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The Experience of Viewing Oneself in the Mirror After a Mastectomy

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Mastectomy continues to be a key treatment option for many forms of breast cancer (Susan G. Komen for the Cure, 2011). Evidence suggests that psychosocial distress and negative feelings about body image are associated with breast cancer (Baucom, Porter, Kirby, Gremore, & Keefe, 2005–2006; Frierson, Thiel, & Anderson, 2006; Parker et al., 2007). Women may have feelings of altered femininity and sexuality, as well as an increase in self-consciousness concerning one's appearance (Avis, Crawford, & Manuel, 2004). Studies have illuminated the difficult experience of suffering with breast cancer (Arman & Rehnsfeldt, 2003; Ashing-Giwa et al., 2004; Langelier & Sullivan, 1998). Although reconstruction may improve body image for women who have had a mastectomy (Nano, Gill, Kollias, Bochner, & Malycha, 2005), those women may have difficulty adjusting to their changed body image (Crompvoets, 2006; Hill & White, 2008; Monteban, 2007; Lo Dato, Baldaro, Morselli, & Rossi, 2007).

The inspiration for the current study was the story of one woman who initially viewed her mastectomy site at home, alone. "I felt like running out on the road and screaming. That's what I felt like doing when I first came home and saw myself in the mirror" (Freysteinson, 1994, p. 108). In a preresearch field work project, women who had a mastectomy suggested that "thinking about viewing the mastectomy site is to think of viewing oneself in a mirror" (Freysteinson, 2010, p. 753).

A survey of the presence of mirrors in 10 hospitals where women who have had breast cancer surgery might stay postoperatively suggested a shortage of mirrors (Freysteinson & Cesario, 2008). Bed-bound patients had no access to a mirror in 70% of the hospitals. For ambulatory patients, the ability to view their chests was

Purpose/Objectives: To describe the experience of viewing oneself in a mirror following a mastectomy.

Research Approach: Ricoeur's hermeneutic phenomenology.

Setting: Three hospitals in a nonprofit healthcare system in the southwestern United States.

Participants: Purposive sample of 12 women 3–12 months postmastectomy.

Methodologic Approach: Structural analysis and phenomenologic interpretation of tape-recorded interviews.

Main Research Variables: Viewing oneself in the mirror after a mastectomy.

Findings: Viewing or not viewing one's own body, energizing and dispiriting thoughts, and supportive and unsupportive others helped to explain the experience of women who have had a mastectomy. The phenomenologic interpretation yielded four themes: I am, I decide, I see, and I consent.

Conclusions: The current study offers an understanding of the multifaceted experience of women postmastectomy. Mirrors appear to be essential in viewing and caring for the mastectomy site.

Interpretation: Nurses should consider discussing the mirror experience with women who are having a mastectomy pre- and postoperatively. Nurses also may choose to offer a mirror to their patients when doing the initial dressing change and teaching wound care. Educational materials are needed for patients and nurses. In addition, future research is warranted on the use of mirrors when caring for patients who have had a mastectomy.

not possible in 20% of the hospitals because the mirrors were hung too high on the wall for most women to see their chest area. No evidence was found in the literature that suggested mirrors may be beneficial for patients who have had a mastectomy. However, mirrors may have therapeutic value for patients with diverse diagnoses such as

dementia, brain damage, body image disorders, phantom pain, and cardiovascular accident (Freysteinson, 2009b).

No articles in the literature were found that describe the experience of viewing oneself in a mirror for women who have had a mastectomy. As a result, the purpose of this study was to describe the experience of viewing oneself in the mirror postmastectomy. The goal was to establish a conceptual foundation for future mirror research that may help to promote psychological well-being for women who have had a mastectomy. In addition, this study may provide direction for future research on the appropriate use and placement of mirrors in hospitals, clinics, and homes where postsurgical care may occur.

Methods

The current study was grounded in the assumption that viewing oneself in a mirror is a basic human right. Without mirrors, an individual is unable to see his or her face, back, and much of the upper body. Ricoeur’s (1966, 1974, 1975, 1981, 1992) philosophy of phenomenology and hermeneutics provided the foundation for this study. Phenomenology attempts to uncover the motives, actions, thoughts, and feelings associated with everyday experiences. Hermeneutics may be used to interpret texts of those everyday experiences. According to Ricoeur (1974), “Interpretation . . . is the work of thought, which exists in finding the hidden meaning in the apparent meaning, in unfolding the levels of meaning implied in the literal meaning” (p. 13).

