

Purposeful Agency in Support Seeking During Cancer Treatment From a Person-Centered Perspective

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Filipa Ventura¹, Ingalill Koinberg¹, Per Karlsson²,
Richard Sawatzky^{3,4}, and Joakim Öhlén^{1,5}

Abstract

People diagnosed with early-stage breast cancer (ESBC) manifest high supportive needs. eHealth supportive programs successfully satisfy those needs, but the process of generating supportive outcomes is less understood. We conducted this study to explore patients' efforts to satisfy their supportive needs throughout the treatment course, not limited to but particularly considering their use of the Internet. Guided by interpretive description, 19 women undergoing treatment for ESBC participated in two phases of focus group meetings. Our results disclose women as self-driven resourceful agents, a perspective that underlay the process of reaching out as women appraised their need for support and intentionally engaged their supportive resources. Our findings convey a need to shift the paradigm of professionals' provision of support in scheduled appointments toward achieving a continuous reciprocal care partnership. This is especially significant for the development of eHealth supportive programs, which assist in the enhancement of the health care accessibility.

Keywords

cancer, psychosocial aspects, coping and adaptation, focus groups, Internet, interpretive description, problem solving, relationships, patient–provider, Ricœur, self-care

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Screening and awareness programs, and advances in imaging and diagnostics increasingly allow the identification of breast cancer in early stages, leading to an increased long-term prognosis, with a 5-year survival rate varying between 80% and 100% for Stages I and II (Kaufmann et al., 2013). However, the breakthroughs in research and treatment of breast cancer are not enough to attenuate the distress of receiving a cancer diagnosis, undergoing treatment, and being a cancer survivor (Härtl et al., 2010; Tighe, Molassiotis, Morris, & Richardson, 2011). Consequently, women diagnosed with early-stage breast cancer (ESBC), often have significant and complex supportive needs that may not be adequately met (Malik & Kiran, 2013).

An extensive body of evidence-based knowledge raises awareness to antecedents of supportive needs throughout the course of care for ESBC (Ankem, 2006; McDowell, Occhipinti, Ferguson, Dunn, & Chambers, 2010; Smith, Hyde, & Stanford, 2015). Such antecedents are factors that precede supportive needs and might refer to socio-demographic factors (e.g., age, civil status, occupation), psychosocial variables (e.g., quality of life, anxiety, or depression levels), or treatment-related aspects (e.g., type of breast surgery, type of oncological treatment) (Ventura, Öhlén, & Koinberg,

2013). This evidence-based knowledge has a recognized value in informing clinical practice by assisting health care professionals in the process of identifying individuals' supportive care needs throughout the cancer treatment (McDowell et al., 2010). However, the perceptions of health care providers and women still differ (Lei, Har, & Abdullah, 2011) and women's supportive needs remain often unmet (McGarry, Ward, Garrod, & Marsden, 2013; Pauwels,

¹Institute of Health and Care Sciences and University of Gothenburg Centre for Person-Centred Care, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

²Department of Oncology, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

³Trinity Western University, Langley, British Columbia, Canada

⁴Centre for Health Evaluation & Outcome Sciences, Vancouver, British Columbia, Canada

⁵Ersta Sköndal University College, Stockholm, Sweden

Corresponding Author:

Filipa Ventura, Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Box 457, 405 30 Gothenburg, Sweden.

Email: filipa.ventura@gu.se



Charlier, De Bourdeaudhuij, Lechner, & Van Hoof, 2013; von Heymann-Horan et al., 2013).

In light of the discrepancy in perceptions of supportive care and supportive needs, the subjectivity associated with the experience of support cannot be neglected. Indeed, the concepts of support and supportive care vary greatly in the literature (Finfgeld-Connett, 2005; Langford, Bowsher, Maloney, & Lillis, 1997). In the current study, we focus on the concept of social support defined as the “perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance” (Wills, 1991). This concept entails several forms of support, including informational, instrumental, emotional and companionship support, and acknowledges the beneficial health effects depending on whether the support is received or perceived (Taylor, 2011; Uchino, 2004). Particularly considering the last mentioned attribute, only perceived support has been consistently linked to positive health outcomes (Haber, Cohen, Lucas, & Baltes, 2007), with the beneficial effects depending on (a) the appropriateness of the support provided in relation to the stressor’s character and (b) the provision of the right form of support by the right person (Taylor, 2011). Therefore, inductive exploration of women’s perceptions of support is urgently needed as the basis for pursuing the enhancement of a clinical practice that meet women’s needs (Fischer, Dolbeault, Sultan, & Bredart, 2014).

The health care professional’s challenge of meeting women’s supportive needs is further complicated by the modern health care context, where most cancer treatment takes place in outpatient settings. Elaborating on these circumstances, the course of treatment of ESBC usually comprises breast surgery and adjuvant therapies (chemotherapy, radiotherapy, targeted therapy, and/or hormonal therapy), which might be combined differently and occur in variable order (Kaufmann et al., 2013). In such a context, the partnership in care has to be established during short encounters at the clinic and persist between those encounters, which may occur with days or weeks apart. Moreover, research evidences that the provision of support at a time point during the course of treatment when the need is not experienced might have an opposite effect to that intended and be perceived as harmful (Case, Andrews, Johnson, & Allard, 2005; Lally, Hydeman, Schwert, & Edge, 2013). Thus, knowing when in relation to the treatment course women diagnosed with ESBC experience their supportive needs and are willing to satisfy them is as important as mapping the antecedents of those supportive needs and the consequences of support seeking (Sherman et al., 2012).

In the process of establishing a partnership in care and ensuring women’s involvement, the provision of person-centered support is essential (Ekman et al., 2011; McCormack & McCance, 2006). By person-centered support, we mean the provision of care through a range of activities departing from the person’s beliefs, values, and their perspectives of what is

happening. The provision of person-centered support then has to occur in an environment where the health care professionals facilitate person’s engagement and participation and integrate the newly formed perspectives into their practices (McCormack & McCance, 2006).

