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Instrumental Relating and Treatment Decision Making Among Older Women With Early-Stage Breast Cancer

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Purpose/Objectives: To understand how women aged 70 years and older who had recently undergone treatment for early-stage breast cancer experienced treatment decision making.

Research Approach: Qualitative, descriptive study guided by grounded theory.

Setting: Participants' houses and apartments in southern California.

Participants: 18 women, aged 70–94 years, who completed treatment for primary, early-stage breast cancer 3–15 months prior ($\bar{X}$ = 8.5 months).

Methodologic Approach: Twenty-eight semistructured personal interviews that lasted, on average, 104 minutes. Data were collected and analyzed using constructivist grounded theory.

Main Research Variables: Gero-oncology perspective of treatment decision making.

Findings: A major finding was that the power of relating spontaneously was used as a vehicle to connect with others. That process, which the authors called "instrumental relating," was grounded in a foundation of mutual caring for themselves and others. Within that mutual caring, the women participated in three ways of relating to share in treatment decision making: obtaining information, interpreting healthcare providers, and determining the trustworthiness of their providers. Those ways of relating were effortlessly and simultaneously employed.

Conclusions: The women used their expert abilities of relating to get the factual and emotional information that they needed. That information supported what the women perceived to be decisions that were shared and effective.

Interpretation: The findings are the first evidence of the importance of relating as a key factor in decision making from the personal perspective of older women with early-stage breast cancer. This work serves as a springboard for future clinical interventions and research opportunities to individualize communication and enhance effective decision making for older patients who wish to participate in their cancer care.

Although the average age of a woman diagnosed with breast cancer is 61 years, 57% of breast cancer-related deaths from 2003–2007 were among women aged 65 years and older (Surveillance Epidemiology and End Results, 2010). Thus, breast cancer-related mortality, the second leading cause of malignancy-related deaths among women overall, disproportionately affects women aged 65 years and older (American Cancer Society [ACS], 2011). Although some treatment regimens are superior to others, efficacious therapy for early-stage breast cancer is dependent on several factors, such as tissue type, degree of differentiation, and invasiveness. Even when evidence shows some treatments are superior, the wide array of therapies available poses challenges to decision making for older adults (Peters, Diefenbach, Hess, & Västfjäll, 2009). Affected women may need to choose between and among surgical therapies, including lumpectomy, mastectomy, and reconstruction; and focused medical interventions, such as radiation, chemotherapy, and hormonal therapies for early-stage malignancies. Balancing those therapeutic choices against a background of the unique age-related issues complicates individual treatment decision making among older women with breast cancer (Peters et al., 2009; Pieters, Heilemann, Grant, & Maly, 2011).

Women 65 years and older with breast cancer receive suboptimal care (Silliman, 2003, 2009). Preexisting comorbid disease, problems with transportation, urgency to receive treatment for a life-threatening disease, and a determination to preserve independence are known to complicate decision making among older women with breast cancer (Pieters et al., 2011; Sinding, Wiernikowski, & Aronson, 2005). Moreover, oncologists feel discomfort and communicate differently with older women with early-stage breast cancer, which creates additional complexities (Institute of Medicine [IOM], 2007; Step, Siminoff, & Rose, 2009).

Women's preferences, as expressed through shared decision making, have shaped the type of surgical treatments available for early-stage breast cancer (Morrow et

al., 2009). When older breast cancer survivors perceived themselves as involved in their clinical decision making, they reported higher self-efficacy (Maly, Umezawa, Leake, & Silliman, 2004), personal empowerment (Roberts et al., 2006), and overall quality of life (Hack, Degner, Watson, & Sinha, 2006). Although collaborating in decision making is highly valued by some older adults with cancer (Singh et al., 2010; Thomé, Dykes, Gunnars, & Hallberg, 2003), differences were found among older women diagnosed with breast cancer as to whether they wanted their physician to make treatment decisions or not (Ciambrone, 2006; Kreling, Figueiredo, Sheppard, & Mandelblatt, 2006; Maly, Umezawa, et al., 2004; Sinding et al., 2005).