Participants

Participants were recruited from three hospitals in a nonprofit healthcare system located in a city in the southwestern United States. Each hospital had an oncology nurse navigator (ONN) who followed patients with cancer throughout much of the course of treatment. The hospital-based ONNs communicate with women who are diagnosed with breast cancer in person or by telephone from the time of diagnosis through surgery and any other breast cancer–related treatments (e.g., chemotherapy, radiation). Women who were aged 18 years and older, spoke and understood English, and had a mastectomy with or without reconstruction within 3–12 months were invited to join the study by ONNs during routine postoperative telephone calls. Interested women were given the principal investigator’s (PI) phone number and were instructed to call the PI.

Of the 20 women contacted to be in the study, 12 women participated. Two women refused immediately; one woman could not yet face the mirror, and one woman gave no reason for refusing. Of the six remaining non-participants, one woman set up an appointment with the PI, but failed to meet the appointment. After one week, the ONNs made one telephone call to the remaining five

women who initially indicated they were interested in the study, but had not yet called the PI. Voice mail messages were left for two of those women, but were not returned. Two women indicated they did want to participate in the study and subsequently called the PI. However, both women called the PI again to indicate they felt too sick to participate. Finally, one woman indicated she was interested in the study but failed to call the PI.

Exclusion criteria were the need for a guardian for medical decisions, significant emotional distress, and body dysmorphic disorder (a psychiatric condition occurring in 1%–2% of the population in which individuals perceive they have severe face and body defects) (Feuser et al., 2009). Institutional review board approval was secured from the University of Texas Health Science Center and Texas Woman’s University, both in Houston.

Each participant was given a choice of where and when to meet the PI for an interview. Three women met the PI in their homes, whereas met the PI at the hospital where

Table 1. Participant Characteristics

Characteristic	\bar{X}	SD	Range
Age (years)	58.8	14.2	32–76
Characteristic	n		
Race			
Caucasian	8		
African American	2		
Hispanic	2		
Marital status			
Married	9		
Widow	2		
Single	1		
Education			
High school diploma	7		
Two-year college	4		
Bachelor’s degree	1		
Annual income (\$)			
Lower than 18,000	2		
18,000–30,000	3		
30,001–50,000	3		
50,001–100,000	2		
Higher than 100,000	1		
Declined to answer	1		
Mastectomy type^a			
Simple	8		
Radical	4		
Bilateral	3		
Months from surgery to interview			
3–5	8		
6–9	4		
Currently receiving chemotherapy	5		
Past treatments			
Chemotherapy and radiation	3		
Previous mastectomy	2		
Radiation	2		
Chemotherapy	1		

N = 12

^a Participants could select more than one response.

they routinely visited the cancer clinic. The ONNs assisted in arranging quiet office areas for those interviews. The PI met the participant at the arranged location, obtained consent, and then administered two instruments. All participants indicated on the informed consent form that they were interested in receiving future publications about the study for their own knowledge.