In the new era of information and communication technology (ICT), women diagnosed with breast cancer, like many others, use the Internet (Protiere, Moumjid, Bouhnik, Le Corroller Soriano, & Moatti, 2012). However, their need for cancer and health-related information and social support is commonly unmet (Ginter & Braun, 2014; Griesser et al., 2011) and a leading reason why women diagnosed with ESBC turn to the Internet (Lee & Hawkins, 2010). Given the significance of the Internet as a supportive resource, understanding its role in relation to other individual supportive sources is important, to adequately assist women and develop relevant supportive programs. This is especially urgent considering the lack of case-specific information and support and the ambiguous quality of cancer websites (Balka, Krueger, Holmes, & Stephen, 2010; Lawrentschuk et al., 2012). Moreover, taking advantage of the ICT availability, eHealth supportive programs might complement outpatient care by increasing the accessibility (Kreps & Neuhauser, 2010). Indeed, eHealth supportive programs have been developed and tested for effectiveness in the last decade (Ryhänen, Siekkinen, Rankinen, Korvenranta, & Leino-Kilpi, 2010). Despite generally positive results (Gustafson et al., 2002), theoretical frameworks underlying the process of interacting with the program to reach the supportive outcomes are scarce and vary if existing (Ventura et al., 2013), which hinders the replication of eHealth supportive programs (Sanchez et al., 2013). Therefore, mapping the active ingredients of satisfying supportive needs is a prerequisite to the development, evaluation, and successful implementation of eHealth supportive programs (Craig et al., 2008).

Within the frame of an overarching project for the development of an eHealth supportive tool, we conducted this study with the aim of exploring patients’ supportive needs and corresponding support-seeking behaviors throughout the course of treatment for ESBC. More specifically, while exploring the support-seeking behaviors we inquired as to (a) the time point in the course of cancer treatment chosen to access the supportive resources, (b) the process undertaken by women to meet their supportive needs, and (c) the supportive role of the Internet in relation to other supportive resources.

Research Design and Method

Design

We used interpretive description as the methodological approach (Thorne, 2008) to inductively explore the research phenomenon, that is, women’s supportive needs and corresponding support-seeking behaviors throughout the course

of cancer treatment for ESBC, and systematically render an understanding of the phenomenon applicable to practice in such a way that enhances the supportive care for women diagnosed with ESBC. Interpretive description allows the sampling criteria, data construction, and the disciplined and inquisitive analytical process to be grounded in a theoretical scaffolding: a combined evidence-based and clinically derived foreknowledge of the phenomenon under study. Detailed foreknowledge is introduced in the following sections along with our methodological choices (Hunt, 2009; Thorne, 2008). However, our perspective on personhood and the derived epistemological roots in person-centered care play a great role in the way by which we approach the research phenomenon and should therefore be explicitly stated. Specifically, we believe that a person is a being bearer of rights, with capacities and vulnerabilities, who detains an own point of view on things and therefore attributes purposes and detains desires or aversions to the surrounding world (Taylor, 1985); an interactional being, who meaningfully and deliberately acts no matter how vulnerable or capable (Ricœur, 1994). In the context of person-centered care, our personhood perspective is translated into the establishment of a partnership, in which women narrate their experiences of being vulnerable and their efforts toward re-establishing their strength and we, health care professionals, learn with them and assist them in strengthening existing resources and identifying new ones, according to personal meaningful goals (Ekman et al., 2011). Ethical approval was received from the Regional Ethical Review Board in Gothenburg (Dnr. 882-12).

Sampling Procedures

Women diagnosed with ESBC, able to understand and provide written informed consent in Swedish, were invited to discuss and reflect on their supportive needs and support-seeking behaviors. Because we wanted to explore the role of the Internet as a potential supportive resource, women also had to manifest interest in using the Internet for support seeking. In addition, to facilitate variation in the experiences of the phenomenon we aimed at including participants of various ages and with variable length of cancer treatment. We initiated the sampling process by purposively recruiting participants from the surgical, radiotherapy, and chemotherapy departments at a metropolitan university hospital from Western Sweden, to ensure that our sample reflected the women's supportive needs and support-seeking behaviors at different time points of the cancer treatment. Progressively, the sampling was theoretically grounded on an emergent pattern from the concurrent data construction leading to the recruitment of women undergoing chemotherapy for ESBC for focused exploration.

During women's visits to each department for either consultation or treatment, registered specialist nurses and nursing assistants approached eligible participants, presented the

study, and provided them with written information. Recruiters annotated the email addresses of women interested in the study, who were further invited by email to participate in focus group discussions. An email reminder was sent to each woman 1 week after an unanswered invitation. Women were offered two possible times and each focus group meeting was scheduled when six women had confirmed their participation in the study (Thorne, 2008). Women manifesting interest to participate but unable to come to the focus group or presenting discomfort in participating in group meetings were invited to individual interviews instead. With this alternative plan for data collection, we wanted to ensure that all eligible women and interested women had the opportunity to express their point of views. Overall, a total of 19 women (1–19) constituted five distinct focus groups (A–E) and only one woman was interviewed (Table 1).

Data Construction

We followed a concurrent data construction process, where the preliminary analysis along with the first interaction with participants informed supplementary data collection, and the new data informed the succeeding analytical processes (Thorne, 2000, 2008). Accordingly, our interaction with participants occurred in two phases, during the first trimester of 2013 and 2014, respectively.

Data collection. Our clinical understanding that some social knowledge about attitudes and beliefs underlying the process of support seeking during the course of cancer treatment was the main reason for the selection of focus groups methodology (Thorne, 2008). Specifically, the group's social dynamic was expected to generate a chain of conversational arguments based on distinct experiential knowledge on supportive needs and support seeking. Ultimately, the data constructed through the argumentation between women would land on an understanding of which processes and behaviors were supportive and at which time point throughout the course of treatment. Moreover, the group interaction was expected to raise awareness about potential needs and behaviors that were unconsciously performed yet generated the experience of being supported. Finally, by taking advantage of the group processes, focus groups would allow for idea networking (i.e., the creative potential of interaction among perspectives) in relation to the features of web-support and the processes underlying support seeking (Thorne, 2008).

During the first phase of data construction, two groups moderated by two researchers each met twice at 4-week intervals for focus group discussions. Women undergoing chemotherapy composed one group, and the other brought together women in the radiotherapy phase. In the second phase, three complementary focus group discussions with women undergoing chemotherapy were conducted, with a single meeting for each group (Table 2). All focus group

Table 1. Study Participant Characteristics.

