, Fornander, Rutqvist & Olsson, 2010).

Lilliehorn, Hamberg, Kero, and Salander (2013) researched a longitudinal study of 56 Swedish women after breast cancer and found that the meaning of work to cancer survivors was significant to their healing process. Work was considered to be a vital part of the healing process, especially since it restored normalcy after the disruption of having cancer. Since cancer survivors' felt that they lost their identity when not working, it became highly problematic because it impacted the self-worth of each survivor and resulted in a financial burden.

Employees with cancer went through changes in attitude and perspective on life, which sometimes impacted their jobs. Grunfeld and Cooper's study (2012) utilized a 12-month follow-up survey and it revealed gynecological cancer survivors' changed attitudes about priorities,

employment, and values. After having gynecological cancer, questions arose about the relevance of work and desire to make work-related changes. Most women interviewed had a desire for employment changes, but few had actually made specific changes. The reality of financial implications played a role in decision-making, whether it was regarding new priorities or realizations. While employment remained similar for most of the women in this study, changes in behavior were reported in these areas: focusing on a healthy lifestyle, spending time with loved ones, and reducing stress.

Besides recognizing changes in attitude, employer support was vital for breast cancer survivors, regardless of a cancer patient's ethnicity. Blinder et al. (2012) arranged 23 women into focus groups, which lasted an hour each. The breast cancer survivors included the following nationalities: Chinese, African American, Filipina, Latina, African Caribbean, and non-Latina Caucasian. These women shared how employer support was vital to a breast cancer survivor, especially through providing a flexible schedule, privacy, medical confidentiality, personal support and advice, and normalcy in the work setting.

Seven women reported negative return to work experiences which resulted from lack of flexibility related to work schedule, job tasks, and failure to obtain adequate medical leave. Financial stressors or concerns about losing health benefits also contributed to the perceived inflexibility or rigidity. Those who had just started a new job feared about losing their employment and health benefits. Two of the women felt their supervisor discriminated against them because of their cancer. Another employee reported that her supervisor betrayed her trust and personal information related to her health, which demonstrated the significance of an employer sensitively and discreetly responding to an employee with cancer (Blinder et al., 2012).

Besides employer sensitivity, research showed that education is necessary to prevent the possible culture of ignorance which occurs within organizations. Employers, recognizing the significance of the relationship between work life and social culture for cancer survivors, were integral in the success of cancer survivors return to work. “Occupational health departments could offer managers improved education, training and realistic guidance in terms of work expectations from employees recovering from serious illness, the need for staged return to work practices, a durable work assessment strategy for work-related targets particularly for manual workers and women suffering from cognitive decline following treatment with chemotherapy” (Banning, 2011, p. 717).

Employers, and the work environments they manage, could be helpful to cancer patients returning to work by being mindful of their experiences and specific health challenges. Survivors faced challenges such as difficulties with memory loss and ability to concentrate, feelings of fatigue, being on an emotional journey, and physical limits. The Nordic Study on Cancer and Work (NOCWO) focused on how cancer survivors navigated returning to work, identified the obstacles, and determined the impact of cancer and coping with a new reality. The study included 3,599 cancer survivors who had either breast, testicular, Hodgkin’s or prostate cancer. There were two surveys; the follow-up was mailed 6-8 years after the initial survey (Lindbohm et al., 2011).

More female cancer survivors were involved in the study (70%) than men (59%). Of all participants, 57% had breast cancer, 29% testicular cancer, 8% lymphoma, and 6% prostate cancer. About 5-10% of cancer survivors had changed their work tasks, roles, or employers. Some of the changes in jobs were related to physical demands and a need for a more accommodating work situation. Women also reported a lack of support from employers or

health occupational services as an impetus for changing employment. Nine percent retired due to the effects of cancer, while 5% indicated that they were unemployed as a result of their cancer. The findings from this study suggested that if employers were more sensitive with hour reduction and adjusting tasks, and intentional with practical and emotional support, they could help cancer survivors maintain their jobs. It was especially beneficial if employers were aware of the healthcare providers' recommendations and evaluated the job tasks and environment accordingly (Lindbohm et al., 2011).

In regards to work accommodations, an employer providing flexibility through a reduction in hours was sometimes all that was needed. Through the Norwegian study facilitated by Torp, Nielsen, Gudbergsson, and Dahl (2012) regarding worksite adjustments and work ability, it was discovered that the most common adjustment requested was a reduction in hours. Sometimes changing job tasks or adjusting physical performance expectations was necessary to reduce mental or physical strain. Out of 653 cancer survivors, 26% needed a workplace adjustment as a result of cancer and treatment. A majority, 93-94%, of cancer survivors coped well with the work demands and rated their work ability high (8.6). The findings indicated that a favorable psychosocial work environment made a difference in the timing of the employee's return and work ability.

Besides employers being vigilant with proactive and practical arrangements for a cancer survivor's returning to work, it was also important to convey a positive yet realistic message about the employee's future. Grunfield and Cooper (2012) observed that when a cancer patient believed positive thoughts about her future and returning to work, it was a strong predictor of her actually returning to work. However, in order to have successful readjustment back to work, it was also important for cancer survivors to have realistic expectations. Based on the findings of

this study, implications for healthcare providers included helping cancer survivors have realistic beliefs about timing and ability to return back to work. Employers were able to be more supportive if a job was analyzed to identify any aspects of the role which presented challenges for a phased return to work plan.

In 2006, Gudbergsson et al. surveyed 317 women and 279 men in a Nordic study. The participants included 216 women with breast cancer, 165 men with testicular cancer, and 49 men with prostate cancer, with 39% from a control group. This study advocated for creating optimism by holding jobs for employees and encouraging them to return to work when they were ready. “The protection hypothesis of holding jobs as a precondition for normal living conditions was therefore confirmed in our study of cancer survivors with a favorable oncological outcome. In our view, these findings can raise a certain optimism concerning cancer survivors’ living conditions if they are able to join the work force even for a short time or between the times of treatments” (p. 1029).

When employers fostered a hopeful outlook on a cancer patient's future and how it relates to work, it helped cancer patients make decisions about their treatment and future. In another study, 379 women with breast cancer answered a survey regarding personal experience, work, and effects of cancer. The goal was to identify factors that determine the feasibility and timing of when women returned to work. While there were medical factors that needed to be considered, not all factors were medical. Personal factors related to self-perception, age, barriers, and processes (psychological, physical, and organizational) needed to make sure the timing was right for returning to work. The findings of this study showed that 82.1% of the women returned to work within three years of the initial cancer diagnosis (Fantoni et al., 2010).

The decision about the timing of returning to work, either while having cancer or waiting until the end of treatment, was a vital element of quality of life for women with breast cancer. Besides financial needs, there were also self-esteem issues to consider. Women who worked experienced feelings of normalcy and social support, in addition to meeting needs for health benefits and a salary. It was found important for employers to realize the significance of maintaining a woman's connection to her work environment. Ideally, it involved an early, multi-disciplinary approach that informed, guided, supported, and encouraged those with cancer about reintegrating back into their jobs.

Besides a hopeful outlook regarding an employee's future, it was also important to make sure that employers were educating employees about their rights. In the following study, 110 gynecological cancer survivors were surveyed after they were diagnosed and were still working. Of the women with gynecological cancer, 26% requested accommodations of their employers. The majority of women, who went through chemotherapy, needed to adjust their work schedules for treatment. While half of the women indicated that they arranged to shift their work schedules due to treatment, only 28% knew about their employer's policies regarding the process of returning to work. This study illuminated the need for healthcare providers and employers to inform employees about options and legal protections of Americans with Disabilities Act and Family and Medical Leave Act (Nachreiner et al., 2012).

Theoretical Framework of Life Course Research

This dissertation utilized Giele and Elder's (1998) emergent field of life course research to reveal how the powerful delayed effects of differences in early experiences impacted later life patterns. The life course perspective shared that while many women had similarities in education, age, race, and economic position, many had different personal characteristics,

attitudes, beliefs, or values that made them more likely to pursue careers or become homemakers. These factors could be revealed in a 1-2 hour interview that used a qualitative approach to encourage a woman in sharing her life's story (Giele, 2008).

Four dimensions were identified to have significant effects on one's direction of a life path: social networks and linked lives, historical and cultural location, agency, and timing of events. There were four factors vital in shaping individuals' adult gender roles: identity, relationship, personal drive and motivation, and adaptive style. The life story interview provided a social context, which elicited stories about key events, turning points, and distinctive themes in a woman's life. An individual's story could be utilized to show which precursors influenced outcomes later in life (Giele, 2008).

The four life course dimensions were illuminating. The first dimension was *identity*. How did her personal identity, background, and qualities play out in her story? The second dimension was *relational style*, and it showed how she related to others. The third dimension was *drive and motivation*. What was her ambition level and determination? The fourth and final dimension was *adaptive style*, which revealed her energy and ability to think and interact with experiences, changes, and her preferred pace (Giele, 2008).