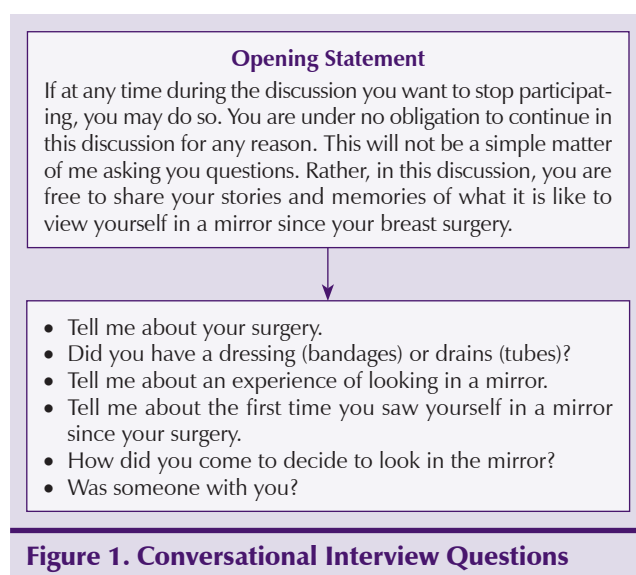
Data Collection

Participants completed the National Comprehensive Cancer Network's (NCCN) primary screening for distress algorithm tool, the **Distress Thermometer**. The Distress Thermometer is a visual analog rapid screening tool that has been validated in ambulatory settings. Individuals rate their perceived level of distress ranging from 0 (no distress) to 10 (extreme distress) on a picture of a thermometer (NCCN, 2012). All participants scored 4 or lower on the scale. A score of 5 or higher would have been indicative of too much distress to the participant (NCCN, 2012). Participants also completed a demographic form (see Table 1). Data were collected in tape-recorded conversational interviews lasting about 30 minutes (see Figure 1).

To ensure confidentiality of data, a pseudonym was assigned to each participant. All consents and paper data have been maintained in a locked cabinet, and all electronic data were sent via secure, password-protected e-mail. In addition, all data will be destroyed five years after the completion of the study.

Data Analysis

The tape-recorded interviews were transcribed verbatim by the PI. The texts then were analyzed in a naive reading, structural analysis, and phenomenologic interpretation. In addition, a metaphor was sought that may help to convey the experience. A metaphor helps to create a simple but all-encompassing verbal picture about an experience (Ricoeur, 1974). The naive reading was done to obtain a general understanding of the text, whereas the structural analysis was an explanation of the text. Using linguistic theory, the text was analyzed for actants (significant people), actions (key activities), and oppositional units (activities that had a theoretically polar opposite meaning). Through that process, the sense of the text was explained. The goal of the phenomenologic interpretation was to illuminate that which the text references regarding the experience of viewing oneself in the mirror after a mastectomy and to "conjoin a new discourse to the discourse of the text" (Ricoeur, 1981, p. 158). Each line of text was studied for phenomenologic themes. As new themes were uncovered, the PI returned to previous interview texts in search of those new themes. With each analysis of an interview, a new electronic document was created. Early interview texts had up to six analysis documents. After the fifth interview, a description of the experience



began to emerge, and data saturation was reached by the 10th interview. Two additional interviews were done to confirm that saturation of data had been reached.

Study Rigor

Lincoln and Guba's (1985) standards for criteria of qualitative research were used to enhance the study. Credibility, dependability, confirmability, and transferability were enhanced by the use of triangulation of analysis and a team of coresearchers skilled in caring for women with breast cancer. A reflexive audit trail was woven directly into each interview analysis by all researchers in the naive reading, and the PI continued that practice in the subsequent textual analyses. Emerging descriptions were shared with participants at the conclusion of each conversational interview. Formal validation meetings were held with two participants.

Findings

In the naive reading, the text was analyzed by all researchers. The PI did the remaining analysis of the texts, with input from all coresearchers. The results of the structural analysis helped to make sense of the data and described the experience of the women who participated in this study (see Figure 2). Three key actants were uncovered: my body, my thoughts, and other people in my world. Those actants were further broken down into oppositional units.

Structural Analysis

My body: When viewing the postoperative site initially without a mirror, three women talked about struggling to see their chest area. Judy would have preferred the nurse to use a mirror when she changed the dressing and instructed her on wound care.

If you're showing somebody something that's out of their eye range . . . just to take the mirror and let you just lay down, kind of like soak it in, your body.

All but one participant initially viewed her mastectomy site in a mirror in her own home. Many women were alone and some had a loved one with them for the initial difficult mirror experience. Eight women suggested they were with a loved one or friends initially or in subsequent encounters when viewing themselves in the mirror (see Table 2). Ellie was the only participant to view her mastectomy site initially with healthcare professionals. A full length mirror was used.

My doctor and the nurse . . . they said, "Are you ready to see yourself?" And my husband was with me. . . . I was happy for me that it was actually going to be in front of other people.

After the initial viewing of the mastectomy, all participants continued to view their postoperative sites in a mirror and, with time, viewing became somewhat easier. Participants also discussed viewing their face, hair, skin, and size in the mirror. Five participants indicated they viewed themselves in a mirror more frequently. Mary said, "When I went through my radiation, I was in the mirror constantly."