Characteristics	Number of Participants (n = 19)				
	Group A (n = 6)	Group B ^a (n = 4)	Group C (n = 2)	Group D (n = 4)	Group E (n = 3)
Socio-demographics					
Age (years)	43–60	30–69	49–64	45–67	39–54
Citizenship					
Sweden	5 ^b	3	2	4	3
Civil status					
Living alone	—	—	—	1	1
Living alone with children <18 years old	—	1	—	—	—
Living together	2	2	1	2	2
Living together with children <18 years old	4	1	1	1	1
Educational level					
Elementary school	—	1	—	—	—
Secondary school	4	1	—	3	—
University degree	2	2	2	1	3
Current occupation					
Employed	1	1	1	1	2
Sick leave	5	2	1	3	1
Retired	—	1	—	—	—
Concerning computer and Internet use					
Computer proficiency					
Not especially proficient	—	1	1	—	—
Fairly proficient	2	2	1	3	2
Very proficient	4	1	—	1	1
Internet proficiency					
Not especially proficient	—	1	—	—	—
Fairly proficient	2	2	1	2	1
Very proficient	4	1	1	2	2
Frequency of Internet access					
Daily	1	2	2	2	1
Several times a day	5	2	—	2	2
Importance of Internet as source of health information					
Not important	1	—	1	—	—
Neither nor	1	2	—	—	—
Important	3	—	—	2	3
Very important	1	2	1	2	0
Importance of Internet to access social networks					
Not important	—	2	—	—	—
Neither nor	1	—	1	2	1
Important	3	—	1	1	2
Very important	2	2	—	1	—
Oncological treatment at the time point of the meetings					
Radiotherapy group, first phase					
Chemotherapy before radiotherapy	NA	4	NA	NA	NA
Concomitant chemotherapy	NA	1	NA	NA	NA
Chemotherapy groups					
Number of treatments received	2–10	NA	3	3–14	2–3
Concomitant radiotherapy	5	NA	1	2	2

Note. NA = not applicable.

^aFor the convenience of presentation, background data from the participant who was interviewed individually are presented together with Group B, as she was the representative of the radiotherapy phase.

^bOne woman was born in Poland.

Table 2. Data Construction: Phases of Interaction With Participants.

Interaction Phases	Focus Groups		Data Collection	
First phase	Group A	First meeting <i>n</i> = 6	Written or audio-recorded reflections between meetings	Second meeting: <i>n</i> = 5
	Group B	First meeting: <i>n</i> = 3 ^a	Written or audio-recorded comments between meetings	Second meeting: <i>n</i> = 3
Second phase	Group C	Single meeting: <i>n</i> = 2		
	Group D	Single meeting: <i>n</i> = 3		
	Group E	Single meeting: <i>n</i> = 4		

^aOne woman unable to participate in the scheduled group meeting was interviewed individually.

discussions were conducted in Swedish, audio-recorded and transcribed verbatim.

At the beginning of the focus group discussions, which lasted between 2 and 2.5 hours, the women were informed about the confidentiality and anonymity of their participation and the possibility to abandon the meeting at any time without further explanation if they felt uncomfortable. In addition, we reinforced the importance of apprehending the perspective of each woman over reaching a consensus, attempting to reduce the risk of eventual non-dominant perspectives to remain obscure (Thorne, 2008). Subsequently, women signed the consent form and completed a one-page survey with background information, which included data on socio-demographics, computer and Internet proficiency and supportive role, and oncological treatment.

According to the specific aims for each of the interaction phases, the subject areas guiding the discussion session of the focus groups differed (Table 3). In summary, during the first interaction phase, we began by broadly exploring women's supportive needs, and perceptions of support and their use of the Internet as a supportive resource. During the second interaction phase, we narrowed the inquiry to more specific and complex support-seeking behaviors, and processes of interaction with the supportive resources.

Particularly considering the focus given to the potential supportive role of the Internet in the first phase of data construction, we displayed three existing and reliable Swedish web resources for cancer support before the concluding remarks of the first meeting and provided the web-addresses for each resource to the participants. Two of the web resources were delivered by cancer organizations (The Swedish Breast Cancer Association and mainly The Swedish Cancer Society) and comprised information about cancer and cancer treatment. The Swedish Cancer Society also provided a support line staffed by health care professionals with oncological backgrounds. The third resource was the Swedish health care guide (1,177), which is a non-cancer-specific supportive platform that presents information on health care services nationwide, and offers health care advice and information. This platform also allowed for anonymous communication with health care professionals. Although all the web resources provided evidence-based information on

cancer and cancer treatment, the design, the information display, and ease of use varied. With this information, we sought to prepare the second meeting and invited for a common reference of online support to facilitate the discussion of women's preferences concerning format and features of web resources. In addition, assuming that women would use the Internet for supportive purposes during the period between meetings, we encouraged them to annotate or audio-record their reflections on the process of support seeking in the Internet whenever they went online for support seeking in relation to their cancer and/or treatment. Women received a guide with trigger questions to assist the think-aloud process during their interaction with supportive web resources. Two participants (one from Group A and one from Group B) retrieved such accounts. This strategy to document women's accounts from daily life situations aimed at complementing the retrospective descriptions compiled during the focus group discussions (Koro-Ljungberg, Douglas, Theriault, Malcolm, & McNeill, 2012).

Data analysis. We applied constant comparative analysis as adapted to interpretive description (Hunt, 2009; Thorne, 2008; Thorne, Kirkham, & O'Flynn-Magee, 2004). The analytical process began with intensive reading of the transcribed data to get a sense of the whole scope beyond the self-evident and immediate impression of each discussion (Thorne, 2008). Thereafter, the process of making sense of the data proceeded to (a) identify data segments relevant to answer our research questions and their interrelations to form patterns and (b) identify interrelations among patterns to form relationships (Thorne, 2008). The identification of data segments was facilitated by an inductive open coding and broad-based questioning to allow structuring the data by answering the question "What are women talking about?" The identification of patterns (i.e., groups of data bearing similar characteristics) was conducted by answering the question "How are women talking about it?" Subsequently, more specific questions facilitated the identification of variation and allowed each pattern to gain density. The inquiry was specifically guided by the following questions: Is the discussion topic common to all women? Or is it an individual perspective? Is there a predominant point of view on the

Table 3. Structure of the Discussion Sessions of the First and Second phases of the Concurrent Data Construction.

Sessions	Subject Areas	Trigger Questions
First phase: First meeting	Existing supportive sources and resources, antecedents, and consequences	What are your supportive sources? How do they influence your well-being? Why do you reach out to them? How do they influence your use of the Internet? And of the health care team?
	Internet as a supportive resource in relation to cancer and oncological treatment	How does the Internet reinforce you and your daily living in relation to cancer and treatment?
	The ideal supportive resource	What difficulties encountered in your daily living go unresolved? How could the health care team assist you in resolving them? How could the Internet mediate the proposed solution?
First phase: Second meeting	Experiences of web-support between meetings	Possible reasons that led the women to the Internet. How did the use of the Internet influence your interaction with the other sources/resources? Internet's influence on the need of face-to-face contact with health care team.
Second phase: Single meeting	Existing websites features	Interactivity, language, multimedia format, usability, feedback
	Supportive resources and interdependence	Which resources strengthened you from the moment you were diagnosed? Why? And specifically during chemotherapy? How do those resources influence the use of the Internet <i>and vice versa</i> ?
	Process of engaging the supportive network	In the presence of a concern, how do you proceed? Possible reasons that lead women to the Internet. Satisfaction of needs succeeded and consequences of Internet use.

subject? Are women agreeing/disagreeing on the subject? Are there alternative approaches to the same subject? Emergent patterns and their tentative relationships were brought together and compared across data to allow the movement from the individual cases to a comprehensive understanding of the patterns and relationships between patterns. This process was facilitated by these questions: What are we learning about with this pattern? Is it, and if so how, related to any of the other patterns? Relationships between patterns were repeatedly discussed and probed at the research team meetings until findings were not only data-grounded but also clinically relevant (Hunt, 2009).