For this dissertation, the focus was on how adaptive style along with drive and motivation influenced women who had cancer while focusing on work-life balance. This exploration was a part of the Digital Women's Project (Weber, 2011) where the sample was gathered through snowballing and conferences. As in Giele's initial format of life story interviews, there were semi-structured interviews that inquired about early adulthood, childhood and adolescence, adulthood-current, and adulthood-future (Giele, 2008). An additional set of questions on strategies for work-life balance was added through the Digital Women's Project (Weber, 2011).

The effective strategies identified for work-life balance while navigating cancer were compelling.

Work-Life Balance Strategies

Throughout this study, five strategies were emphasized: social support, faith, counseling, exercise, and wise nutritional choices. Ching et al. (2012) emphasized the importance of having the cancer patient know her religious and cultural values, strengths, limits and how to seek help from loved ones and healthcare professionals. Since personal relationships fostered hope, it was vital to have social support in place during the cancer journey. In the Burke et al. study (2012), there were two strategies that the Filipina women emphasized: family support and the importance of religious/spiritual support during the cancer journey.

In the Johnson et al. (2011) study, they concluded that several of the American Indian cancer survivors needed more support when faced with having cancer, which was why a rehabilitative approach was needed. Rehabilitation was described as counseling, education, support, and accommodations to the cancer survivor and family members. Grunfield and Cooper (2012) shared that changes of behavior in regards to focusing on a healthy lifestyle, spending time with loved ones, and reducing stress were effective strategies for women dealing with gynecological cancer.

Breast cancer patients used a variety of coping strategies, which included yoga, social and family support, increased religious practices, and exercise (Ching et al., 2012). These and studies emphasized effective strategies for helping women with cancer navigate work-life balance.

Summary

This literature review explored how women with cancer or cancer survivors navigated the personal and professional challenges of having cancer. Besides physical impacts, there were also identity issues that arose, especially when related to breast or gynecological cancer. Since more women are educated, contributing in the work force, and in leadership roles, issues related to work-life balance were explored. Treatment and recovery were more successful with supportive family and friends, faith, focus on health/well-being, and hope related to continued employment. Yet economic, cultural, geographical, multiple health issues, and unsupportive environments (personal or professional) continued to be the reality for many female cancer patients or survivors. This highlights the need for loved ones, healthcare professionals, and employers to understand the personal impacts of having cancer, along with how to help rehabilitate a female with cancer. This study revealed that more resources, strategies, and purposeful planning were needed to support a female with cancer, who is also navigating work-life balance.

Chapter 3: Methodology

This study analyzed the experiences of employed women who balanced work, life, and cancer. Through a qualitative methodology of an interview process, narratives allowed for a profound understanding of experiences that shaped the life course. Giele and Elder (1998) described life course as “a sequence of socially defined events and roles that an individual enacts over time” (p. 22). The life course method related the lived experiences with their developmental processes and identified themes regarding what the women shared (Elder and Giele, 2009). The life course method focused on four phases in women’s lives: early adulthood, childhood/adolescence, current life, and future plans (Giele, 2008). Exploring how cancer impacted work-life balance revealed insights into their motivation and goals and influences on their adaptive style.

This methodology chapter includes a restatement of the research questions, description of the research process, data sample, definitions of key terms, and the validity and reliability of data. It details what techniques were utilized to collect information and examine the data. A section was dedicated to describing the Institutional Review Board’s role and process regarding this study. It concludes with a summary of the methodology utilized for this study on employed women who balanced work, life, and cancer.

Research Questions

These research questions guided this study:

1. How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance?
2. What socio-demographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions?

3. What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance?

4. What effective strategies or resources help women navigate the work-life "balancing act" when diagnosed with cancer?

Research Methodology

This study utilized qualitative research as the methodology. “Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2007, p. 37). In order to study this social or human problem, researchers used an emerging qualitative approach. This emerging qualitative approach was a collection of data sensitively obtained, taken in a natural setting, which allowed an inductive data analysis creating themes and patterns. These themes and patterns were revealing. Denzin and Lincoln (2005) wrote, “Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world” (p. 3).

Qualitative research illuminated the world of women navigating work-life balance. Weber duplicated Giele’s 2002 study, which focused on identity and work-life balance with four sets of questions related to childhood, young adulthood, current adulthood, and future adulthood. It allowed the Digital Women’s Project (DWP), led by Dean Weber, accompanied by her research team of doctoral students, to better understand women’s work-life balance. This dissertation used a subset of the larger Weber (2011) sample.

Giele’s life course methodology revealed patterns and allowed for women to reflect on their lives. Through their narratives, each woman was able to share information about the events

that were personally important in her life. Elder and Giele (2009) maintained that while each story was unique, there were crucial aspects, such as gender, class, and race, that influenced each woman's beginning and subsequent life events. They also noted that Kohli (1981) viewed life stories as a comprehensive approach to sharing individual insights and social aspects of one's life. Through narratives, a subjective view and insights that can only be captured from that vantage point were obtained (Elder & Giele, 2009).

Life stories allowed the research to be chronicled as a series of case studies. A comparison method was utilized similar to the Giele (2008) study, which analyzed 48 college-educated women and their choices of either career with families or becoming full-time homemakers. In order for logic to be utilized in analyzing each life story as a case study and understanding the differences and similarities, these steps were involved: “(1) selection of cases; (2) collection of data; (3) description of key attributes of the cases; and (4) comparative analysis to identify similarities and differences” (Elder & Giele, 2009, p. 244).

Once the case studies were selected, key attributes were identified. “Whenever possible, life course studies should collect data on historical context (location); relationships in family and work and other social settings (linked lives); health, well-being, and subjective aspects of meaning and satisfaction (human agency); and event histories in major domains of activity (timing)” (Giele & Elder, 1998, p. 26). Elder and Giele (2009) also shared that a person's traits, family environment, social pressures, and the economy played a significant role in shaping a life story.

Interviews

Weber's (2011) study began in fall 2009, through a sample section of women who were new doctoral students at Pepperdine University's Graduate School of Education and Psychology.

With Institutional Review Board (IRB) approval in late fall 2009, the sampling extended to women outside of the doctoral project. Female doctoral students, who were initially interviewed regarding work-life balance, were then requested to find additional women to participate in the study. This sampling method, called snowballing, worked by asking each interviewee if she knew someone who would be willing to participate in interviewing. It was a purposeful way to utilize sampling, to involve diversity and variation in the experiences and backgrounds of participants (Stone, 2007).

Work-life balance has been discussed and studied over the last ten years. The Digital Women's Project (Weber, 2011) put together several research team members pursuing their dissertation research. There were a variety of topics which revealed the breadth of Giele's (2008) qualitative methodology. Krymis (2011) concentrated on understanding women of faith and its role and impact on balance issues. Barge (2011) focused on the competing priorities of African American women and their experiences with work-life balance. Heath (2012) researched and categorized the numerous strategies employed by women with children who achieved work-life balance. Almestica (2012) explored the impact of work-life balance issues on employed women in male dominated work environments. Jenson (2013) examined Native American women, the role of technology, and their ability to balance work and family. There were many other researches tackling other facets of this project (Weber, 2011).

Weber (2011) and her doctoral students conducted more than 200 interviews based on a qualitative methodology of life course interviews. The DWP project studied the experiences that shaped the life course of female leaders as they navigated work-life balance. Each woman completed a consent form and a socio-demographic information. Then, an interview was

conducted and centered on the four main questions from the Giele (2008) study and an additional question created by Weber (2011) focused on strategies for work-life balance.

Before any interviews took place, each interviewer went through training regarding the interview protocol. This training prepared each interviewer with instructions regarding professionalism and importance of consistency with procedures. The training emphasized being objective and facilitating an interview which allowed each participant to comfortably share her responses to the questions. Each interviewer read information and participated in one or more practice interviews before interviewing on behalf of the DWP project. This training created a place for confidence building and skills to be developed before participating in doctoral research (Weber, 2011).

A majority of interviews were conducted in person, and a few interviews were done via phone. Most women were comfortable being recorded, but there was an option for not being recorded but allowing notes to be taken instead. While most interviews lasted approximately an hour, there were a few women who were more succinct and other women who shared a lot of information. Then, all of the interviews were coded by mother's maiden name in order to provide each participant confidentiality. Providing anonymity was intentional in order to cultivate an environment where each woman could share more freely. Each interview was then transcribed and added to the DWP research project (Weber, 2011).

IRB required that each researcher go through Human Subjects and IRB training. Each researcher had to successfully pass the IRB training in order to be granted approval to participate in the DWP research and utilize the database of 200+ women. Since some of the questions had the potential to trigger emotional responses, each interviewee had the choice to share what she felt comfortable. The interview process was designed to allow each woman the opportunity to

share in a manner that she felt most secure. Each interviewer was encouraged to provide empathy and sensitivity non-verbally as needed (Weber, 2011).