Women identified two key reasons for not viewing oneself in a mirror: (a) lack of or no recall of mirrors in hospitals, clinics, and physician offices; and (b) avoiding the mirror. Three women avoided a mirror for days after their surgeries because of fear as to what the mirror would reveal. Lisa tried to convey that the thoughts she had while she avoided the mirror were worse than viewing herself.

If I could, you know, I would have [looked] at myself in the mirror, like right away . . . just to be avoiding more expectations or your mind saying . . .

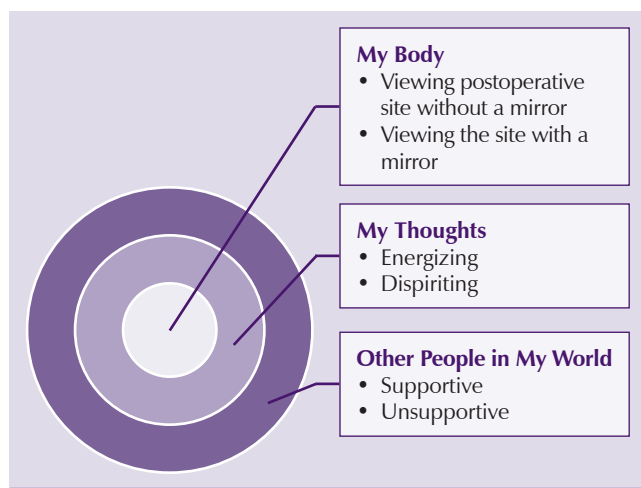


Figure 2. Structural Analysis of Women's Experiences Postmastectomy

like, how will it look like? . . . Seeing myself in the mirror is confronting it like, yeah, it is confronting, and I think if I could confront that sooner I can sooner start dealing with it.

My thoughts: Thoughts after a mastectomy may be classified as energizing or dispiriting. Thoughts such as putting one's life into perspective, having faith, and thinking of ways to help others are positive and help individuals to keep moving on in life. Eleven women talked about ways in which they put life into perspective. Battling cancer was one way for many. Sarah said,

Yeah, it's ugly looking and it always will be unless I have reconstruction surgery. But it really doesn't bother me, because . . . I was excited to get the cancer out. It was a tradeoff; it was worth every stitch.

All 12 participants indicated faith was essential to helping them view themselves in the mirror. Angie described the experience of all participants. "Somebody up there is giving me the strength. That's all I can say. It is not just me." Finding ways to help others was a third way in which eight participants expressed having an energizing attitude.

Women had dispiriting thoughts involving the mastectomy site. Eight participants expressed concern that loved ones may not accept the surgical site. Joanie asked, "You think, is this going to interfere with my sex life or is my husband going to accept me?" Nine women worried or wondered whether people would know they had a mastectomy, even with the use of a prosthesis, checking one's appearance in a mirror, or careful choice of clothing. Ericka said,

At first I thought, you know, everyone can tell. . . . I just feel like everybody can see it, even with the bra on and stuff. I still feel like everybody can see or they can tell you know something is off.

Other people in my world: Other people in the lives of women may be classified as supportive or unsupportive throughout the mastectomy journey. All participants had family or friends who were considered helpful. Jamie said,

My husband is wonderful. Ah, I can tell him everything I am feeling. . . . I remember saying to him, "Gosh, it's really hard to look in the mirror."

Mary said,

My husband helps me all the time now. I'll stand in the mirror and see if I'm crooked. I'll ask him if I'm straight and he'll tell me, "Yeah, you gotta straighten it, you know."