The analytical processes from the first interaction phase allowed us to understand the behaviors of support seeking in relation to the course of treatment, which assumed great variation among participants. In particular, the preliminary data generated from the first phase brought to our attention that women commonly actively engaged in support seeking at the start of chemotherapy and their seeking behaviors intensified throughout the chemotherapy phase. These intermediate findings were still complex and insufficient to answer our research questions specifically considering this time point in the course of treatment. Consequently, and in line with the responsive relationship that characterizes the concurrent process of data construction (Hunt, 2009), we carried out the second phase of data construction to further explore the complexity associated with the variability and interdependence of supportive resources specifically during chemotherapy.

Here, we started by planning for one focus group meeting, which only reinforced the patterns from the first phase without allowing deepening our understanding. Consequently, we planned for two more focus groups. Along with the last phase of the data construction process, the focus groups discussions from Groups D and E did not lead us to the identification of more variation in the phenomenon. Specifically, these two focus group discussions allowed to assess tentative relationships between the patterns previously identified, enhancing their density. Upon the variation and density of the findings at that stage, we decided that no further exploration was required.

Results

The need for knowledge and support and the seeking behaviors varied greatly among the participants. Nevertheless, the women generally portrayed a great need for health-related knowledge and support and displayed a willingness to be involved in their treatment and care for their health and well-being. This common perspective emerging across group discussions led us to the conceptualization of women as self-driven resourceful agents of knowledge and support seeking.

The self-driven resourceful agent reached out on a perceived need for knowledge and support. Reaching out was a proactive behavior, which intentionality shifted according to experiential beliefs and circumstantial aspects. The self-driven

agent engaged her supportive network according to (a) their perceived need for support based on the concern's severity, the resource's availability, and the specificity of the support needed; and (b) the resources' meaningfulness attributes, which finally determined their firsthand engagement. Each contact established with a specific resource had an impact on the interaction with the remaining supportive resources. In this context of interdependence of supportive resources, the women's personal supportive assets were perceived as continuously available, were primarily engaged, and influenced their need to contact the health care team (HCT). The HCT in particular was only engaged in case of severe concerns, even though it was considered the most trustworthy source of health-related support. At this level, a mismatch between the support received from the HCT and the women's perceived need for support was identified.

Perceived Need for Support in a Continuum of Knowing and Feeling

While facing great distress caused by events related to the disease or oncological treatment, the participants described a process of turning themselves inwards. Manifesting an attitude of endurance, all they needed was the unconditional presence of their loved ones—for them to be genuine, and just be there to provide the needed reassurance. Turning inwards meant the women would focus on self-preservation and introspection. In contrast, following an improvement in their well-being, the women could reach out to their surroundings and engage purposively with their supportive resources to understand the processes behind the ongoing and possible upcoming changes to their bodies.

This transition from turning inwards to reaching out was framed in a feeling-knowing continuum. The positioning of the women in the continuum reflected their state of action: Women turned inwards focused on their feelings, whereas women reaching out focused on building a knowledge foundation. The women in one of the groups expressed the state of being turned inwards in association with the immediate period following diagnosis:

P1: It's all about surviving.

P2: Psychological, the mental pressure is the hardest.

P1: It's awful in the beginning. And you just hang on to your husband or whoever you have. Just having a loved one walking beside you, that's what really matters . . . Yes, you just have to process . . . I just wanted to be with my closest loved ones, calm down, and just be allowed to discuss the negative feelings and possible darker outcomes, yeah, and that takes long time.

P2: You become quite withdrawn.

P1: Yes, it was how I felt.

Variations of Reaching Out

Overall, women recognized their interest in searching for knowledge and support. Nonetheless, different levels of intentionality transpired in association with their reaching out behaviors. Accordingly, variations from intensive seekers to sporadic seekers, and observers were identified. Exploration of the data allowed us to identify experiential beliefs, which underlay the predominant reaching out behavior, and circumstantial aspects, which prompted the shifting from the predominant reaching out behavior to another.

Experiential beliefs. Some women attributed the predominantly observer behavior to being older (two women aged above 65) and being women (assuming the role of primary caring figure of the family), which they perceived as a prompt for endurance. Having previous family caregiving experience was considered by one participant to increase her confidence and lead to observing or sporadic seeking behaviors. Intensive seekers discussed their professional experience of computers, the health care system, and their family situation (living alone or having young children) as factors underlying their behavior, whereas other women thought their previous experience of disease or health complication contributed to heightening their awareness and engagement in searching for knowledge and support.

Circumstantial aspects. Shifting from the predominant reaching out behavior to another (e.g., from observer to intensive seeker) was also common, especially as the women progressed along the course of treatment. The behavioral change in this context might have been prompted by circumstantial aspects such as (a) perceived complexity of diagnosis and level of involvement in the decision-making process, (b) unmet expectations in relation to the course of care, (c) perceived time elapsed between critical events, (d) perceived influence, (e) experienced well-being, and (f) perceived processing capacity.

For some women, the diagnosis and the treatment plan had been straightforward: a decisive process without room for discussing alternative treatment pathways. With this straightforward plan came the confidence to go along with decisions and the women's behaviors leaned toward the observer end of the continuum. In contrast, other women found themselves in a complex decision-making process, becoming intensively preoccupied with the kind of surgery that would be performed, and experiencing the uncertainty of following an alternative procedure, depending on the surgeon's findings. Here, this uncertainty prompted the women toward the seeker end of the continuum, where they would contact cancer organizations and compile knowledge that would assist them in the decision-making processes.

Unmet expectations in relation to the course of treatment could also trigger observers into becoming seekers. This was

the case for several women only expecting radiotherapy who were later presented with the inclusion of chemotherapy in the treatment plan after surgery.