Older women with primary breast cancer have been found to rely on social support from family and support people, revealing another component of treatment decision making (Ciambrone, 2006; Kreling et al., 2006; Maly, Umezawa, Leake, & Silliman, 2005). Decision making was more stressful when older cancer survivors perceived that their family members were distressed by the cancer diagnosis (Bowman, Rose, & Deimling, 2006).

People diagnosed with cancer need to learn a new vocabulary to communicate with clinicians to maximize cure and minimize adverse outcomes of potential treatments. Educational interventions for breast cancer survivors provided by nurses (Meneses et al., 2007) and physicians (Hack et al., 2010; Maly, Leake, & Silliman, 2004) have been received favorably by patients. However, little is known about the age-appropriate informational needs of breast cancer survivors (Roberts et al., 2006). To the best of the authors' knowledge, no age-appropriate teaching instructional methods or materials have been developed for older women diagnosed with breast cancer.

Despite the complex interaction between cancer and older adults in today's rapidly aging society, older cancer survivors are seldom the focus of research (Hewitt, Greenfield, & Stovall, 2006). Another IOM (2007) report specifically called for more primary research in geroncology. Oncology nurse researchers also have accentuated the ultimate importance that aspects of age itself be the focus of research, rather than studying age merely as an influencing variable (Payne, 2006). Research on the processes of decision making used by the aging population with cancer to improve patient-provider communication is needed (Adler & Page, 2008; Peters et al., 2009). The current study with women aged 70 years and older was a response to those calls. The purpose of this research was to understand how women 70 years and older, who recently had been treated for early-stage breast cancer, experienced decision making and communication with the providers of the health care that they received during treatment, throughout recovery, and beyond.

Methods

Constructivist grounded theory (Charmaz, 2006) guided data collection and analysis. Grounded theory encompasses both the research product and the analytic method of creating that product (Charmaz, 2008). Although the originators of grounded theory, Glaser and Strauss (2009), focused on analyses that produced generalities using objective methods to create a theory grounded in the experiences of participants, constructionists recognize the influence of the experiences of the researcher on the data collection and analysis process. Therefore, constructionists emphasize the active influence of the participants and the researcher in coconstructing meaning through interviews (Mills, Bonner, & Francis, 2006) and highlight the importance of researcher reflexivity as crucial to the method (Charmaz, 2008). Symbolic interactionism, including the claim that human beings dynamically act back on people and things in their environment instead of passively responding to them (Charon, 2010; Mead, 1934), was a central tenet of the methodology for the current study, which focused on older women's experiences of treatment decision making following a diagnosis of breast cancer. This work also was informed by various feminist epistemologies (Harding, 2004; Hesse-Biber, 2007). That is, theories of knowledge that recognized, respected, and made central the concerns of women influenced the study's methodologic approach to collecting, managing, and analyzing data, thereby guiding the authors to continually question and critique their interpretations of what was meaningful to the women.

Recruitment, Participants, Data Collection, and Analysis

After the appropriate institutional review boards from two universities in southern California approved the research, flyers were placed in waiting rooms and public areas at 25 recruitment sites in southern California, including oncology departments of medical centers, offices of private oncologists, cancer support agencies, and retirement centers. Participants also were invited to participate through letters, advertisements, and the snowball technique, where participants were asked to invite others who they knew who were potentially eligible to call the first author (Marshall & Rossman, 2006). Eligible women spoke English, were aged 70 years and older, and had completed treatment for primary breast cancer within the past 3–15 months. Women were excluded from participation if they had stage IV disease or a history of a previous cancer because the authors wanted to focus on women's first experiences with a new and early-stage cancer.

From September 2008 to July 2009, 35 women called the researcher and were screened over the phone. Of those respondents, 18 women were eligible and all agreed to participate. After informed consent, face-to-face, intensive

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interviews were conducted in English using an interview guide designed to explore the women's experiences with decision making and communication throughout their cancer trajectory. Ten women were invited and agreed to second interviews. The average duration of the 28 interviews was 104 minutes (range = 52–170 minutes). Theoretical saturation was achieved easily. The women received a cash incentive of $50 for each interview. The first author conducted the recruitment and interviews. All interviews were tape-recorded, transcribed verbatim, and checked for accuracy. Data collection and analysis occurred concurrently (Charmaz, 2006).