Many nurses and physicians were perceived as being compassionate and giving good care. Nine participants felt the ONN was the only medical team member who

Table 2. Selected Examples of Actants, Opposing Actions, and Supporting Statements

Actants, Opposing Actions, and Subthemes	Supporting Statements
Viewing My Body	
Viewing without a mirror for the first time	I could see the breast was gone but I couldn't see all this stuff back in under my arm.
Viewing incision in a mirror for first time at home alone	When I saw myself in the mirror, I [had] that feeling like I was mutilated. Okay. And, um, it is kind of like, how did this happen to me?
Viewing the incision in a mirror with another	One or two [girlfriends], they looked in the mirror with me. . . . They're in shock . . . but they try not to let it show on their face, but you know I can still see it. . . . You know they feel bad for me.
Viewing oneself more often	Oh definitely [I was looking in the mirror constantly] . . . maybe 15 times a day . . . because I was always constantly making sure, is it clean? I don't want to have another infection. I don't want another surgery. I don't, I don't want any of this stuff, so I was constantly making sure that it was . . . just clean.
Not Viewing My Body	
Lack of or no recall of mirrors in hospital, clinics, or physician office	I was only there that morning and then I left the next day and I got up and I used the rest room. . . . I don't remember seeing no mirror. I really don't.
Avoiding the mirror	I wouldn't look because I just didn't want to see anything. I wasn't encouraged to look, either.

really cared about them. Joanie said, "But I am talking about in the entire medical world, she's the only contact I had." Seven participants found support groups, written information, and Web site communication helpful.

Many friends and relatives simply could not help because of their own troubles, including terminal illness, advanced age, or work schedules. Some family or friends were perceived to be rude, squeamish, or not caring. Jane said some people could even be "hurtful."

The unplanned medical journey was frustrating for eight participants. Joanie called it the "domino effect." Insurance concerns were, at times, exasperating for some of the participants. Some physicians and nurses were perceived as being rude, lacked communication skills, or provided poor care. Ericka suggested the following.

I think you nurses should let women talk about [the mirror]. Not that "how you doing today" stuff 'cause we are just going to say, "Fine, thank you." . . . You know, you should say to women, "How you really doing, how you really feeling?" and then give folks a chance to say what's really on their minds.

Phenomenologic Interpretation

Viewing oneself in the mirror, even for a moment, contains layers of meaning. The role of the researcher is to tease those layers of meaning out from each other and create a novel discourse or description. Throughout this process, four key phenomenologic layers emerged: I am, I decide, I see, and I consent (see Figure 3).

I am: Each participant said in her own way, "I am me." One's way of being in all experiences, decisions, and actions, including viewing oneself in a mirror,

is the constant that allows individuals and others to recognize who they are. Each person approaches the mirror and finds meaning in the experience in a unique and individual way. Heredity, environment, and life experiences may help to create this unique way of being in the world. For example, Sarah said, "I'm a tough old bird." Sandy indicated she was Scandinavian: "We're just not an emotional bunch of people."

I decide: An individual decides to view oneself in the mirror based on personal motives. Curiosity as to what one looks like is a key reason for viewing oneself in the mirror after a mastectomy. A woman simply wants to look and see "what it looks like." Jamie said,

I didn't know if I wanted to look at it or not, but a natural curiosity overcomes you. . . . You have to take a breath and swallow and say, "This is going to be okay."

A second motive in deciding to view oneself in the mirror is the necessity of having to care for the mastectomy site and drains. Lisa had a very difficult time looking in the mirror initially.

I mean, sooner or later I needed to [look in a mirror]. . . . I had the drains so I needed to, to see where they were . . . and clean the area.

The third motive to view oneself in the mirror is to care for one's appearance. The mirror is needed to put on make-up, fix the hair or wig, and ensure one looks symmetrical. Angie said,

I don't care how bad or how ugly or how gray I'm looking. If I put my face on, I feel like a million

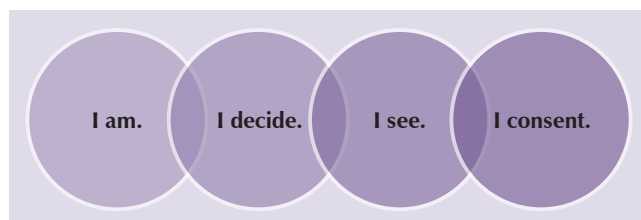


Figure 3. Phenomenologic Themes of Viewing Oneself in the Mirror Postmastectomy

dollars. . . . The mirror makes you think how you need to improve yourself, what to do with yourself.

Seeking and ensuring one's body appears symmetrical was important for all participants. Some women were having or considering reconstructive surgery. Others had or were going to get a prosthesis. Several participants talked about how they had to be careful in their choice of clothing. Mary suggested one has to be resourceful.