The start of chemotherapy was a common trigger of seeking behaviors, particularly for the women who perceived the time elapsing between diagnosis, surgery, and start of chemotherapy as being insufficient for reflection. In addition, chemotherapy generally demanded an intense involvement from the women in terms of self-care, with greater opportunities to influence their well-being.

In general, perceived enhanced well-being and increased processing capacity similarly led to seeking behaviors. An exception to this occurred during the radiotherapy phase when the women acknowledged experiencing increased well-being but were mainly observers. The technical environment and limited contact with health professionals were perceived as indicative of a treatment that would be accomplished without unforeseen complications.

In one focus group, the involvement in the decision-making process and its influence on the reaching out behavior of becoming a seeker came to surface:

P1: Well, it was just when I found out that I had breast cancer, the doctor said. . . . So you have breast cancer and now we have to decide together if we take all the breast or just part of it. . . . It came as a shock to me, so I just said but what happens if I don't take anything? Yes, because it wasn't very clear, you weren't able to feel the lump, it was just visible with the ultrasound. Well, then you have to do some more stringent check-ups, but I really do not recommend it. So, by the time I went home we had decided that I would just take a piece of the breast. Then the next day I started thinking that he probably thought I should take the entire breast. I just had that feeling, so I contacted the nurse. . . . She said that was probably it—when you started talking about not taking anything the doctor probably backed down a bit. Then it's probably better for me to take the entire breast. What's really the best way to go? And I felt that I was very alone with that decision, I wanted to talk to a doctor again but it wasn't possible until the day before hospitalization for the operation. . . . Then I contacted the social services here, and I called the cancer foundation, just to try to get an answer to how I should proceed and what I should choose. Because I really felt that it was my choice.

P2: I'm very grateful that I didn't have to make that kind of decision—the answers have been straight forward all the time . . . I've just played along and I am confident with that. It's such a relief.

Engagement of the Supportive Network

As well as discussing common stages of the course of treatment when a specific source satisfied a specific need, the women described mutable supportive systems that depended on certain circumstances. In addition to the HCT, which was a common constituent of all supportive networks, the women's personal supportive assets could include loved ones,

significant others with lived experience of breast cancer or from a health care background, fellow women, cancer organizations, and the Internet.

Interdependence of supportive resources. The process of engaging with the supportive network implied that the women sometimes turned to more than one resource with the same or a consequent query, reflecting the interdependence of the supportive resources. Specifically, some connections could be reassuring and completely satisfy the women's supportive needs at the time or at least to a level which could then be developed in discussion with the HCT at the next medical appointment. Other connections could raise women's awareness and reinforced the need to establish contact with the HCT immediately. The women would continuously establish connections with the supportive assets until they experienced the reassurance needed to continue their daily living. Two women from two different groups described the interdependence between the Internet and the HCT in her supportive network.

P: I'm on the Internet a lot. The web is my job . . . I look for information there first before I decide to contact the hospital. . . . If I don't find the answer there then I get in touch with the hospital. Although I might have calmed down just by knowing, you know certain webpages that, you think oh ok, it might actually be that. Sometimes that's reassuring enough.

Perceived need for support: Severity, availability, and specificity. The women appraised the severity of their daily emergent concerns and did not push for immediate contact with the HCT, instead they attempted to answer minor concerns mainly by engaging their personal supportive assets. The immediate availability of a resource in the supportive network was the most prominent factor steering its firsthand use before engaging others. In addition, the specificity of the support needed would also steer the women's choice of which supportive resource to engage. Specifically, knowledge and support tailored to the specific circumstances of each woman was the most valued form of support although it was the least available among the personal supportive assets, being only fully provided by the HCT. In the following citation, a woman reflects on the need for knowledge tailored to her specific situation and the adequate resource to give her that support.

P: I cannot just search online for information about how I react to my chemotherapy, it is of course difficult, but I can call my nurse and she knows exactly: Oh yes, you did get that treatment and it is not so unusual that you feel like that on the fourth day after receiving it. So, in those circumstances I have no problem to call.

Moderator (M): So you're saying that the information you need is very personal, you feel that what is online is somehow too general to answer your questions at that moment, and the

information you receive from your nurse is specific to your situation, do I understand you right?

P: Yes, that's exactly what I mean. For some things are difficult to search on the Internet because it is just so broad online. So if I feel something new I think—Should it feel like this? Then it is easier because my nurse knows exactly what treatment I receive and what day I'm in after treatment, and then I feel more calm and confident if I call.

Reaching out to the Health Care Team: Mismatch between received and perceived support. Across women's accounts, a pattern was identified where (a) women's receptivity to support routinely provided by the HCT did not always match their active support-seeking behaviors, and (b) while being active seekers, the women did not necessarily engage the HCT, if at all, even though they considered it the most relevant in terms of health-related support.

When exploring this mismatch between the received and perceived support, we found that regardless of women's predominant reaching out behavior, all of them manifested a reaching out state during the face-to-face meetings with the HCT, when they acknowledged the provision of knowledge and support but did not really experience it. During these encounters, the women became receivers: The knowledge made available to them both orally and in the form of brochures was precious but their assimilation and accommodation capacities were limited. The women diffusely assembled knowledge that could be helpful later on, but the knowledge disseminated by the HCT often lacked applicability to their present concerns. In the absence of a perceived need, the integration of the knowledge provided was partial and its meaningfulness was diminished.

P: Although there was a lot of information, it was still fairly general stuff—this can happen but it might not happen. But of course, it was a lot to absorb; then you can get ill but it's not certain you will, but you might. I had one hour with the nurse and the doctor and then they asked me if I wanted to participate in a study, so it was another hour with another nurse and at the end, I had two or three brochures with me. And you know, these brochures they are, there are a lot of good things in them, but I had them lying on the table certainly for several weeks before I started looking into them.

M: Why did you choose to wait?

P: I didn't have the energy. I had already gotten so much.

As active support seekers, the women made a severity assessment of their concerns, according to which only severe concerns justified the engagement of the HCT. Severe concerns were commonly described as a feeling of strangeness, something they had never experienced before and of which they could no longer make sense. Otherwise, the women assessed their concerns as unworthy of disturbing

the medical ward and instead chose primarily to support themselves through their own personal supportive assets. These personal supportive assets were deemed as continuously available, in contrast to the HCT, where the perceived availability would therefore vary according to the concern's severity. Specifically, increased severity was associated with an increased perceived availability and would lead to establish contact, progressing from telephone to face-to-face contact, as the severity increased. A woman in one of the focus groups discussed the perceived availability of the HCT in relation to a headache that she experienced between chemotherapy sessions:

P1: I didn't dare take any pills or consider contacting the hospital. No, I'll hold out, I can ask them the next time I'm at the hospital. Because I also believe you don't dare to pose these little, you know, when it doesn't really, I can endure it, like it isn't that big of a deal.