Initial coding was followed by focused coding (Charmaz, 2006). ATLAS-ti, version 6.0, software was used to facilitate organization of the data. Analysis of emergent categories was conducted to develop the dimensions, properties, and subcategories. Next, theoretical coding was conducted to identify relationships between categories. Memos, field notes, early hunches, and diagrams were used throughout the data collection and analysis of the study to conceptualize the data.

The average age of the sample was 76 years (range = 70–94) (see Table 1). Eleven women self-identified as White, two as Latinas, and five women identified themselves as African American or Black, Chinese, Filipino, Indian, or Persian. Clinical characteristics are presented in Table 2.

Findings

Seamlessly woven into the fabric of sharing decision making about treatments was a process that the authors called "instrumental relating." Grounded in a simultaneous and mutual process of caring for both self and others, instrumental relating involved three goal-oriented ways of relating invoked by the women: obtaining information, interpreting healthcare providers, and determining the trustworthiness of clinicians (see Figure 1). It is important to note that participants' descriptions of mutual caring and the ways of relating were not something the women identified, critiqued, or questioned objectively. Rather, the process of instrumental relating went unnoticed as a taken-for-granted part of navigating the healthcare system.

All participants spontaneously emphasized that the cancer diagnosis was unexpected. Cancer immediately was associated with death, uncertainty (e.g., "What are they going to do to me?"), and suffering. The women narrated the many treatment choices that were associated with the diagnosis. For example, an octogenarian remembered that her surgeon said, "Here are your options: first, do nothing; second, a lumpectomy; third, a lumpectomy and radiation; forth, lumpectomy, radiation, and chemotherapy; and the fifth, a mastectomy." A strong urgency to receive treatment was common and the participants felt called on to make rapid decisions about treatments that had short-term and long-term implications. However, the women felt unprepared, such as one woman who, when diagnosed, compared her sense of vulnerability to that of the helpless nature of a small child when she thought, "Is this going to hurt?"

Mutual Caring for Self and Others

Women frequently spoke about meaningful others, including family, friends, and neighbors, who made up

Table 1. Sociodemographic Characteristics

Characteristic	n	$\bar{X}$	Range
Marital status (years)			
Married or living as married	6	50	24–62
Divorced	6	29	25–37
Widowed	5	8	2–23
Never married	1	–	–

Characteristic	n
Highest completed education	
Some high school	2
Graduated from high school	9
Some college	2
Bachelor's degree	1
Some graduate school	1
Graduate degree	3
Annual household income ($)	
20,000 or less	8
20,001–40,999	3
41,000–60,999	3
61,000–80,999	–
81,000–100,999	2
More than 101,000	2
Living situation	
Alone in house or apartment	5
With spouse in home	5
With family member(s), in their home	5
With family member(s) in home	2
With friends, in their home	1
Contact with family	
Daily	11
Several times a week	1
Once a week	2
Does not have children	4
Talking with friends	
Daily	12
Several times a week	4
Once a week	1
Less often than several times a month	1
Main support person(s)	
Daughter	6
Sister	3
Other family member	3
Friends	4
Self	2
Spouse	1
Others	4
Ambulation and commute	
Drives and ambulates independently	11
Does not drive, ambulates independently	5
Does not drive, uses a wheelchair or walker	2

N = 18

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their social world. One woman spoke about her daily walk in her retirement village and how the context of her everyday world involved relating to others.

> When I walk in the morning, I get to talk to a lot of people; well, the men don't stop and talk very much, sometimes they do, but the women always want to talk, to stop and talk. I think it's very, very important. It's not gossip. It's just talking about the world and what's going on.

Mutual caring, as the foundation of treatment decision making, was described by a participant who received treatment at the same hospital where her younger sister was treated. She said, "I picked my doctors and then selected from what they recommended because I had seen my sister before me do the same treatment . . . I went with my sister and my sister went with me." That woman returned to the importance of connecting later when she said, "I think it's really important that women get together and talk. It helps because you get so much information."