You become very creative after you have this surgery . . . putting my bra on and having to put my socks in [her bra while viewing herself in the mirror]. Make sure I am, you know . . . not lopsided or one's bigger than the other and stuff like that.

I see: One sees in the mirror in three ways: with the mind's eye, with the eyes, and by perceiving the meaning. An individual brings to the mirror a picture in her mind's eye as to what the mirror image may reflect. That mental image may be accompanied by apprehension, expectation, or hopefulness (see Table 3). Although the entire experience of viewing oneself in the mirror takes varying degrees of effort, seeing with the eyes is relatively effortless unless an individual has low vision. Helen had macular degeneration and she discovered she needed a magnified mirror to see herself.

Perceiving the meaning of what one sees in the mirror is a two-part construct of understanding and explanation. An individual initially understands what is reflected in the mirror and then explains to oneself the reason for what is seen in the mirror. Mary described how the mirror changes one's meaning of the mastectomy site.

If you just look down, you kind of see it, but you're not really putting two and two together . . . but when you look in the mirror, you see, like, your whole self. And it's just, boom, there it is . . . your whole self.

Each woman expressed a different meaning or understanding of what was seen in the mirror. All women in the current study perceived part of their bodies to be disfigured, fat, bald, or ugly in some way when viewing themselves in the mirror. That disfigurement was accompanied by many emotions and feelings: shock, surprise, unworthiness, disgust, frustration, anger, fear, hurt, sadness, relief, and happiness (see Table 4). Ericka

said, "Actually, honestly, sometimes I would feel like less of a woman."

All participants in the current study used terms such as *it* or *that* when talking about the mastectomy site. For example, Jane said, "You're seeing *that* every time you stand in front of the mirror. It was not a pretty site."

Those words may be evidence of distancing of body to self. Some women occasionally used words such as *my*, *I*, or *me* to refer to the mastectomy site. That language suggested appropriation of the mastectomy site to the self. Helen said, "I don't think that I want implants anymore and I am satisfied with the way I am." Angie was the only participant who referred to her mastectomy site using the word *my*: "My scar is not healed."

The participants explained their understanding of what they saw in the mirror. Each woman had her own perception or reasons as to why the mastectomy site looked as it did. That reason was medical in nature for most women, but was theological or societal for others.

I consent: Consenting to what one has seen in the mirror results in suffering, acquiescence, or thrusting forward into the future. Suffering was associated with grief, sadness, hurt, frustration, and sorrow. Angie said, "It hurts very deeply, very deeply." Jamie said, "I sat there in that tub and I cried like a baby. Just cried, and I prayed." One has no choice but to accept or acquiesce to seeing the mastectomy site in a mirror. Joanie explained, "I still do look in the mirror and wish I had more, you know, up there, but may have to learn to accept it, the way it is." Lisa said, "Somehow I kind of need to start loving that part of myself again. Okay. It's a mastectomy . . . that's the reason why I [look at] myself in the mirror."

When viewing themselves in the mirror, individuals may thrust forward into the future in their minds. For example, an individual may imagine what the scar will look like when it fades. Decisions are made as to whether or not to get reconstruction or a prosthesis. Ellie said,

It's not the end of my story. I'm still in the middle of it. It's not going to be what I am going to look like in

Table 3. Examples of Seeing With the Mind's Eye by Subtheme

Subtheme	Supporting Statements
Apprehension	The first time I looked in the mirror, I was afraid to look into the mirror, because I didn't know what it would be like to have a portion of your body removed.
Expectation	This scar is uglier than I thought it would be. I thought it would be a little bit prettier. A little nicer looking.
Hope	I think I look more . . . with the hope to think that things are going to change.

a year from now, but it is what it is. So I finally had my mind set of, you know, I've got to get over this. . . . I'm not going to look like this for the rest of my life.

Metaphor

In dwelling with the textual data, the metaphor *battle spot* was created. Sarah’s words spoke for many of the participants regarding winning the battle with cancer: “I was going to win no matter what.” However, the mastectomy scar was not always understood to be an honorable badge. Jane called it a “spot,” and Judy stated that it was “my secret.” The mastectomy site was, at times, unbearable to view in a mirror. All participants expressed that the spot needed to be hidden, reconstructed, or disguised.