Instrument

For this qualitative study, Weber obtained permission from Dr. Giele to utilize her life course framework to develop a similar project related to work-life balance. Before discussing the instrument, each woman filled out an informed consent form (see Appendix B), which explained the research project and how the information would be utilized. Then, each woman was requested to fill out a socio-demographic form (see Appendix C), which provided relevant information to the researchers. The demographic information included: mother's maiden name, date/place of birth, level of education, employer/occupation, marital status, marriage date, spouse's information (date of birth, education, and occupation), children's information (gender and date of birth), mother's and father's information (education and occupation), siblings' information (gender and date of birth), household income, own earnings, health, illness, accidents, disabilities, religion, languages, and countries visited (along with indicating living abroad).

Next, each woman was asked to participate in a retrospective interview. The retrospective interview was the main instrument that facilitated these questions and the subjects' responses (Scott & Alwin, 1998). The four main questions were created by the Giele (2008) study, and Weber (2011) added a question that focused on strategies for work-life balance. These were the questions utilized for the retrospective interview's instrument (see Appendix D):

Question #1 [Early adulthood/

About the period in your life immediately after college, or your early twenties. What was your major, name of your college, and year of graduation? What about graduate

education? What did you think you would like to become in terms of occupation and type of lifestyle or family life? What were you thinking then, and how did things actually turn out?

Question #2 [Childhood and adolescence]

Thinking of the period in your life before college and the goals that you and your family held for you, what was your family's attitude toward women's education and you going to college and what you would become? What was the effect of your parents' education, presence of brothers and sisters, family finances, involvement in a faith community, and family expectations? How was your education different from or similar to that of your parents and brothers and sisters?

Question #3 [Adulthood – current]

Since college, what kinds of achievement and frustration have you experienced? What type of mentors have you had? What has happened that you didn't expect in employment, family, faith, further education? Has there been job discrimination, children, a separation or divorce, health problems of yourself or a family member? What about moves, membership in the community, faith community, housing problems, racial integration, job loss? And feelings about yourself? Have there been good things such as particular rewards, satisfaction, or recognition?

Question #4 [Adulthood – future]

Looking back at your life from this vantage point, and ahead to the future, what are your main concerns? What are your goals, hopes and dreams for the next few years? What problems do you hope to solve? Looking further out, where do you hope to be a few years from now with respect to work or finishing graduate school, family, faith, community, mentors, health, finances, etc.?

Question #5 [Strategies for balancing life]

What coping strategies do you use to respond to concerns related to the plurality of roles? Have you ever felt pressured to choose between work and home? What made you think that you could do both successfully? Do you feel that your family life or work life have suffered because of your involvement in work or family? Have you felt any guilt related to either family or work? Are there times that you felt particularly successful at juggling the demands of both work and home? Why? Were you prepared for the demands of work and life balance? Why or why not? What strategies did you implement in your own life in order to remain balanced?

Validity and Reliability of Data

Patton (2001) noted that in the design of a qualitative study, there were two important factors: validity and reliability. In order to attain reliability, researchers analyzed the results and judged the quality of the study. Golafshani (2003) also emphasized that in qualitative research, the quality of the study provided reliability. In qualitative research, there was a quest for “understanding,” which was knowledge gained from visiting with participants and seeking to find detailed meanings (Creswell, 2007). Bryman (2008) described validity as “the issue of whether an indicator (or set of indicators) that is devised to gauge a concept really measures that concept” (p. 151). This research offered *face validity*, which meant the measure reflected the content that was being explored by the research questions. *Face validity* offered an intuitive process through interviewing. Bryman described distinctions between reliability and validity, but without validity, reliability could not be ensured.

Creswell (2007) shared that “validation” in qualitative research was a way to assess the “accuracy” of the findings, which was best described by the researcher and participants. Validation proved to be a strength of qualitative research because of the time spent with the

participants. Creswell shared how Lincoln and Guba (1985) established “trustworthiness” by utilizing terms such as “credibility,” “dependability,” “authenticity,” “transferability,” and “confirmability.” Dependability and confirmability could be established through auditing the research process (Creswell, 2007). Reliability in qualitative research could be enhanced by quality tape recording and transcribing.

For this study, the responsiveness of the inquirers cultivated credibility. Since this was a narrative study, inquirers were required to obtain permission before a participant shared information. Each participant was apprised of the motivation of the researcher, granted anonymity if she desired, and informed about the objective of the research. This disclosure by the inquirers helped build credibility and rapport (Creswell, 2007).

Due to the training of the research team and conscientious approach to the interview processes and transcription, reliability was ensured. Weber (2011) instructed each doctoral student about the importance of conducting interviews in a professional and sensitive manner, along with being mindful of each step with consent, completing all of the forms, and accommodating the participant’s comfort level throughout the entire process. Each woman’s responses were protected by using her mother’s maiden name for coding, and students were mindful to not disclose any details in a dissertation that might reveal someone’s identity.

Proposed Data Analysis

This phenomenological study explored how having cancer impacted female cancer patients or survivors’ ability to achieve balance in their personal and professional lives. By exploring via narratives (DWP interviews) and through Giele’s life course method (2008), a broader approach was gained in understanding the competing needs and priorities of female cancer survivors striving to achieve work-life balance.

The DWP research data was protected by a secure DWP database. There was a secure place to upload recordings of each interview and transcribed interviews. After being granted approval and access by IRB, each researcher was allowed access to the data. DWP allowed access to the DWP database with instructions on how to use NVivo software selected for coding to search the interviews for applicable research (Weber, 2011).

When applicable interviews were discovered, NVivo was used for coding. Coding identified themes and the researcher set up nodes to identify specialized categories for comparison and use for doctoral research. NVivo allowed the user to gather, organize, analyze, and visualize research. NVivo helped make the results more apparent. Each applicable interview was coded to determine how female leaders with cancer navigated work-life balance.

IRB Process

After going through DWP interview training and approval from Dean Weber, interviews were allowed with the larger IRB umbrella approval granted to Dean Weber (2011) and her research team for the study called Digital Women's Project: Work-Life Balance Issues. Each researcher was expected to conduct 25-30 interviews for the DWP database as a part of their contribution to the DWP team. Once preliminary exams were passed and IRB approval was granted for my study, then the DWP data could be accessed for my research and dissertation.

Summary

Through the conducted DWP interviews, this study analyzed the experiences of employed women who balanced work, life, and cancer. The life course method revealed the four phases in women's lives: early adulthood, childhood/adolescence, current life, and future plans (Giele, 2008). The methodology utilized by Giele concentrated on identity, relationship style, drive and motivation, and adaptive style of women.

This study consisted of individual interviews with each subject following the four general themes from the Giele (2008) study, strategies for balancing life activities, and seeking responses that indicated the impact of being a cancer patient or survivor. In regards to the specific women who were selected for this study, there were 10 women who identified as having cancer. A comparison group matched on age via random sample for the birth year was utilized to explore the differences between the two groups when contrasting motivation, goals, and adaptive style.

The themes from the interviews of women who experienced cancer were analyzed to see which factors impacted their personal work-life balance. There was also a comparison of women from the DWP research who had no personal health challenges to women with cancer. This illuminated strategies and resources used by the women who experienced cancer while balancing life and work responsibilities. This research focused on how motivation and goals and adaptive style were influenced when women had cancer.

The interviews were representative of a diverse group of women with cancer in contrast to women with similar demographics in the study who did not have any health challenges. In examining the differences between the two groups of women, it revealed how cancer impacts work-life balance. This study sought insights into women with cancer navigating work-life balance:

1. How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance?
2. What socio-demographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions?
3. What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance?

4. What effective strategies or resources were used to help navigate the work-life "balancing act" when diagnosed with cancer?

Chapter 4: Data Analysis and Findings

Introduction

Imagine the scenario:

“What would you do if you were diagnosed with cancer today? How would a cancer diagnosis affect your life? How would you respond to the diagnosis?”

For women who are already juggling work-life balance, this diagnosis resulted in a significant interruption. Cancer intruded into these lives like an unwanted guest who will not leave; each life endured a major disruption. As poignantly described by Helen Person, “Cancer rears its ugly head and strikes a family. And another family. And another family. It knows neither age nor gender. It distinguishes not among socio-economic levels, education achieved, professional successes. It doesn’t care,” (*Barrow Journal*, 2010). This study featured the personal experiences of 10 diverse women who received a cancer diagnosis which interrupted their lives.

This qualitative phenomenological study explored how cancer impacted women’s ability to navigate and achieve work-life balance. Since female cancer patients and survivors encounter unique stressors, challenges, and experiences related to their cancer journey, this study compared 10 women identified as having cancer and a comparison group matched on age via random sample for the birth year. The personal experiences of the 10 diverse women who received a cancer diagnosis (Group A) described ways that cancer changed their lives. The comparative sample of women without a cancer diagnosis (Group B) were also analyzed along these themes. The findings revealed differences between Group A and B in regards to their outlook on life, lifestyle choices, and how work-life balance was navigated. Successful strategies for navigating work-life balance for the two groups were explored: faith, support systems, healthy lifestyle, resources, therapy, and hobbies.