Deciding who to take: The mutuality of caring reflected women's decisions of who to take along to appointments with providers. With a focus on both caring for self and others, one woman invited her daughter along to see the surgeon but not the oncologist. She said,

> Because we live together, I felt that she should know exactly from the surgeon what to expect and she wanted to know, too; she wanted to hear it from the surgeon's mouth. When I saw the oncologist, I didn't feel like I needed to have anybody helping me make a decision. I felt like it really *was* my decision because if somebody would advise you and it turns out bad, they blame themselves.

Women who had enjoyed good health prior to the cancer diagnosis cared about their adult children being confronted with their physical vulnerability. One woman reflected on her knowledge that breast cancer is a deadly disease and that caution was needed to protect vulnerable loved ones from the frank discussion at clinic appointments when she said that she knew her son was the only one who could go with her. Laughing, she added that she could not invite any of her daughters to appointments because "I cannot talk to my daughters about anything that has to do with death. I'm supposed to be around forever."

Another woman, noting that her daughter was very afraid of losing her, used the first visit with the oncologist as a technique for exposing her daughter to the reality of her physical vulnerability and her decisions about treatment. The woman got teary-eyed when she explained that she informed the oncologist of her decision not to have chemotherapy while in the presence of her daughter. "My daughter is [was] there and I says, 'I want you to hear that it's my choice.' I said that so she can prepare herself for the fact that I am getting older."

Table 2. Clinical Characteristics

Characteristic	n	$\bar{X}$	Range
Months since diagnosis	18	12.5	3–30
Months since completion of primary treatment	18	8.5	3–15

Characteristic	n
Stage reported by women	
Ductal carcinoma in situ	1
I	4
II	4
III	2
Unknown	7
Primary treatments received	
Lumpectomy	12
Radiation	11
Mastectomy: lateral	5
Mastectomy: partial	1
Mastectomy: double	1
Proton therapy	1
Chemotherapy	1
Hormonal therapy	
Aromatase inhibitor	10
Selective estrogen receptor modulator	1

N = 18

Ways of Relating: Obtaining Information

Within mutual caring, obtaining information was the first way of relating that the women invoked seamlessly as part of their daily life but also with purpose. That was all part of the process of moving toward making informed decisions. Very much engaged in their health care, the women valued information about breast cancer, particularly because they had no knowledge of the disease or its treatments when they were diagnosed. Interacting through asking questions was what the women ordinarily did to gain knowledge so they would be in a position to review treatment options and then make a decision that made sense to them. Treatment-related questions were posed to various others, such as their clinicians, friends, family, and also strangers.

Obtaining information by asking their clinician questions: Most of the women wanted to obtain information from professional experts. In addition, the participants not only asked their clinicians questions to gain information, but they also created conversation to connect with providers. The participants felt recognized, respected, and engaged when their questions were answered, and vividly recalled incidences of how being able to engage in a dialogue of questions and answers expanded their knowledge of breast cancer and treatments. That was explained by a woman who said,

> I wanted to know as much about it as there was to know. Maybe I'm just too inquisitive, but I just really want to know what was being done and how and

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how come. They never kept you in the dark. I was fully informed. And they made you feel like a friend.

Although the women depended on clinical consultations to gain information, at times they did not know what questions to ask. The women often invited others who had previously undergone treatment for breast cancer to accompany them to consultations because, as one woman said about a friend with prior experience, "Having been through it, she knew more questions to ask." However, pressure from family members to ask more questions was sometimes unhelpful because often the women did not know what questions to ask. One woman's daughter had been diagnosed with another type of cancer only two months before her own diagnosis of breast cancer. She said her daughter insisted, "You've got to ask lots and lots of questions." Despite all the prompting from her daughter, she said,

> I did the best I could under the circumstances and the time I had. But never having had cancer before, I'm not sure I knew all the right questions to ask. . . . The hard part was what questions to ask, but I did the best I could.