Discussion

To the authors’ knowledge, this study is the first published description of the experience of viewing oneself in the mirror after a mastectomy. The structural analysis described the experience of women who have had a mastectomy as being focused on one’s body, one’s thoughts, and the influences of other people. The phenomenologic interpretation described the experience from the viewpoint of a woman viewing herself in a mirror.

The fact that participants could not recall seeing a mirror in the hospital corroborated Freysteinson and Cesario’s (2008) survey on the lack of mirrors in breast cancer hospital units. The study description of initially viewing the mastectomy site in a mirror as opposed to attempting to view the postoperative area by looking downward helps to substantiate breast cancer survivors’ feelings that a mirror is needed to view the postoperative area (Freysteinson, 2010).

Initially viewing the mastectomy site in a mirror alone, with a loved one, or with a healthcare professional brings a perspective of the mirror that has not been published previously. Support from family and loved ones and having a strong faith reinforce Ashing-Giwa et al.’s (2004) multicultural qualitative study of women with breast cancer. In the current study, women found the ONN to be helpful. In addition, Swanson and Koch (2010) found that patients with an ONN may have lower distress scores.

The phenomenologic interpretation is one description of the experience of viewing oneself in the mirror and is similar to a framework of this phenomenon for terminally ill women (Freysteinson, 1994): I decide, I see, I know, and I consent. The interpretation stresses that each woman creates her own meaning or understanding and explanation of what she sees in a mirror. Collie and Long (2005) suggested the meanings women give to breast cancer may be different than meanings ascribed by healthcare professionals. Feelings of disfigurement, deformity, and fear also were reported by Avis et al. (2004). In addition, the need to seek symmetry was alluded to

Table 4. Examples of Seeing the Meaning by Phenomenologic Construct

Construct and Subtheme	Supporting Statements
Understanding	
Anger or frustration	I went into the bathroom [and looked in the mirror], and go ahh! What is this, you know? And then I felt around it and I thought, can you believe they did this to me?
Deformed	I do feel deformed when I look in the mirror. . . . And I wonder, is this normal? And you keep thinking, is this normal?
Disgust	I looked like a burn victim. . . . [I was] looking in the mirror constantly. . . . It was gross, it was so disgusting. I couldn't hardly face myself or look at it because it was so disgusting.
Fear	Well, I am not as scared of [the mastectomy site] as I was.
Relief or happiness	But I was so ecstatic that [the mastectomy incision] was closed! See the attitude change? I'm like, look at this, it's stitched closed! So for me, I guess that's where my story is a little bit different because every time I got stitched up I was ecstatic, like it was ridiculous, like, look at it, it's closed! It's closed!
Sadness or hurt	When I looked, it looked bad, and I did cry some.
Shock or surprise	I was in shock. I started crying. Wondering why. . . . Why, why, why? . . . 'Cause at first it was, it was just unbelievable.
Unworthiness	Some people may even feel like I'm unworthy . . . because I don't have the beauty of both breasts.
Explanation	
Medical	I thought it might have been a little bit nicer looking, but then it's not plastic surgery, it was just surgery.
Societal	My hair is just a big problem for me [because of alopecia] . . . it's noticeable.
Theologic	It's like the devil's trying to get to you. . . . You know, that's the devil in there.

in research on reconstruction and body image (Baucom et al., 2005–2006; Cromptvoets, 2006; Montebanocci et al., 2007; Nano et al., 2005; Parker et al., 2007).

Limitations

This study was limited by the small sample size and setting. The 12 participants were women, many of whom were married and living in a city in the southwestern United States. Only three women were younger than 50 years, and eight of 12 were Caucasian. The setting was

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unique because all participants were from a nonacademic community-based hospital and received care from an ONN. Those factors do not allow for transferability to a larger population. In addition, reflecting on one's thoughts and feelings is the methodology used in phenomenologic research, yet those memories of past events may be influenced by time and other variables.

Implications for Nursing

The use of the mirror in nursing may be likened to an unexplored landscape. As nurses journey into that landscape, they should be aware that the mirror is a tool that may be used to view one's mastectomy site. The uniqueness of individuals and the need for a personal choice as to whether or not to use a mirror should be emphasized.