P2: Yes, I don't want to bother them with these small questions.

P1: Yes, I think that you see them all working with really terrible things at the hospital.

P2: Exactly.

P1: They work with terribly ill people, and it just happens that I go there sometimes as well, but I'm not as ill as them really. It's also a reaction that I can't identify myself with other cancer patients. I still can't and that's strange.

P2: No, I tend to go in that direction too. Sometimes I'm at the other end, but I feel a lot like you too. I'm not that ill.

P1: Yes.

Along with the progression of the course of treatment, the women found frequent appointments with the HCT (e.g., chemotherapy sessions, medical consultations) reassuring. These scheduled encounters reflected a high perceived availability, in that the women would share unresolved concerns that had emerged between appointments but lacked the severity to establish contact with the medical ward. One woman described a change in the treatment plan schedule during chemotherapy, from one treatment every 3 weeks to weekly treatment sessions, and recalled the reassurance of meeting her contact nurse more frequently:

Anyway, they decided that in the second round . . . I would get another substance that is administered once a week because I reacted so strongly to the other . . . This means that I went . . . 3, 6, 9, 12 treatments once a week instead of one treatment every three weeks. . . . It was so valuable, because then I didn't need to check the blogs and search so intensively. Instead, after those two awful experiences, I was here once a week, I could talk with my nurse, how has it been this week? How did you feel? . . . I had the benefit of being in close contact with the nurse once a

week, especially when it really felt like a crisis, just having the opportunity to talk.

Personal supportive assets and meaningfulness attributes. Passed the severity, availability, and specificity judgment, women engaged with their personal supportive assets according to (a) the desired proximity to others, (b) the kind of knowledge needed, and (c) the form of support needed. These aspects constituted the meaningfulness attributes of each supportive resource and determined their firsthand engagement.

Loved ones and the Internet were consistently the women's first choices. Some used the Internet more often than others, depending on their ability to manage the level of detail and the scope of the search. Those who found this difficult, depended more on loved ones to mediate this information, a process two older women described as an aid to reducing their anxiety. Their daughters would search for knowledge and filter the relevant information.

I talk to my youngest daughter, she goes to the Internet and says mom, I've seen this and that . . . she searched Google for cancer and then she took questions to pose to the doctor which he responded to, and that has helped me. Mom, it says here that if you have a cough, she goes into different things just like I did before; I once arrived at the diagnosis of appendicitis—yes—but for me it's different . . . I just wait and think it will probably pass.

The women's discourse revealed the high availability of the Internet as the key feature leading them to use it. Nevertheless, a step-by-step, proactive approach of reaching out characterized their search process: finding the best fit of keywords for the initial search, selecting reliable informational and supportive webpages, and combining knowledge from reliable sources. Such an approach was time-consuming, yielded mostly impersonal information and consequently required more energy than directly asking a health care professional. In the following, the energy that an Internet search process might demand is exemplified.

M: So you get your answers from the Internet?

P1: Yes, so far I have.

M: And that was the reason why you didn't have to contact the hospital?

P1: No, and that's what I feel, that sometimes, it's a very long way until I get, I might end up with ten webpages.

M: Yes, because, if I understand you correctly, you might get an answer from one page, but you don't stop there?

P1: No, so if I've typed it on Google and maybe 25 pages come up, then I read all of them, and I probably get different answers from all of them. Really? Which one is the right one now? Which one matches? Which one is true?

Although the Internet was a source of knowledge and lived experience, the process of judging the reliability of the webpages was difficult. Moreover, the lived experience was mostly conveyed by personal blogs or forums portraying emotionally charged stories. Women with limited access to lived experience of breast cancer and health care professionals in their surroundings would commonly compensate by searching for comparable knowledge and support on the Internet because of its immediate availability. In the following citation, a woman described the importance of having contact with lived experience, which she found in her neighbor by coincidence.

Yes, it was just by coincidence that we got in touch and had like, yes, sometimes it's just chance. If I didn't have her, I would probably have searched the Internet more, I really believe so. But for me she was enough then.

The women's tendency to use the Internet also identified relational aspects. Here, a desire for proximity to others emerged in association with the approaches they adopted to problem solving. Some of the women mentioned their uneasiness to discuss concerns with others, instead using the Internet as an individual and anonymous approach to problem solving. Other women were more socially oriented and found that even a single contact with another human without the computer interface was already meaningful.

Significant others with lived experience of cancer and cancer therapy or with a health care background assumed an important supportive role. The comprehension and empathy implicit in these supportive connections made them easier to draw on. More specifically, significant others with health care experience could, for example, provide the women with personalized medical advice.

P: Yes, I mean we are a little older and we are usually not, I look at my friend, she's a physiotherapist—you know my friend who got this too. She sat and searched—she was used to doing that. So she would give me the information and so I don't need to make those efforts.

M: So you have other resources than the Internet?

P: Yes, I have some friends who are doctors also, yes, and then you don't need to go to the health care center even if they are really trustworthy.

During the focus group discussions, it was recognized that fellow women receiving care at the same medical ward were very important supportive sources. Although the women's illness journeys could vary in terms of treatment plan and where they were on the course of treatment, the comprehension and empathy coming from similar quests in a shared care environment generated a group identity. The context provided the women with both lived experience of cancer and cancer therapy, and evidence-based knowledge. While

constantly recognizing the specificity of each course of treatment, the women trusted each other's advice, particularly in regard to self-care tips. The sharing of stories and advice turned the group discussions into meaningful connections.

P1: Just having a group like this, we notice right here the need we have, just to talk a little at different stages.

P2: That was just what I was about to say, that here the need is so clear the need to just meet like this, because we are quite alone on this journey unless you have a friend. I actually have some friends who have gone through this and everyone was cured, so they are good role models but it's just while you're under treatment, that's when it becomes, have you also felt this? How have you been? No, I haven't felt that . . . you know, just like this here.

Cancer organizations were the least mentioned supportive entities, but when engaged they constituted an important role as second-opinion sources and self-management strategies.

Finally, considering the form of support needed, women's discussions about their needs and supportive approaches, reflected great variation in terms of contact with others' emotions and reasoning, as supportive mechanisms. This variability spanned from specific time points when the women found confidence in overlooking their emotions and focused on reasoning, to other moments when they preferred to get in touch with not only their individual emotions, but also other women's positive and negative experiences. A woman who had to decide between a partial mastectomy and a mastectomy recalled a discussion she had with her son, who helped her reason about the loss of her breast.