The women knew what worked best to effectively provide information they could digest. For example, one woman deemed "the big book I got from the hospital" as unhelpful. Although she was an avid reader, she explained that "I hate to read a bunch of technical stuff like that because it's like working again. . . . Just give me a short synopsis of it." Clear, concise information with tangible examples and drawings were helpful. A woman laughed when she recalled the first consultation with her surgeon,

> [The surgeon] said it was X number of millimeters, and my daughter and I looked at each other and my daughter goes, "I have no idea, in measurements, what that would be, can you be more explanatory of the size?" So she got a piece of paper and she drew and she said, "It's the size of an M&M, so you won't need a large surgical incision."

Receiving information repeatedly and in both verbal and written forms helped the women understand many new facts. One woman spoke appreciatively about a nurse who gave the assurance at an information meeting immediately after diagnosis that the information would be repeated. She said, "We heard everything at least three times and then it was in the book, too."

Obtaining information through questions to friends, family, and strangers: When asked how she made the decision to have a lumpectomy and radiation treatment without chemotherapy, one participant said that she had read two books "from beginning to end, [and] the one had a few case scenarios." Her decision also was based on several informative meetings with a friend, a younger woman whom she had known for years who recently was treated for breast cancer by the same oncologist, whom she trusted implicitly. Describing her friend, she said, "She went on chemo[therapy]. I know how sick people get. I just didn't want to put myself into chemotherapy and make myself sick if there wasn't a big 'yes' or 'no' either way." By actively seeking information from a trusted friend, literature, and a clinician, the woman was able to decide against chemotherapy.

Asking questions from friends sometimes brought disappointments. For example, one participant asked her friend about the possibility of removing lymph nodes. The friend, who had a lumpectomy by the same surgeon, "was telling me, 'Don't let him remove any of the lymph nodes.' She wouldn't let him remove any of her lymph nodes." The participant consequently discussed lymph node removal with her surgeon and learned that lymph nodes were removed, "to find out if the cancer had spread." The participant also asked questions from other women who were treated for breast cancer by the same surgeon. "Everybody else said this was a great doctor, so I went ahead (and had one lymph node removed)." Later, she said that she was no longer on speaking terms with this friend because her early advice was not helpful.

Women also asked others with experience questions about treatment. One woman said that the scariest time in her cancer experience was when she needed information to choose a surgeon from a list of names. She

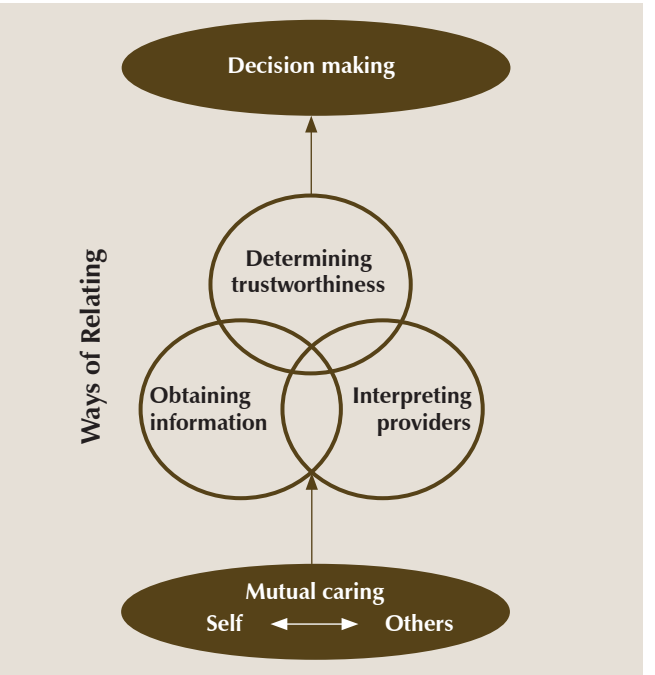


Figure 1. The Process of Instrumental Relating and Treatment Decision Making Among Older Women With Early-Stage Breast Cancer

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decided to connect with two female healthcare professionals to get their opinions.

> Fortunately, I ran into a nurse at the place where I volunteer and she was probably the first one I confided to about my problem. She worked at the hospital where I had the tests. She mentioned one of the names on the list. Then I called my gynecologist, she's a woman doctor in her late forties; I figured she would be pretty aware of who was good. The first person she said was the same doctor. So I thought, "Well, that's good for me."