Nurses may choose to prepare patients for the impact of the mirror experience. Discussing the mirror experience with women preoperatively may allow patients to voice their preunderstandings of what they believe they may see in the mirror. Education about what the postoperative area will look like may help to alleviate unrealistic expectations, hopes, and fears. Gently encouraging women to discuss their thoughts of viewing themselves in the mirror postoperatively may allow for a reflective healing moment. Nurses may consider carrying a mirror in their pocket and offering the mirror when teaching postoperative incisional site and drain care. In the Netherlands, the nurse discusses the mirror with patients prior to mastectomy surgery. After surgery, the nurse offers a small, medium, and larger mirror for looking at the mastectomy site. The goal of the mirror intervention is that a woman may view her postoperative site at least one time in a mirror prior to discharge (Freysteinson, 2009a). Mirror talk may be of value.

The mirror talk, in my practice, usually came only when I saw a patient pre- and immediately postoperatively. . . . I offered to help them and to "take a look" with them, if they wished. Some took me up on that offer; others preferred to be alone or to be with their spouse/partner. Since women are discharged so early these days . . . the dressing change may occur in the surgeon's office a few days after discharge; in that case, it's the surgical nurse who may have the window of opportunity for the mirror talk (S. Moore, personal communication, May 6, 2011).

Home healthcare nurses also may have an opportunity to offer and discuss the mirror. Developing awareness of the language used by patients may help nurses as-

sess whether women experience distancing or appropriation of body parts (i.e., "my scar" versus "that scar"). Questions about the mirror and body image may need to be developed and incorporated into baseline psychosocial assessments and body image questionnaires. Nurses may use the mirror as a discussion topic for breast cancer support group meetings. A small mirror may be appropriate in tote bags or with other gifts given to women who will have mastectomy surgery. Nurse administrators in clinics and hospitals may choose to survey existing mirrors for appropriateness for use by bedbound, wheelchair-bound, and ambulatory patients.

Educators may consider including a mirror in patient and caregiver educational materials. Education on awareness of the experience of viewing oneself in the mirror and the use of the mirror is needed for nurses who work with patients who have had a mastectomy.

Research is needed on the appropriate use of the mirror with women. The effect of mirrors on patient satisfaction, patient-loved-one relationships, and acceptance of body image also may be of value. Of interest may be the effect of mirrors on spiritual and cultural care. Research is needed on ideal types of mirrors, mirror placement, and mirror lighting for this patient population.

Conclusions

This study brings a unique perspective regarding the experience of women who have had a mastectomy. In trying to peer through a woman's eyes into the reflection she may see in a mirror, researchers are brought closer to understanding her world. Usefulness of descriptive research (Parse, Coyne, & Smith, 1985) is concerned with the applicability of the description for nursing practice. Essentially, the reader determines whether the description may help to guide nursing practice in honoring an individual's choices and meanings regarding the mirror.

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1. Body image is an important part of our self-image, as well as our sexuality. How comfortable are you with talking about this with your patients?
2. Does your hospital, clinic, or other work setting have mirrors at the appropriate height so that women can see their torso when procedures such as dressing changes are being done? If not, how can you initiate practice change?
3. All but one of the women in this study first saw the surgical site at home, often alone. What are the risks and benefits to this? How could this have been improved for these patients?
4. How can we best prepare our patients for the changes that might occur to their self- and body image after surgery that alters their body in a visible way?
5. In what ways would your approach to talking about body image with a woman who has had a mastectomy differ from what you would say to a male patient who has had surgery, such as creation of a stoma?

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Author Sheds New Light on Topics Discussed in This Article



With a simple click of your computer mouse, listen as *Oncology Nursing Forum* Associate Editor Diane G. Cope, RN, PhD, ARNP-BC, AOCNP®, interviews Wyona M. Freysteinson, PhD, MN, about how nurses can facilitate the experience of viewing oneself in the mirror for women who have had a mastectomy.

Freysteinson is an assistant professor in the College of Nursing at Texas Woman’s University in Houston. Her body image research program has focused on the study of mirrors, resulting in several publications and local, national, and international presentations.

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