The foundational theoretical framework, provided by Giele's (2008) life story method, analyzed the narratives through the lenses of identity, relationship style, drive and motivation, and adaptive styles of women. However, this study utilized only the guidelines of these two following themes, drive and motivation, and adaptive style, from the Giele (2008):

“Drive and motivation: Need for achievement, affiliation, power. Is A ambitious and driven or relaxed and easy going? Is she concerned to make a name for herself? Focused more on helping her husband and children than on her own needs (nurturance vs. personal achievement)?

Mentions enjoying life and wanting to have time for other things besides work. Enjoys being with children, doing volunteer work, seeing friends. A desire to be in control of her own schedule, to be in charge rather than take orders.

Adaptive style: What is her energy level? Is A an innovator and a risk taker or conventional and uncomfortable with change and new experiences? Does A like to manage change, think of new ways of doing things? Is she self-confident or cautious? Used to a slow or fast pace, to routine and having plenty of time, or to doing several things at once?” (Giele, 2008, p. 402).

From the transcription of the Digital Women's Project data and the basic coding through NVivo, themes emerged while looking through the lens of drive and motivation, and adaptive styles of women. Additionally, strategies for work-life balance emerged through the narratives. The following research questions were utilized as the basis to analyze the findings and guide this study:

1. How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance?
2. What socio-demographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions?

3. What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance?

4. What effective strategies or resources help women navigate the work-life "balancing act" when diagnosed with cancer?

Population Description

The 20 women interviewed for this study were a subset from the Digital Women's Project. The subset was comprised of 10 women diagnosed with cancer (Group A) and 10 women without a cancer diagnosis (Group B). Out of the group, there were seven women younger than 50 years old, while 13 women were over the age of 50. In regards to this sample being an ethnically diverse, here is the representation: Korean (1), Filipino (2), African American (4), Caucasian (9), and undisclosed (4). Considering that an age match with birth year designated Group B, the diversity represented was beneficial towards the findings of this study. In regards to religious preference, here is what was comprised our sample: Catholic (2), Christian (13), Mormon (1), Jewish (2), None (1), and Undisclosed (1). The reported annual income ranged from \$57,000 to \$500,000. The average salary was \$150,000. In addition, Table 1 (see next page) helped to illustrate information about marital status, number of children, occupation, and education level.

In order to protect the identity of the 20 women involved with this study, a naming process was developed utilizing the letters A – T. Each woman was given a synonym which corresponded to a letter of the alphabet. It was organized alphabetically beginning with "A" through the letter "T". For example, the alphabetical order and synonyms corresponded "A" identified Amy, "B" identified Beth, "C" Identified Christy, etc.

Table 1
Population Demographics, Group A (1-10) and Group B (11-20)

	Education	Occupation	Status	Children	Religion
#1 Amy	AA	Business	Divorced	1	Christian
#2 Beth	BS	Technology	Married	1	None
#3 Christy	BA	Entertainment	Married	2	Jewish
#4 Darlene	BS	Aerospace	Living Together	2	Christian
#5 Emily	MA	Education	Divorced & Living with New Partner	0	Christian
#6 Fiona	MA	Education	Widowed	2	Christian
#7 Grace	PhD	Education	Married	2	Christian
#8 Harriett	AA	Education	Divorced	3	Christian
#9 Ilaria	PhD	Education	Married	2	Christian
#10 Joyce	PhD	Education	Single	0	Undisclosed
#11 Kerri	MBA	Financial	Married	2	Christian
#12 Lolly	PhD	Education	Married	1	Christian
#13 Mary	JD	Legal	Married	2	Jewish
#14 Nina	JD	Corporate	Single	0	Christian
#15 Oksana	MA	Education	Divorced	2	Christian
#16 Penny	PhD	Education	Married	0	Catholic
#17 Qadesh	MFT	Counseling	Married	2	Christian
#18 Ronda	MA	Marketing	Single	0	Catholic
#19 Sarah	PhD	Education	Married	2	Christian
#20 Tina	AA	Government	Married	3	Mormon

Women with Cancer (Group A)

There were 10 diverse women identified as having cancer who were selected from the Digital Women's Project (Weber, 2011). The women selected in Group A represent various ethnicities, generations, marital statuses, educational backgrounds, and religious backgrounds. In regards to ethnicity, there were Filipino (1), African American (3), Caucasian (5) and undisclosed (1) represented in the sample. In regards to marital status, the sample included the following: single (1), married (4), divorced (2), widowed (1), and living together (2). Eight of the women from Group A had children. The diversity in the sample pool of 10 females with cancer substantiated the findings, which is important for validity and credibility of this study.

Group A experienced the following types of cancer: breast (5), colon (1), colorectal (1), Hodgkin's lymphoma (2), and undisclosed (1). These were the types of treatment indicated: chemotherapy (7), chemotherapy/radiation (1), treatment not disclosed (2). In regards to surgical solution, four women indicated they had tumor(s) removed via operation(s), three women experienced a lumpectomy procedure, and one endured a mastectomy.

Chemotherapy, one of the most common forms of cancer treatment, stood as a challenging treatment for many patients. Grace shared, "So, I had a 5cm tumor in my neck and 7cm tumor in my chest and I had six months of chemo, which was hell. So you know the cancer, I wasn't sick from the cancer, but the chemo, I wanted to die, it was miserable." Grace explained that her daughter wanted to know who was going to take them to school since Mommy was bald. For many patients, the side effects of chemotherapy included hair loss, nausea, vomiting, and diarrhea. (Chemotherapy, Mayo Clinic, retrieved from <http://www.mayoclinic.com/health/chemotherapy/MY00536/DSECTION=risks>).

Women without Cancer (Group B)

There were 10 diverse women who did not have cancer and were randomly selected from the Digital Women's Project based on the age match of birth year for women in Group A (Weber, 2011). Group B also represented various ethnicities, generations, marital statuses, educational backgrounds, and religious backgrounds. In regards to ethnicity, there were Filipino (1), Korean (1), African American (1), Caucasian (6) and undisclosed (1) represented. In regard to marital status, there were: single (2), married (7), and divorced (1). In Group B, there was not anyone who was widowed or living together. There were seven of the women from Group B who had children.

Data Analysis

The Digital Women's Project interviews were recorded with permission of each woman. The 20 interviews, comprising Group A and Group B for this study, were fully transcribed and uploaded to NVivo 10 software for coding purposes. In order for themes to emerge and to make sense of the data, the information was grouped together into codes (Creswell, 2007). NVivo software classified these codes and main themes as "nodes." As I reviewed each transcript of Group A's and Group B's interviews with the research questions as the foundation, any pertinent theme was translated into a node. If there were any other similar themes that applied to the created node, then the applicable quote was entered into NVivo. In order to ensure that there was a conscientious review of each interview and the qualitative data, there were at least two readings of the interview transcript before coding. All of the pertinent quotes were entered into the respective nodes and subnodes in NVivo, which further described main emerging themes.

Findings

The first research question was, “How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance?” This question was applied to Group A and Group B. For Group A, two themes emerged: 1) Having cancer often forced lifestyle or a mindset change, which resulted in being proactive or reactive to circumstances, and 2) Health challenges provided a perspective about having a more meaningful life and created a focus on being more nurturing to important relationships. Here are a few comments that highlighted how cancer impacted their motivation and goals while striving to achieve work-life balance:

Joyce: I’m at stage 4, I’m very sick, its in my bone marrow, I have 7 tumors, you know, its very far advanced and my parents had died. And I was standing at their gravesite and I was thinking, I don’t know what life is all about anymore. I mean you work; you do all these professional things, yada yada yada. But at the end of the day, life is just short and you’re all going to end up you know 6 feet below and all of this stuff that I’m busy doing and accomplishing in my life, and all this work and all these kind of things, it all just becomes, I don’t want to say meaningless, but yeah in a way it just didn’t hold the same kind of, like I just didn’t have the drive. I never in fact, ever since that year, I’ve never had the same ambition that I had before that. Because ambition all of a sudden became futility. Life is more than that but it’s not more than that. Life is really very simple. It comes down to some very simple things. It comes down to happiness and love and compassion and curiosity. And it comes down to living the day and all those types of things. And we make it much more complicated because we have egos and we have ambitions and we have those types of things.

Beth: When I was 40, I was diagnosed with cancer, and of course that was a health challenge. I spent a couple of years working through all of that. And um, it was a challenge that is for sure. I would also say though, and I do, that everything happens for a reason. Having that happen to me at 40 was a fabulous life lesson because I learned not to sweat the small things. All of the things I thought were so important were insignificant.

Emily: I think the first is a backhanded gift from experiencing traumatic illness, so again, having advanced stage cancer and all the things that come along with a fear for your mortality. The backhanded gift to that is things get put into perspective pretty quickly now. So I have a different perspective now on what’s a crisis or a concern. And how, or even if, it needs to be responded to. The first coping strategy is just being able to step back, and I get to measure everything against the yardstick of an advanced stage cancer, and very few things are that. I think the second thing is, again, the beauty of aging is I

have a track record of God and my faith, and seeing that He's brought me through the many valleys and peaks that I've been through so far.