P1: But I know my son, he's 22 years old. He said, Mom, of course you should take the entire breast. The main thing is that you survive. That's nothing, your breast you can just live without. That was so incredibly rational for him. Boy, or man. . . And it did some good to hear that actually, in a way, even if I couldn't discuss my emotional experiences with him really.

P2: I understand exactly what you mean. The breast was just a breast, it wasn't the most important . . . it wasn't the most important to . . .

P1: No, for him it was already . . . it had already done its part.

Discussion

Our findings bring women's self-driven resourceful agency to the center of the adjustment process to breast cancer, as reflected in their different states of reaching out to purposefully selected supportive resources. These resources constituted an interdependent network, in which we found the relationship between the women and the HCT with regard to knowledge and support seeking of special significance. During medical encounters, the women became observers

and did not always experience the provided support. Between medical encounters, however, the women actively sought knowledge and support. HCT was nevertheless only engaged in extreme experiences of strangeness or severity, even though it was considered the most trustworthy and desired source of health-related knowledge and support. As opposed to the HCT, the personal supportive assets were perceived as continuously available, which was the primary reason for their firsthand engagement in between medical encounters.

In the following discussion, we conceptualize women's self-driven resourceful agency in the light of personhood and accordingly translate the results into potential contributions to achieve a reciprocal partnership in care, that is, a partnership that attends to women's agency, fosters their expertise, and acknowledges the interdependence of personal supportive resources. We discuss our findings toward the establishment of such a partnership at the face-to-face encounters and its maintenance outside the hospital walls. Specifically, by capitalizing in the accessibility of supportive eHealth, we should be able to enhance the perceived availability of the HCT and assist women in the severity assessment of their daily concerns.

Purposeful Agency in the Light of Personhood

The common link connecting women's accounts beyond the variability of supportive processes and resources along the course of treatment was their determined resourceful agency, which Paul Ricœur has conceptualized as one of the core capacities of a person (Ricœur, 1994). Drawing the parallel with Ricœur's philosophical stream, our study revealed that women receiving treatment for ESBC adjust to cancer and cancer therapy more or less actively as a *Homo capax*, a person with inherent capabilities and vulnerabilities, who continuously assumes responsibility for her actions in an interdependent relationship with others (Ricœur, 2005; Smith, 2010; Ugglä, 2011). In a continuum of well-being, a person who is suffering might have less active behaviors, numbed capacities, and increased vulnerabilities. Nonetheless, the person's agency is still a purposeful manifestation.

In the context of our study, the women's willingness to manage their daily lives and seek answers to their questions supplanted the vulnerability of the cancer diagnosis and treatment. They were willing to participate even at a lower level of agency, that is, as observers. Moreover, we assisted to an interdependent autonomy throughout the whole process of reaching out: along with the women's self-sufficiency and initial appraisal of their concerns and following the deliberate and thorough engagement of personal supportive assets from their surroundings when they were no longer able to find the needed reassurance in themselves (Ricœur, 2005; Ugglä, 2011). This interdependence fosters balance in the well-being continuum (Ricœur, 1994). If we allow Ricœur's perspective to inform the health care context and specifically the provision of knowledge and support, the care partnership should

attend to the agency of the women, and acknowledge the interdependent autonomy by being continuously accessible.

Women's Agency at the Center of the Reciprocal Care Partnership

In such a reciprocal care partnership, women are as much experts in their experience of being ill as the HCT is an expert in care (Charon, 2001). Also, reinforcing the need to put patient expertise at the center of the care partnership is other body of research on health behavior change in chronic illness (Paterson, 2001). In such a context, individuals with chronic illness must not only self-administer medication over time, but also recognize and report adverse effects or failure to achieve symptom relief. Doing so demands knowledge to make decisions and find support in managing distressing emotions (Ryan, 2009) as a lack in this regard may diminish engagement in care. Although cancer treatment is perceived as a temporary condition in ESBC, the same level of care engagement was demanded from women as from persons with chronic conditions. Specifically, the health care model reflected by our findings for provision of knowledge and support was highly dependent on face-to-face meetings. However, we see that these scheduled encounters occurred less frequently and were of a shorter duration because the women spent most of their treatment time in outpatient settings. With the main goal of achieving a reciprocal partnership in outpatient clinical practice that attends to women's agency and fosters their expertise, our findings might contribute not only to enhance the meaningfulness of the face-to-face encounters, but also to improve accessibility to the HCT between encounters.

Meaningfulness of Face-to-Face Medical Encounters

During face-to-face medical encounters, patient-provider communication becomes meaningful when patients feel like they are known, which is a deeply subjective experience. Therefore, the success of standardized communication guidelines might be undermined (Thorne et al., 2005). Instead, care providers need to view the patient as a learning person and train their awareness to identify experiential beliefs that reveal specific needs for seeking knowledge and understanding (Friberg, Andersson, & Bengtsson, 2007). Other studies on patient-provider communication have grouped such beliefs into typologies to assist care providers in adapting their behavior during medical encounters, thereby increasing their potential to become meaningful to the patients (Rottmann, Helmes, & Vogel, 2010).

The reaching out behaviors identified in our study complement the body of evidence mentioned above. Specifically, by bearing in mind the various ways in which women expressed concerns and acquired knowledge, the person-centered clinician in the medical encounter must endeavor to

meet the women's priorities as a seeker and provide tailored preventive reminders at the observer state (McCormack et al., 2011). A woman in the seeker state, whose awareness is oriented toward other concerns, will most likely consider the support provided as irrelevant, unless their concerns are addressed. It also follows that the observer will only integrate the discussion of current issues perceived as specific to her situation. Indeed, our findings strengthen the notion of a dynamic process in adjusting to breast cancer (Sherman et al., 2012). Acknowledging different reaching out behaviors along with varying patient capacities might assist the person-centered clinician in structuring the medical encounter in a meaningful way, thus enhancing the experience of support.

Enhancing Perceived Availability Through eHealth

Concerning the accessibility between the medical encounters, other authors have also pointed out the importance of increased access to care and patient agency to enhance patient health (Street, Makoul, Arora, & Epstein, 2009). Translating the person-centered principles to the care partnership, the HCT is desirably perceived as continuously available in an environment of shared deliberations, decisions, and responsibilities (Ekman et al., 2011; McCormack & McCance, 2006). In this context, supportive eHealth programs could advantageously be part of the solution to meet women's reaching out behaviors beyond the hospital walls. Not only might these programs increase the perceived availability of the health care system, but also allow for an equitable provision of person-centered supportive resources (Jung, Ramanadhan, & Viswanath, 2013).