Ways of Relating: Interpreting Healthcare Providers

Fine nuances of the behavior of providers during interactions were noted as important elements of what was happening overall. The women constructed knowledge and made treatment decisions by purposefully interpreting the disposition of their clinicians and by recognizing the age of physicians.

Reading providers' dispositions: The feelings of providers mattered to participants. The women frequently and naturally described their perceptions of the disposition of their clinicians.

The participants characterized their clinicians as "caring," "warm," "open," "accommodating," "no-nonsense," and "irritated." Their perceptions of the clinicians' attributes seemed to be linked to the participants' own unique needs, which contributed to their perception of provider-patient compatibility. One woman who felt particularly fearful about her diagnosis described an "insensitive" physician, saying, "Patients have never had this experience [cancer], so a doctor or a nurse who is impatient and not sensitive to their fright and their ignorance does not let the patient know that you're on the same team." She subsequently sought a second opinion. Another woman, who was foreign-born and described herself as "caring" in her own work as a healthcare provider, described her provider by noting how many clues she can find during a simple, routine clinical visit.

> When someone asks you "How are you?" you can see in their face that they really care; there's something about the eyes. There's something like compassion, kindness, and when they explain things to you, they're gentle . . . no matter what the nationality is, they're kind.

She spontaneously said that her surgeon was "one of the nicest, one of the busiest" doctors in the comprehensive cancer center and yet she took the time to ask, "Are there any questions?" at the end of their consultation session. That participant rejected the option of getting a second opinion. She decided to stay with this surgeon because she felt "comfortable" with this "gentle doctor."

Although some women spoke about connections with providers, others told of *dis*connections. One woman described why she decided not to tolerate an "insensitive" physician.

> I decided not to deal with him . . . some doctors do what they absolutely have to do. They also do not know how to relate to other people, like as a person, not just an object. Especially when you're going through something as serious as cancer, sensitive care matters.

Recognizing providers' age: The women noted the age and, particularly, the youth of their doctors. Then, they put it into the context of knowledge, relationships, and communication. Some women were optimistic when they perceived their physician as youthful, as described by a woman who said, "I figure that the young doctors might know something that the older doctors didn't know." However, another woman described the oncologist who took over after her first oncologist retired as less interactive. She described her first oncologist as, "Really great. He was a person that would sit and listen to you and anything you wanted to say. He was there for you. Now, I've got a new one and he's younger, very young." Then she interpreted his relational style as paternalistic and spoke about pondering the decision of changing doctors.

> I noticed that he don't seem to have the different letters after his name, like maybe he doesn't have the experience. He's, like, very abrupt and he's, he wants to tell *you* how it's gonna be and he didn't really want to hear what you've got to say. It's gotten to where I feel like I'd like to change 'cause I need a doctor that's gonna make me feel better about it.

Ways of Relating: Determining the Trustworthiness of Providers

The women reflected on many disappointments in providers that eroded trust, either earlier in life or during their treatment for breast cancer. These older women knew that ageism potentially could impede their agency with decision making. One woman summed it up by saying, "Others have told me that you say to a doctor, 'This is bothering me,' and they say, 'Well, that's because you're old.'" Within the context of mutual caring, the trustworthiness of a provider was determined by whether they received satisfactory answers to their questions and by noting the power balance during consultations.

Receiving satisfactory answers: Although asking questions about breast cancer and treatments was a crucial action the women took, receiving answers was linked to an emotional response about whether or not the women were satisfied by what they were told. The latter was crucial to the process of determining whether the provider was trustworthy or not. Therefore, the act of asking for information was in continuous dynamic

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interplay with the emotional response the women experienced based on their perception of the quality of the information they were given, which further influenced their perception of their relationship with the provider.

A woman who had sought a second opinion about surgery decided to trust and receive care from the second surgeon, explaining it was "because she was more distinct in giving me the details. I liked the way she explained. She was good. Then I said, 'Okay doctor, you go ahead.' That's when I gave permission." Receiving satisfactory answers trumped the characteristic of warmth that was frequently associated with trustworthiness, as with a woman who said, "I have an oncologist who is, you ask a question, she'll answer it right off and she'll tell you, but she's not exactly a warm person, but you can tell how knowledgeable she is. To me, that's very important." When encouraged by a family member to seek a second opinion, the woman responded with "I don't want it at all. I have absolute trust in her."