Grace: Well like I said I just first hope to be living. You know, that's my... you know (emotional pause). Especially when you almost die, and you have kids, its not like I wanted to leave my husband alone, but it's the kids you know. When you take a step to have kids, you expect to be their mom... So yeah. I mean first I just pray to be alive at least until my kids are grown up.

As the result of a serious cancer diagnosis, Group A had compelling reasons to examine their drive and motivation. Due to being proactive or reactive, it often caused deep reflection about what was important and sometimes, resulted in a lifestyle change.

For Group B, two themes emerged about how competing priorities impacted the motivation and goals of those striving to achieve work-life balance: 1) Circumstances regarding financial challenges often resulted in unexpected lifestyle choices, and 2) Unexpected health issues of a family member impacted drive and motivation. Here are a few comments that highlighted how financial or health challenges impacted their motivation and goals while striving to achieve work-life balance:

Tina: Well, I think you already realized what happened that I did expect was that my income was needed for my family. And I did try to further my education, several times, I went back to school and took classes and loved it. And I was supported by my husband to take care of the kids because I really did want to finish. There came a point where my children were in college and I was still working on it and at that time I decided that it was more important that they get educated than that I finish and so that's where the finances came in, helped them finish college, which they did, and I am so proud of them.

Nina: As far as family, um, you know what's happened that I didn't expect family obligations; helping out family financially has taken a significant toll in my life personally, ...and so, I can't do what I need to do. So that is very difficult in helping out family a lot, um, it is very hard when you are trying to operate your household.

Sarah: I mean we spend a lot of time in the hospital and we spend a lot of time dealing with insurance and mess like that. Um otherwise the rest of us have been really healthy. The main problem with Jake is seizures so we have to sleep; one of us has to sleep with him at night so that's kind of a weird family dynamic. We take turns and now that we're getting older and he's getting bigger we're also feeling, I just tore my rotator cup recently so things

like that are starting to happen that are not good. Not good at all. So we don't sleep much and we don't, which would be another reason why I can't ever picture having a job.

As the result of unexpected life circumstances, Group B also had compelling reasons to examine their drive and motivation. In the case with Sarah's severely disabled son, her lifestyle significantly changed. Even though she achieved her PhD, Sarah's love for her son outweighed using her education. Financial challenges also impacted Tina from continuing her education and Nina's ability to have enough money for all of her expenses.

The second research question was, "What socio-demographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions?" This question was applied to Group A and Group B. For Group A, two socio-demographic variables stood out: 1) Single parent, and 2) Age – older. These two comments highlighted how these socio-demographic variables influenced work-life decisions:

Harriett: The divorce was definitely hard for me and coming back and having to be the sole provider and what have you... was a little difficult for me. I don't want to get emotional about that, but it still bothers me and it's been over 20 years since I've been divorced.

Ilaria: I'm a really good caregiver. But not so much as the patient. Although, you know I probably tend to push myself. Probably. And I tire more now and so I have to try to be better.

As the result of socio-demographic variables, Group A had additional factors which influenced their work-life decisions. For Harriett, being a single parent of three children, made it difficult to make that lifestyle adjustment. She went from a two-story house to a one-bedroom apartment. For Ilaria, being over 50 years old, the recovery time after chemotherapy took a significant toll on her energy level. These are two examples of life factors which transpired while navigating work-life balance as a cancer patient or survivor.

For Group B, being a single/divorced parent is the socio-demographic variable that stood out. These two comments highlighted how being a single/divorced parent influenced work-life decisions:

Kerri: I was early in my career, and I had small children, and I had to leave my children with family, with my parents for extended period of times in order to be successful at my current job. And, I felt I did have a tremendous amount of guilt having to leave my children for an extended period of time but it was one of the things I needed to do in order to provide a better life for them.

Oksana: I wanted a career, I feel the need to work, I want to work, I like working. But it can be overwhelming. So that's, I had to make that decision and it was good for me, it worked for me. But I know at points my kids suffered, my family suffered but I think they benefitted a lot too. So it's, you know, again it's that balance. And, and when it was difficult.

The third research question was, "What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance?" This question was also analyzed for Group A and Group B. For Group A, a major theme was having cancer impacted personal decisions regarding work-life balance. For example, Joyce was self-confident, innovative, and successful professionally; however, her outlook completely changed after having a serious battle with cancer.

Joyce: You're not just living your life; you're making your life. And if you're making you're life then you really have to decide what's important to you and what gives you meaning on a deeper level and that might not be what society thinks is meaningful and purposeful, but you got to figure out for yourself. And if it's purposeful, if it provides you with peace and purpose to work in your garden, then you should work in your garden and that should be the number one thing that you do and you should not worry about not grading 18 papers that day.

Joyce switched her fast paced career for a more meaningful existence. She decided to be very intentional about seeking harmony, "playing", and finding daily joy.

Before cancer, Amy was traditional, appreciated routine, and uncomfortable with change; however, after testing positive for BRCA gene and enduring breast cancer, Amy changed her

life. Amy's desire to make a difference has opened new doors of opportunity including motivational speaking and creating a radio show.

Amy: And with being BRCA positive, genetics being what they are, there's a good chance that she [my daughter] is going to have to face a cancer battle. I just hope that I am going to be here to fight with her and be with her and support her through it and that she survives it. So that's a big reason why I do the volunteer work that I do. I want to make sure I can do whatever I can if my baby, who is my world, has this ticking time bomb inside of her. How can I just sit there and let it go off without doing everything I can? So, that's why I do all the fundraising, volunteering, and speaking. And it's not just for my daughter. I don't want to see anybody lose anyone.

Amy realized it is not about seeking material possessions but rather facing adversity and becoming stronger because of what you experienced. As a result, cancer gave her the courage to live life more boldly.

For Group B, an example which stands out is Sarah's experience of having a PhD, being active, and then having a severely disabled son changed her life. Instead of being innovative, multi-tasking in a fast paced environment, Sarah was intentional with slowing down her environment. She became cautious when making a commitment.

Sarah: We're very, like doing what we like doing, we are not very easily guilted into doing stuff we don't feel like doing. Yeah, I'm not easily guilted into stuff and I try not to be too ambitious, not pack too much stuff into the day because I need to sleep. I don't know when I am going to sleep again, so I think knowing and having that sleep issue actually forces you to pace yourself in a really realistic way; that maybe not everyone has to do, so they don't. By pacing myself, I'm really very selective about what I get into.

As a result of her son's condition and experiences, Sarah became a disability advocate for her son and others who may need similar accommodations. While Sarah slowed down the pace in her life, her research, passion, and advocacy skills are quite engaged.

The fourth and final research question was, "What effective strategies or resources help women navigate the work-life "balancing act" when diagnosed with cancer?" This question was applied to Group A and Group B. There were six main nodes that emerged from the coding.

These successful strategies of navigating work-life balance for the two groups explored: faith, support systems, healthy lifestyle, resources, therapy, and hobbies. The top two that resonated with Group A and Group B were support systems and resources. Healthy lifestyle and hobbies were the third and fourth strategies for the combined groups.

For women in Group A, they were intentional about using at least 3-5 strategies to achieve work-life balance. The women in Group B mentioned 2-3 strategies for work-life balance. In looking at the contrast of concerns between Group A and Group B, there was a marked difference. All 10 women in Group A valued good personal health and mentioned the future concern of the cancer returning or their health being jeopardized. However, only three of the women from Group B referenced their health as a future concern.

There were several quotes from the women Group A who indicated that having cancer changed them. The majority discussed how their outlook/mindset changed. Additionally, several of the cancer survivors were also intentional about their lifestyle regarding their health, faith, therapy, and hobbies. These examples highlighted the intentionality these women exhibited after being diagnosed with cancer:

Beth: So I started 4 years ago actually practicing presence. And by that I mean, the being in the moment, and that learning and practicing being present has created joy in my life in some of the most subtle and very small ways. And has helped me manage my stress. So, uh, that's been a huge, a huge help for me.

Christy: And I don't think I was ready to soul search and grow and grow spiritually and grow as a person until my cancer. And a lot of people that I worked with were very spiritual and I never knew that. And after my cancer when I was searching, they all came forward and I said where were you before? I said I never knew that you were so spiritual. And they said you weren't ready. When you're ready, the teacher will come. So I had just opened myself up and people came in. And I can't even name the mentors that I have had.

Fiona: But now I minister to widows unfortunately. That's something I do. Also, minister to cancer patients now. That's something I do. So the Lord calls you to minister, but you don't want sometimes, but I am one not to live in denial and to think

okay Lord, what do you want me to do with this? So those are the ways I hope to leave a legacy of encouragement to people. I like to encourage people. And do what the Lord puts before me.