While integrating the supportive network, the HCT will be able to nudge women specifically in case of preventive behaviors at relevant time points, and will be continuously available to the purposive process of seeking for knowledge and support. Furthermore, supportive communication processes that assist problem solving have been found to foster resilience, which contributes to reduced distress and increased well-being (Molina et al., 2014). Accordingly, supportive eHealth programs might also assist women in the severity appraisal of their concerns, which is likely to bolster their capabilities by (a) facilitating their interpretation of their experiences and (b) assisting in the assessment of their need for further support. In the context of enabling patient knowledge-seeking and learning, this assistance might also help the women in building their health-related knowledge foundation, develop skills for self-care, and raise confidence to manage their health (Jarvis, 2009).

The existing evidence allow us to understand that even the most meaningful medical encounter or computer-mediated assistance might not be enough to satisfy the purposeful agent needs (Longo et al., 2009; Walsh et al., 2010). These women will keep engaging their personal supportive assets to find comfort and reassurance. Other studies have shown

the importance of acknowledging patient supportive resources outside the patient–clinician relationship (Anker, Reinhart, & Feeley, 2011). Namely, the care provider response influences patient outcomes (Bylund, Gueguen, D’Agostino, Li, & Sonet, 2010) and patients need the care provider assistance not only in recommending reliable informational sources, but also in interpreting the acquired knowledge (Carlsson, 2009; Hou & Shim, 2010). These supportive relationships were crucial in women’s experience of cancer and cancer therapy and should be seen as an inherent component of their whole as a person (Eneau, 2008). Accordingly, the establishment of a person-centered reciprocal partnership at the outpatient clinic that persists between medical encounters may require awareness of the clinician to expand horizons beyond the person diagnosed with the cancer (Illingworth, Forbat, Hubbard, & Kearney, 2010) and acknowledge this interdependence of resources. In such a process, the clinician should understand the way by which the supportive relationships strengthen women’s agency and learning as a whole. In the long run, the acknowledgment of women’s supportive resources should transpire an openness that has the potential to foster empathy and enhance the perceived availability.

Study Limitations

The integrity of an interpretive description product should be ensured throughout the research process, which should then have specific trustworthiness strategies embedded, aiming at enhancing the study’s credibility (Thorne, 2008). In our study, the representative credibility might be questioned because multiple data sources were limited. Although group discussions represented the main data sources, we also conducted individual interviews and included written descriptions of two other participants from the engagement of supportive resources between sessions during the first phase of data collection. Ultimately, the data gathered from these complementary sources did not add any further depth to the inquiry but were confirmatory of the core perspective that began to take shape at the end of the first phase of data collection. For us, this confirmatory aspect of the complementary sources of data collection was indicative of sufficient data density at this stage and consequently indicative of the comprehensiveness of the used data sources to understand the variability of the phenomenon and its depth (Carnevale, 2002).

Moreover, the variation reflected in the participants’ characteristics allowed us to believe that the sampling process (initially purposive and progressively theoretical) and the concurrent data collection and analysis processes were successful in rendering an interpretive description product representative of shared realities of women under treatment for ESBC in their agency for knowledge and support seeking.

Another issue that might be considered to affect study’s credibility is the variation in size of the focus groups. Two to

three participants might be regarded as being too small for a focus group leading to potential concerns of reduced group interaction and consequent limited point of views emerging from those interactions. However, we deliberately decided to recruit smaller groups of maximum four participants (Morgan, 1997) after conducting the discussion with Group A, which was composed of six participants. Here, the intensity of women’s experiences and interest in the research phenomenon transpired from their need of telling their stories and giving constant response to each other’s comments. To have more in-depth insights regarding support seeking throughout each woman’s course of treatment, we needed smaller groups as these women were highly engaged, presented lengthy and strong experiences, and detained great contributions (Krueger & Casey, 2009). Ultimately, we wanted to give more time for each woman to present her point of view, an approach that has been suggested in the methodological literature (Morgan, 1997). As data construction progressed, the patterns emerging from the first group discussion were replicated and gained density. In this sense, we believe that having smaller groups covered the range of views concerning support seeking with greater depth.

During the second phase of data collection, the participation of women after completion of chemotherapy, who could retrospectively account for their experiences during that course of treatment, could have elicited point of views not yet relevant for women undergoing chemotherapy. This aspect might be considered to limit the study’s theoretical generalizability. However, the women participating in the second phase of data collection had varied number of chemotherapy sessions completed, which was expected to allow for variability in the experiences of support seeking during that course of treatment. Moreover, given the smaller group sizes, we had the opportunity to explore the experiences in depth. Such in-depth inquiry was considered to produce rich descriptions of the studied phenomenon that allow to foster insights in the clinical context which is the ultimate endeavor within interpretive description (Thorne, 2008) and argued to be an important goal when discussing external validity issues in qualitative research (Groleau, Zelkowitz, & Cabral, 2009).

Conclusion

Women diagnosed with ESBC present a self-driven resourceful agency manifested in reaching out to supportive resources for knowledge and support seeking. Specifically, women are aware, identify and report perceived harmful concerns, and seek out to meaningful supportive resources to resolve them. From a personhood perspective, the self-driven resourceful agency implies women’s desire for a reciprocal partnership with the supportive resources and thus in care situations. The challenge for the establishment of a person-centered partnership in outpatient oncology, however, remains with the health care system along with the provision of knowledge and support beyond the hospital walls. Hence, our findings convey a

need to shift the paradigm of providing professional support in predetermined appointments in outpatient oncology toward the achievement of a reciprocal partnership, which attends to patient agency and enables patient knowledge and support seeking for well-being. In this process, person-centered eHealth supportive systems, complementary to face-to-face meetings with the HCT, might be part of the solution by linking outpatient health care with women's reaching out behaviors.

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Author Biographies

Filipa Ventura, MSc, RN, is a PhD candidate at the Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

Ingall Koinberg, PhD, RN, is a senior lecturer at the Institute of Health and Care Sciences, Sahlgrenska Academy, and researcher at the Center for Person-Centered Care, University of Gothenburg, Gothenburg, Sweden.

Per Karlsson, PhD, MD, is a professor at the Department of Oncology, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

Richard Sawatzky, PhD, RN, is a visiting associate professor at the Nursing Department, Trinity Western University, Langley, Canada, and a research scientist at the Center for Health Evaluation & Outcome Sciences, Vancouver, Canada.

Joakim Öhlén, PhD, RN, is a professor at the Institute of Health and Care Sciences, Sahlgrenska Academy, and researcher at Center for Person-Centered Care, University of Gothenburg, Gothenburg, Sweden.