Although satisfactory answers were valued by all of the women, not everyone was concerned about whether or not the questions led to more knowledge acquisition. A well-educated participant, who highly valued information, spoke with great appreciation of her surgeon's explanations during their first consultation and added, "Although I probably understood something like 10% of what she was saying, I just took it in as a whole without understanding." The woman was not bothered by her limited understanding; instead, she felt empowered by the relational component of the situation.

Noting the power balance: Women who opted to invite their husbands (or, as it was with one woman, an ex-husband), who were retired physicians, to consultations with clinicians all naturally spoke about how the power balance in the triad influenced how they determined the trustworthiness of their provider. The women described their appreciation that the physicians with whom they consulted in the presence of their husbands (or a former husband) did not form a coalition with the spouse, but instead related primarily with the women and specifically gave *her* the treatment options. One woman noticed that her surgeon met with her alone first before inviting her former husband and son in from the waiting area to join them. The woman deeply valued the empowerment and agency that she received while relating with the surgeon. She said,

> She [surgeon] gave *me* the decision to make and she even said it when all three of us were together with her, she said: "It's totally *your* decision." I thought that was kind of unusual and kind of nice and wonderful to me, that a doctor would be able to say that to a patient. I mean, sometimes you're told, "This is what you'll do."

Decision Making

The seamless flow between the interrelated components of instrumental relating culminated in treatment decision making. As they reflected on their cancer journeys, the women were quite certain that they made the best decision for their unique circumstances and that these decisions were their own.

Making the best decision: The women recognized the individuality of patients ("Everybody's cancer experience is different"), providers ("Nurses have bad days, too"), and the problems of the healthcare system ("All the corporations think about is money"). Likewise, they reflected on their own unique sociodemographic and clinical characteristics and then each woman made the decision that was best for her. Clinicians frequently were unaware of these personal characteristics, such as women who were caregivers of spouses with dementia, that had a profound effect on decision making. That is, women made their treatment decisions based not only on the dyadic patient-provider relationship, but also in relation to the best interests of a loved one, something that often was invisible to the clinician. Other women considered their lack of financial and social support when they made decisions, such as a participant who was single, of low-income, with no independent transportation, and who spoke English as a second language. She described her oncologist as impatient, saying, "Maybe she was not very happy with me because she wanted me to immediately take up chemotherapy. She said, 'You have 30% recurrence chance. So you have to do chemotherapy.'" In response, however, the woman privately thought, "I don't have anybody to take care of me. If I do chemotherapy and I get sick and land in the hospital, who'll take care of me?" With that, she chose not to receive chemotherapy.

Making my own decision: The women found agency within the context of mutual relating, but they were not dependant on others for decisions and felt confident that they had made their own treatment decisions. Self-reliance was particularly evident when the women gave an overview of their cancer experience, such as one woman who reflected that cancer was like fighting a battle, but "you do not depend on someone else. You do it yourself as much as possible." Most women felt support from their physicians about their treatment decisions, but they were careful to point out that they did not make decisions just to gain approval. For example, one octogenarian, after giving careful thought to all her treatment options and consulting with her children, declined radiation.

> He gave me five options and when I chose the lumpectomy, I said, "I'm sure you would prefer that we go for the lymph nodes and that I do the radiation," but I said, "I don't want to do that." He said, "That's your decision." . . . And what he thought, I don't know, he didn't say, but I chose.

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Discussion

Instrumental relating was the vehicle used by older women of the current sample to share in treatment decision making for early-stage breast cancer as part of daily life and pragmatic problem solving. Women engaged in "relating" because it made a difference in how they weighed their options, was useful for interpreting who could be trusted, and was meaningful as they faced the serious decisions before them. Although literature and lore imply that women's abilities to relate to others emotionally bring a variety of benefits, the current study's detailed analysis is the first that the authors know of that focuses specifically on older women's ways of relating as part of healthcare decision making.