Amy: Everything is just a little sweeter. Time with my daughter is more meaningful. Time with my mom is more meaningful. Time with my sister is more meaningful. Taking the time to say hello or smile and nod at a perfect stranger standing in a Starbucks line is just a good way to start my day.

Emily: And not that I'm scared that I won't be here, but I'm just so happy and content to be here, and I'm learning how to just enjoy the now. I was so future-focused before I got sick, so focused on I'll be happy when I stop, when I rest. Now I feel like I've got the pendulum swung in the opposite direction from where I am so happy, so content. I can smell the breeze, feel the sun, and appreciate the wind, and taste an orange that it's very hard for me to think five years out. Again, not because I don't think I'll be here, but because I am so delighted to be here right now."

Christy: We're living in a healthy state, we're living in a happy state, sure we don't have everything, but we're grateful for what we do have and my 365 letters of gratitude will be out as of next October 25, which I have vowed to send 365 letters of gratitude to friends within the next year. And to remind myself of all that I do have.

Amy: Cancer has changed me of course. I don't know how it could not. I would like to think it has changed me for the better. Not that I was so horrible before, but I think I was just a child before. Cancer made me grow up. And so I just want to keep doing what I'm doing. I want to keep doing good things. It makes me happy to do good stuff. It makes me really happy to make someone else smile. Or to have someone walk up to me at an American Cancer Society (ACS) event and say I saw you speak or I heard you speak at this other event, can I hug you? You just made me happy.

Harriett: So I've learned just to take really good care, even though I was taking good care of myself then, it's just, you just need to become even more vigilant about your health. You just become more vigilant of your health and so I am that.

Grace: And I can still work. I can still do things that are fulfilling to me, but so what if I'm not a star professor or whatever. That's been important to me. And you know frankly since I had cancer, I just kind of prayed that I would live to be 50 because then my kids would be graduated from high school.

These quotes demonstrated the significance of a cancer diagnosis. It was powerful to reflect on how a cancer diagnosis impacted a person's outlook, lifestyle, and work-life balance.

In regards to successful strategies for work-life balance, both Group A and Group B recognized the importance of the following support systems: husband, family, friends, and

community. Most of the women interviewed indicated that it would not be possible to juggle work-life responsibilities without their husband, family, or community. Lolly describes her deep appreciation for her husband:

Lolly: I have a really amazing husband, who without him, I couldn't do the job that I do. He is extremely supportive, he is a full partner in our marriage and in raising our child and in taking care of the house and life stuff.

However, another successful strategy was identifying resources to make the balancing act easier. These were the resources that were highlighted by Group A and Group B: mentors, flexible job, technology, nanny/cleaning person, and medical insurance.

Therapy was also considered a resource. However, there were several types of therapy recognized: therapeutic counseling, pet therapy, act of playing, practice gratitude, massage therapy, and retail therapy. Qadesh reflected on how it is essential for her to be in a peaceful environment and to reduce technology levels.

Qadesh: I've known this for a long time that my environment and setting need to be aesthetically pleasing, plus the nature of my office and home to visually give me a sense of calm, color, and response to the visual design of my space.

Qadesh also preferred human interaction engagement. She was mindful of setting up her schedule and creating an environment which was people friendly.

Healthy lifestyle was important to both Group A and Group B. Healthy eating, exercise, and wellness programs were featured in the responses. After Beth implemented a regular morning exercise routine, she reflected, "Because I feel better, I am healthier, and it still provides me that space and time for myself."

Faith was more significant to Group A (8 women mentioned faith) as a successful strategy for work-life balance. While two women from Group B mentioned faith as a vital strategy for juggling work and life, it was not mentioned as prominently in Group B. Roff et al.

(2009) indicated that a cancer diagnosis caused deep soul searching about meaning, purpose, and spiritual support. Fiona described it well, “But I think any health problem, it puts you, you know, closer to God. You think you are, but it puts you on your knees and in His presence. And you draw on His strength and His guidance”.

The final work-life balance strategy was hobbies. These hobbies were highlighted: volunteering, web show/radio show, motivational speaking, new adventures, fun, creativity, art, movies/reality TV, food, creative writing/journal, and music. Qadesh described, “I just love music! So just to play along on stage or in my living room... it just brings me great joy”.

Summary

These were the research questions which guided this study, along with a brief summary of the findings:

1. How do competing priorities impact the motivation and goals of cancer survivors who are striving to achieve work-life balance? For Group A, two themes emerged: 1) Having cancer often times forced lifestyle or a mindset change, and 2) Health challenges provided a perspective about having a more meaningful life. For Group B, two themes emerged: 1) Circumstances regarding financial challenges often resulted in unexpected lifestyle choices, and 2) Unexpected health issues of a family member impacted drive and motivation.

2. What socio-demographic variables (age, ethnicity, education, family, profession, marital status, etc.) influence work-life decisions? For Group A, 1) Single parent, and 2) Age – older. For Group B, being a single/divorced parent stood out.

3. What experiences (adaptive style) shape female cancer survivors and their decisions regarding work-life balance? For Group A, the major theme was having cancer impacted

personal decisions regarding work-life balance. For Group B, the experience which stood out is Sarah's experience of having a PhD, being active, and having a severely disabled son.

4. What effective strategies or resources help women navigate the work-life "balancing act" when diagnosed with cancer? These six successful strategies of navigating work-life balance for the two groups were: faith, support systems, healthy lifestyle, resources, therapy, and hobbies. The top two strategies that resonated with Group A and Group B were support systems and resources. Healthy lifestyle and hobbies were the third and fourth strategies for the combined groups.

Through the 20 narratives, the lens of Giele's framework of drive and motivation, adaptive style, and the analysis of the work-life balance strategies, Group A's findings showed that a cancer diagnosis changed their outlook on life, lifestyle choices, and/or use of successful strategies for work-life balance. While Group B may be intentional in their outlook on life, lifestyle choices, and/or strategies for work-life balance, it cannot be compared to Group A's level of engagement, intentionality, and purposefulness.

Chapter 5: Summary of the Study

This phenomenological study explored how cancer impacted female patients or survivors while striving for personal work-life balance. Since female cancer patients and survivors encountered unique stressors, challenges, and experiences related to their cancer journey, this dissertation examined the narratives of ten women, who had cancer and a comparison group matched on age via random sample for birth year. The twenty narratives were a subset of the larger Weber (2011) sample collected by the Digital Women's Project research team.

The foundational theoretical framework provided by Giele's (2008) life story method, analyzed narratives through the lenses of identity, relationship style, drive and motivation, and adaptive styles of women. This study focused on the following two themes: drive and motivation, and adaptive style. The personal experiences of the ten diverse women, who received a cancer diagnosis (Group A), described many ways that cancer had changed their lives. The comparative sample of women without a cancer diagnosis (Group B) was also analyzed along these themes. The findings revealed differences between Group A and Group B in regards to their outlook on life, lifestyles choices, and how work-life balance was navigated. Successful strategies of navigating work-life balance for the two groups were explored: faith, support systems, healthy lifestyle, resources, therapy, and hobbies.

Findings Related to Research

Through the findings of this study, the experience of receiving a cancer diagnosis often provided a perspective about having a more meaningful life. In the narratives, there were several descriptions of positive outlook, deep appreciation, not sweating the small stuff, and wanting to make a difference. These findings were in line with Blow et al.'s (2011) study, which encouraged female cancer patients to envision the experience as transformative, which could

lead to life-changing experiences and personal growth. A cancer diagnosis was significant and there were many different coping strategies (Blow et al., 2011).

Additionally, supportive relationships were indicated as very helpful for women who receive a cancer diagnosis or in the midst of a cancer journey. In Blow et al.'s (2011) study, the women who handled the stressors of cancer had several sources of support. One of the main strategies for women with cancer was dependence on support systems. Blow recommended, "Women would benefit from treatment tailored to their unique needs that enhance support, reframe beliefs, reduce stress, and allow an opportunity to talk and reflect on their feelings and circumstances" (p. 1333). The strategies of work-life balance highlighted in Group A's narratives in this particular study included the support system of husband, family, friends, and communities.

Another work-life balance strategy for female cancer survivors was maintaining a healthy lifestyle. Group A indicated that healthy eating, exercise, and wellness programs helped with their health and overall outlook. These findings were in line with Blanchard et al.'s study (2003) describing how exercise was beneficial for adult cancer survivors, specifically in physical, psychological, functional, and emotional wellbeing. Examples of some benefits include: muscle strength, decreased anxiety, reduced fatigue, and encourages optimism.

In regards to socio-demographics, education was one of the factors reviewed for both Group A and Group B. It should be noted that there were no women in Group A or Group B who had a less than a high school degree. This study showed the importance of education's impact on cancer survivors' opportunities. In Chan et al.'s (2008) study, researchers found "that cancer survivors with less education had a significantly lower chance of becoming employed after receiving vocational rehabilitation services. Specifically, high school dropouts had a 57%

reduction in odds and high school graduates had a 35% reduction in odds compared to college graduates” (p. 175).

Demographics

The 20 women interviewed for this study were a subset from the Digital Women’s Project. The subset was comprised of 10 women diagnosed with cancer (Group A) and 10 women without a cancer diagnosis (Group B). Seven of the women were younger than 50 years old, while 13 were over the age of 50. Considering that an age match with birth year designated Group B, the diversity represented was beneficial towards the findings of this study. In regards to being an ethnically diverse sample, the following ethnicities were represented: Korean (1), Filipino (2), African American (4), Caucasian (9), and undisclosed (4). In regards to religious preference, the study included the following: Catholic (2), Christian (13), Mormon (1), Jewish (2), None (1), and Undisclosed (1). The reported annual income ranged from \$57,000 to \$500,000. The average salary was \$150,000.

Table 2 provided information about marital status, number of children, occupation, and education level of the subjects in this study.

Table 2
Population Demographics, Group A (1-10) and Group B (11-20)

	Education	Occupation	Status	Children	Religion
#1 Amy	AA	Business	Divorced	1	Christian
#2 Beth	BS	Technology	Married	1	None
#3 Christy	BA	Entertainment	Married	2	Jewish
#4 Darlene	BS	Aerospace	Living Together	2	Christian
#5 Emily	MA	Education	Divorced & Living with New Partner	0	Christian
#6 Fiona	MA	Education	Widowed	2	Christian
#7 Grace	PhD	Education	Married	2	Christian
#8 Harriett	AA	Education	Divorced	3	Christian
#9 Ilaria	PhD	Education	Married	2	Christian
#10 Joyce	PhD	Education	Single	0	Undisclosed
#11 Kerri	MBA	Financial	Married	2	Christian
#12 Lolly	PhD	Education	Married	1	Christian
#13 Mary	JD	Legal	Married	2	Jewish
#14 Nina	JD	Corporate	Single	0	Christian
#15 Oksana	MA	Education	Divorced	2	Christian
#16 Penny	PhD	Education	Married	0	Catholic
#17 Qadesh	MFT	Counseling	Married	2	Christian
#18 Ronda	MA	Marketing	Single	0	Catholic
#19 Sarah	PhD	Education	Married	2	Christian
#20 Tina	AA	Government	Married	3	Mormon

Implications Related to the Findings

The findings revealed that Group A had the most marked change in their outlook on life, lifestyles choices, and how work-life balance was navigated. Due to the significance of having cancer, women in Group A seemed to have a deeper appreciation for life in general, to live their days more intentionally, and to seek meaningful ways to contribute to others. Group A was also more devoted to their faith.

Both Group A and Group B recognized the benefits of the six strategies featured in this study: faith, support systems, healthy lifestyle, resources, therapy, and hobbies. In order to successfully balance work-life, most of the women were involved with at least two strategies.

Table 3
Summary of Work-Life Balance Strategies for Group A and Group B

Work Life Balance Strategies	Examples
Support Systems	<ul style="list-style-type: none"> • Husband • Family • Friends • Community
Healthy Lifestyles	<ul style="list-style-type: none"> • Healthy eating • Exercise • Wellness programs
Resources	<ul style="list-style-type: none"> • Mentors • Flexible job • Technology • Nanny/cleaning person • Medical insurance
Therapy	<ul style="list-style-type: none"> • Therapeutic counseling • Pet therapy • Act of playing • Practice gratitude • Massage therapy • Retail therapy
Hobbies	<ul style="list-style-type: none"> • Volunteering • Web show/radio show • Motivational speaking • New adventures • Fun, • Creativity

	<ul style="list-style-type: none"> • Art • Movies/reality TV • Food • Creative writing/journal • Music
Faith	<ul style="list-style-type: none"> • Personal faith • Prayer • Hope • Faith community • Meditation

(Continued)

This table revealed examples of the types of strategies utilized by both Group A and Group B. Group A, females with cancer, averaged 3-5 strategies to effectively manage work-life balance. Group B, females without any health issues, only identified 2-3 strategies for maintaining work-life balance. The women from Group A needed more strategies due to their health challenges in the midst of navigating work-life balance with cancer. The data suggested that when women were self-aware and practiced more of the identified work-life balance strategies, it helped them be more effective in life overall. It also seemed that women were most effective when they found personalized strategies that suited their lifestyle.

In looking at the life stories shared, women thrived in flexible work environments. This finding provided necessary justification for industries to invest in support for employed women who get a cancer diagnosis. In Nowrouzi et al.'s study (2009), researchers recommended a work environment where cancer can be handled in sensitive, personalized manner for each employee with cancer. The women in this study benefitted from such supportive environments; therefore, the implications for employers were clear.

Limitations

This study involved the examination of twenty narratives from the Weber (2011) data collected by the Digital Women's Project. This study was comprised of twenty women and each

woman determined the level of information shared with each interviewer. As a result, some of the interviews were more detailed than others. It was important to the study that we had 10 women (Group A) who had cancer. If the size of the sample were bigger, the significance would be higher. Conducting research on such a deep and rich data source imposed a limitation on follow up with the subjects. In regards to other limitations, since it was not feasible to provide follow-up questions to Group A, then the researcher was limited on specifics of their cancer journey.

Conclusion

Female cancer patients and survivors encountered unique stressors, challenges, and experiences related to their cancer journey. This dissertation revealed through Group A's narratives that an experience with cancer changed women's outlook on life, encouraged changes in their lifestyle choices, and invited new ways to navigate work-life balance. The top two work-life balance strategies that resonated with Group A and Group B were support systems and resources. Healthy lifestyle and hobbies were the third and fourth strategies for the combined groups. Additionally, several of the cancer survivors also shared about the importance of intentionality regarding their health, lifestyle, faith, therapy, and hobbies. This study revealed that more emphasis must be placed on getting women with cancer the support, resources, and healthy lifestyle options needed during their cancer journey.

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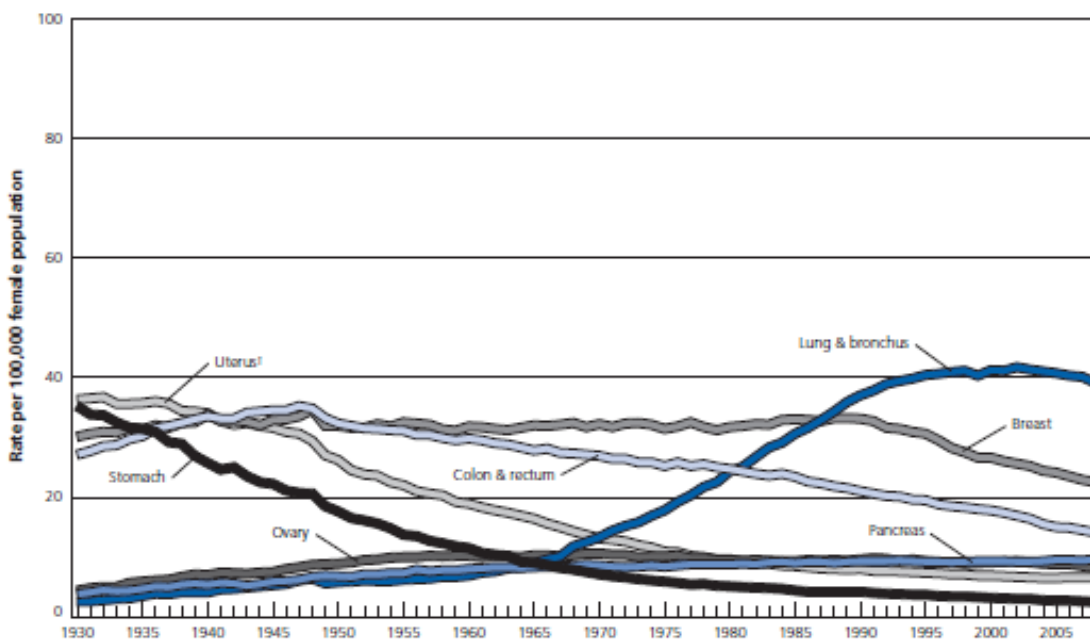
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APPENDIX A

Death Rate Chart

Age-adjusted Cancer Death Rates,* Females by Site, US, 1930-2008



*Per 100,000, age adjusted to the 2000 US standard population. †Uterus cancer death rates are for uterine cervix and uterine corpus combined.

Note: Due to changes in ICD coding, numerator information has changed over time. Rates for cancer of the lung and bronchus, colon and rectum, and ovary are affected by these coding changes.

Source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2008, National Center for Health Statistics, Centers for Disease Control and Prevention.

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APPENDIX B

Informed Consent

The following information is provided to help you decide whether you wish to participate in this research study. The purpose of this study is threefold:

1. What experiences (identity, relationship style, drive and motivation, and adaptive) shape the life course of women that impact life balance decisions?
2. How do socio-demographic variables (education, age, ethnicity, family composition, profession, marital status, spouse education and profession) influence work-life balance decisions?
3. What are the relationships between influencers (family background, mentoring and faith) and career goals on life balance decisions? The results of this research study have significance for women and men, as well as organizations as we seek to understand more about the life balance issues facing individuals and families today. The results could help in providing women with better understanding of coping strategies both for career and family life; policies that might be more family friendly; as well as contribute to the body of knowledge that supports women pursuing their dreams.