Previous work in psychotherapy is synergistic to the findings of the current study. Examples include the crucial role of relating among younger women (Miller, 1986, 1991) and women's unique ways of knowing that include constructing knowledge by integrating their own inner voices with what is heard from the input of others (Belenky, Clinchy, Goldberger, & Tarule, 1986). In the context of gero-oncology, the participants of the current study were involved in a complex process of decision making that usually was outside of their own awareness and transparent to them as they naturally, effortlessly engaged in instrumental relating. They did not specifically refer to or draw attention to their use of their expert relating skills to emotionally connect and interpret others, or the confidence it gave them to make decisions.

The older women in this study had lived for many years when healthcare decisions were made in the paternalistic model (Charles, Gafni, & Whelan, 1997). However, they were able to participate actively in their medical decisions by engaging in an unequal relationship with healthcare providers who were informed, healthier, younger, and in more powerful positions. Most of the women considered themselves to be the primary decision maker and some selected to forego aspects of treatment, which is similar to what was previously described with younger (Charles, Whelan, Gafni, Reyno, & Redko, 1998) and older breast cancer survivors (Crooks, 2001; Maly, Umezawa, et al., 2004; Sinding et al., 2005). Different from previous findings with older breast cancer survivors (Crooks, 1996), participants in the current sample did not wait to raise issues in communication with physicians after treatment was completed, but instead spoke up before or during their treatment. Some women stayed with providers whom they distrusted, whereas others sought second opinions.

The women were active seekers of information, but too much information was unhelpful. That finding confirms previous results with samples such as younger patients diagnosed with various cancers (Thorne, Hislop, Stajduhar, & Oglov, 2009), women immediately prior to surgery for breast cancer (Lally, 2009), older adults (Reed, Mikels, & Simon, 2008), and older breast cancer survivors (Kreling et al., 2006). Recent evidence from the field of cognitive neuroscience indicated that, unlike younger adults ($\bar{X}$ = 22.58 years old) older adults ($\bar{X}$ = 72.43 years old) who were faced with a healthcare decision performed better when they focused on their emotions rather than the details of facts or information (Mikels et al., 2010). Likewise, the current sample valued their emotional appraisals as part of instrumental relating and their relationships with clinicians, but details of information did not matter as much. Satisfaction with answers to questions hinged on how knowledgeable the provider was perceived to be and whether or not the woman's opinion mattered to the provider during an in-person interaction. That was similar to Lally's (2009) work that showed women valued receiving information in person when making breast cancer treatment decisions over written information.

Limitations and Implications

Because the current sample was recruited using flyers and snowballing, participants may possess a unique inclination toward active engagement in the world, which may have influenced their perception of clinical decision making. In addition, the results are limited in that they are based on self-report, which may not correlate with actual behaviors.

Clinical implications: In their own words, every interaction mattered to the participants because they interpreted fine nuances of the behavior of providers and the interactions between care providers and family members or friends who accompanied them to appointments. Recognition of and respect for every aspect of the person, not just a part of their body (e.g., their breast) or a component of their disease, was key. In the "notoriously complex challenge" (Thorne, Armstrong, et al., 2009, p. 1383) of communication in cancer care, being heard was the cornerstone on which trust was built, credibility was established, and treatment decisions were made by the current sample. Participants asked questions not only to obtain information, but also to determine trustworthiness. However, because cancer was a new experience for the women, a common dilemma was that many of the participants did not know the appropriate questions to ask. Clinicians can anticipate that need and introduce topics of potential concern to stimulate a shared discussion. That should involve not just a list of frequently asked questions, but topics to facilitate interaction and relating between patient and clinician, because the current study showed that relating was the crux from which trustworthiness was established. Creative solutions for optimizing time

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spent with patients who have cancer is crucial (Thorne, Hislop, et al., 2009) and genuine empathy in deliberation with older healthcare consumers is valuable, even if time consuming.

Research implications: Future research with younger women and/or with men could illuminate how instrumental relating is enacted within the context of age and gender. Research with older women diagnosed with other types of cancer, immigrant populations, those without insurance, those with a family member who also has cancer, homeless women, or those with strained social networks is needed to further knowledge of instrumental relating in decision making.

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