The research study follows the life story method. The study will consist of personal interviews with the entering female students in the doctoral programs in Education and Psychology. The first data collection will consist of an one-to-one interview. It is anticipated that the interview will require about 60 minutes of your time. Graduate Research Assistants will be completing the interviews and your name will be coded so that your responses will be confidential and anonymous. The second data collection will be focus groups of 5-6 participants

to explore in greater depth issues for strategies of support. The anticipated timeframe for this study to begin is mid-September, 2009. It is anticipated that all interviews will be completed by mid-November. All individuals that participate in this study will receive a copy of the findings. There will be minimal risk. However, some of the questions could be sensitive and provoke an emotional response (i.e. Workplace discrimination, questions about family). Additionally, given that the request for participation in the study comes from me, the Dean of the School, there might be a perception of indirect coercion. The interview process has been carefully developed to minimize the concept of perceived coercion. Graduate Research Assistants will conduct all of the interviews and will de-identify the data. Each of the Graduate Research Assistants have had special training in the interview process.

In order to use the data from the study, I would like to ask your permission and if you would agree with the following arrangements. Please initial the appropriate line:

I agree to participate in this research and would allow appropriate quotes to be used in publications. These individual responses would not be associated with my name or workplace, and would be referred to only by a pseudonym.

OR I agree to participate in this research but do not wish for any of my quotes to be used in publications.

In either case, you should be aware that the foreseeable risks or potential discomfort to you as a result of participating in this study are minimal. Your participation in this study is voluntary. You are free to decide not to participate or to withdraw at any time without it affecting your relationship with me, the University, your program, or any other entity. Upon your request, I will provide a copy of any published papers that take place as a result of this study.

The researcher plans to use the data collected in this project for subsequent analyses and would like to share the raw data with other researchers. Before doing so, all personally identifying information will be removed from your interview transcript.

_____ please initial if you consent to these plans. If not, please leave the line blank.

The researcher may like to contact you at a future point in time to invite you to participate in follow-up studies regarding the same topic as this study. Longitudinal studies can provide some important additional understandings to life histories.

_____ please initial if you consent to these plans. If not, please leave the line blank.

With your permission, interviews will be recorded electronically, and then stored as computer files. The interview content will then be transcribed. All data collected will be confidential. We are asking you for your mother's maiden name and will code each interview with that name. A schematic will then ascribe a numeric code to each interview randomly. This is to be able to associate the series of focus groups with series of interviews. The schematic will not be associated with the interview. All relevant data collected within the jurisdiction of the investigator, including interview notes, recordings, transcriptions, and the computer files will be placed in locked cabinet and destroyed after all interviews are transcribed.

Please feel free to ask us to stop or resume taping this discussion at any point in our conversation. Please initial below if you are comfortable with the format of the interview session.

_____ May I record this interview? If no, please rest-assured that no one will be recording any portion of the interview.

_____ May I take notes during the interview using a personal computer?

Please feel free to ask any questions about this study before we begin or during the course of the study by contacting the Graduate Research Assistant that is/did conduct the interview or by

contacting me, Margaret Weber, Principal Investigator. For any general information regarding your rights pertaining to this study, please contact Dr. Doug Leigh, IRB Chairperson at Pepperdine University's Graduate School of Education and Psychology.

At this point, I want to inquire if you fully understand these statements and if so, to sign this form.

Signature

Date

APPENDIX C

Socio-demographic Questions:

Mother's Maiden name _____

Birth date _____ Place of birth _____

Education level _____

Occupation _____

Employer _____

Race/Ethnicity _____

Marital Status _____ Year _____

Spouse (partner) birth date _____

Husband's (partner's) education and occupation _____

Current social class of your family _____

Children (gender and year of birth) _____

Mother's education and occupation _____

Father's education and occupation _____

Social class of family of origin _____

Siblings (gender and year of birth) _____

Total Household income in 2012 _____ Own earnings (% or amount) _____

Health, illness, accidents, disability _____

Religious background _____

Second language(s) _____

Lived in foreign country (name of country(ies)) _____

Travel outside of the US (name of country(ies))

APPENDIX D

Interview Questions

Questions for Work Life Balance Research**Question #1. [Early adulthood]**

About the period in your life immediately after college, or your early twenties. What was your major, name of your college, and year of graduation? What about graduate education? What did you think you would like to become in terms of occupation and type of lifestyle or family life? What were you thinking then and how did things actually turn out?

Question #2 [Childhood and adolescence]

Thinking of the period in your life before college and the goals that you and your family held for you, what was your family's attitude toward women's education and you going to college and what you would become? What was the effect of your parents' education, presence of brothers and sisters, family finances, involvement in a faith community, or family expectations? How was your education different from or similar to that of your parents and brothers and sisters?

Question #3 [Adulthood – current]

Since college, what kinds of achievement and frustration have you experienced? What type of mentors have you had? What has happened that you didn't expect in employment, family, faith, further education? Has there been job discrimination, children, a separation or divorce, health problems of yourself or a family member? What about moves, membership in the community, faith community, housing problems, racial integration, job loss? And feelings about yourself? Have there been good things such as particular rewards, satisfaction, or recognition?

Question #4 [Adulthood–future]

Looking back at your life from this vantage point, and ahead to the future, what are your main concerns? What are your goals, hopes and dreams for the next few years? What problems do you hope to solve? Looking further out, where do you hope to be a few years from now with respect to work or finishing graduate school, family, faith, community, mentors, health, finances, etc.?

Question #5 [Strategies for balancing life]

What coping strategies do you use to respond to concerns related to the plurality of roles? Have you ever felt pressured to choose between work and home? What made you think that you could do both successfully? Do you feel that your family life or work life have suffered because of your involvement in work or family? Have you felt any guilt related to either family or work? Are there times that you felt particularly successful at juggling the demands of both work and home? Why? Were you prepared for the demands of work and life balance? Why or why not? What strategies do you implement in your own life in order to remain balanced?

APPENDIX E

Pepperdine University EDOL Course List

	Course	Instructor
<u>Fall 2010</u>		
EDOL 714	Organizational Behavior Theory and Design	Dr. June Schmieder-Ramirez
EDOL 724	Ethics and Personal Leadership	Dr. Farzin Madjidi
EDOL 755	E-Learning: Theory and Practice	Dr. Kathleen Plinske
<u>Spring 2011</u>		
EDOL 700	Leadership Theory and Practice	Dr. Farzin Madjidi
EDOL 763	Program Learning Design and Evaluation	Dr. Mark Allen
EDOL 766	Research Design and Analysis	Dr. Kay Davis
<u>Summer 2011</u>		
EDOL 754A	Economic Systems & Political Systems	Dr. Farzin Madjidi
EDOL 754B	International Leadership and Policy Development	Dr. Farzin Madjidi
EDOL 758A	Consultancy Project	Dr. Ronald Stephens
<u>Fall 2011</u>		
EDOL 734	Advanced Data Analysis and Interpretation	Dr. AnnMaria De Mars
EDOL 764	Consultancy Project	Dr. Ronald Stephens
EDOL 767	Quantitative Research and Analysis	Dr. James DellaNeve
<u>Spring 2012</u>		
EDOL 759	Law and Dispute Resolution	Dr. John Tobin
EDOL 765	Strategic Leadership and Management of Global Change	Dr. June Schmieder-Ramirez
EDOL 785	Contemporary Topics	Dr. Jennie Wong
<u>Summer 2012</u>		
EDOL 753	Leadership, Advocacy, and Policy Development	Dr. Jack McManus
EDOL 757	Entrepreneurship	Dr. Vance Caesar
<u>Fall 2012</u>		
EDOL 787	Comprehensive Exam Seminar	Dr. J. L. Fortson

APPENDIX F

IRB Approval

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

July 31, 2013

Dr. Margaret Weber

Protocol #: E0719F03-AM2013-01
Project Title: Work-Life Balance Issues of Women

Dear Dr. Weber,

Thank you for submitting a request for modifications to your previously approved IRB application to the Pepperdine Graduate and Professional Schools Institutional Review Board (GPS IRB). The nature of your research continues to meet the federal requirements for expedited review under 45 CFR 46.110 (Research Category 7). Your request to add Veronica Ufoegbune, Shante Toston, and Stacy Rothberg as investigators on your study has been approved.

As noted in the IRB approval letter from March 21, 2013, the approval period for your study ends March 21, 2014. If any further changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a Request for Modification Form to the GPS IRB. If contact with subjects or data analysis will extend beyond March 21, 2014, a Continuation or Completion of Review Form must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. If notified, we will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Veronica Jimenez, GPS IRB Manager at gpsirb@pepperdine.edu.

Sincerely
Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs