Published in final edited form as:
J Aging Stud. 2016 January ; 36: 17–25. doi:10.1016/j.jaging.2015.12.006.

The meaningfulness of time; Narratives of cancer among chronically ill older adults

Susan M. Hannum[a,*] and **Robert L. Rubinstein**[b]

[a]Cancer Epidemiology, Prevention, and Control Training Fellowship, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway, Rm. 263, Baltimore, MD 21205, United States

[b]Department of Sociology and Anthropology, University of Maryland, Baltimore County, 1000 Hilltop Circle, Baltimore, MD 21250, United States

Abstract

This study, using ethnographically-based interviews, sought to describe how chronically ill older adults experience a new cancer diagnosis and the effects of this on their interpretations of personal health, aging, and the future. Three semi-structured interviews were conducted with each of the fifteen informants. We asked questions that explored the individual's life history, chronic illness occurrence, and direct experiences with cancer. Interviews were structured to provide social and historical contexts to enhance our understanding of the informants' illness narratives. Interview transcripts were analyzed thematically to describe how individuals described the cancer experience, its meaning, and its consequences. One of the major findings of our study was the role of cancer in disrupting individual biography, an interruption that fragmented time into three distinct segments: the Recalled Past, the Existent Present, and the Imagined Future. We highlight three main themes around the experience of illness-related time: (a) disruption found in individual biographical accounts as a result of fragmented time dimensions; (b) altered projections of a continuous sense of self into the future; and (c) modified treatment decisions resulting from a perceived altered life course and the finitude of advancing age. We further introduce the concept of Anomalous Time as a permutation of time central to individual experiences of cancer. Implications for how older adults understood their cancer and individual reactions relevant to seeking care are discussed.

Keywords

Cancer; Chronic illness; Lived experience; Narrative inquiry; Older adults; Phenomenology

Introduction

Research on the separate domains of meaning in the cancer experience and on chronic illness in later life is not well established. What is specifically lacking is how co-occurring experiences of cancer and chronic illness interact with one another in later life. The current

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[*]Corresponding author. Tel.: +1 443 413 8341. shannum@jhsph.edu (S.M. Hannum).
rrubinst@umbc.edu (R.L. Rubinstein).

article looks at the effects of time, age, and meaning on reactions to a new cancer diagnosis that co-occurs with pre-existing chronic illness, an event that is common among older adults. The theoretical perspective adopted here is found in both symbolic interactionism (Berger & Luckmann, 1966; Blumer, 1969) and phenomenology (Gubrium & Holstein, 1999), particularly in how these approaches illuminate ideas about time, an element that has been found to be a critical aspect of meaning-making in illness. This article sheds light on notions of time through analysis of ethnographically-based interviews with fifteen older cancer patients. The theme of time, in relation to meaning and the larger illness experience, was closely examined to describe how time was implicit in meaning making and affected treatment-related decisions. A central question this article thus discusses is: What is the effect of a new cancer diagnosis in the later life notions of the future? This research seeks to better inform health care practitioners about how time becomes a meaningful component of the cancer experience in the diagnosis and treatment of cancer throughout later life. That is, how projections of and decisions for the future may be significantly influenced by one's current health conclusions.

Background

As of January 2014, there were approximately 14.5 million people living in the United States with a history of cancer, with an expected 1,658,370 new cancer cases in 2015 (American Cancer Society, 2015). Older adults represent a disproportionate number of these cases; 77% of all cancers are diagnosed in those aged 55 years or older (ACS, 2015). In addition, the number of new cases diagnosed in those 65+ is expected to increase by more than 40% over the next ten years (ACS, 2015).

Disease impact and the illness experience

Limitations from cancer can occur variously; risks of limitations and disabilities are associated with primary cancer site, stage of cancer at diagnosis, and the type and extent of treatment (Koroukian et al., 2007; Reeve et al., 2009; Satariano, 2006). Pertinent to older cancer patients, Lawton (1991) described perceived quality of life as defined through a metric — one derived from individual health status, functional capacity, and social behaviors (Given & Given, 2008; Patrick, Kinne, Engelberg, & Pearlman, 2000; Reeve et al., 2009; Stineman, Wechsler, Ross, & Maislin, 2003; Thomé, Dykes, Gunnars, & Hallberg, 2003; Wedding, Röhrig, Klippstein, Pientka, & Höffken, 2007). Aside from Lawton's paradigm, quality of life can also be negatively affected by social stigmatization felt by the chronically ill, who might isolate themselves or experience diminished social contact as a result of their illness (Choi & McDougall, 2007; Engberg et al., 2001; Holley, 2007). Older cancer patients might additionally experience profound suffering specifically related to the treatment, progression, and potential recurrence of their cancer, as well as generalized anxiety and uncertainty about the future (Conrad, Garrett, Cooksley, Dunne, & MacDonald, 2006; Morse & Johnson, 1991). The root of this suffering is often in personal beliefs that one's future is highly uncertain or that illness itself represents a future of pain and physical deterioration. In this regard, older cancer patients might revise their senses of both personal identity (who they are in the world) and agency (how they act in the world), mediating negative psychosocial effects of a cancer diagnosis and resulting in a renewed sense of self and personal identity (Kaufman, 1988; Zebrack, 2000).

The illness experience

Lee (2008), following many others, described a general sense of “global meaning” in lived experience, noting that “global meaning” refers to a personalized life schema that provides order and purpose to one's life and which results from a set of personal beliefs and assumptions about the self and the self in the world. She found that an orientation to “global meaning” is generally what enables each person to function in their normally occurring world, with its known contexts and rewards. This system remains intact and unquestioned until moments of radical change, such as the diagnosis of a serious illness like cancer. This break marks the beginning of new meaning-making associated with the cancer experience and ends only when the person is able to incorporate the changes, limitations, and identities created by serious illness into a new life schema, thus establishing and sustaining a new system of time, order, and purpose (Lee, 2008). The structure of time as well as temporal bracketing, in the relationship of human experience and time can be very complex and often cloudy (Brockmeier, 2000; Crossley, 2000).

Illness itself appears to bear great impact on individual conceptualizations of and responses to the experiences of symptoms, treatment, and debility (Morse & Johnson, 1991). Research from an experiential perspective presents chronic illness as a threat not only to the body but also to an individual's sense of personhood (Lawton, 2003; Lutpon, 2012; Morse & Johnson, 1991; Pierret, 2003). A review of research in this area throughout the previous 25 years (Lawton, 2003) identified three key findings, each implicated by time:

1- ‘Loss of self’ associated with chronic illness and as an element of the life course (Charmaz, 1983),

2- ‘Biographical disruption’ through temporal dislocation caused by chronic illness (Becker, 1997; Bury, 1982), and

3- Narrative reconstruction as a process over time to account for and mitigate biographical disruption and leading to a sense of recovery or renewed identity (Williams, 1984).

The theoretical framework for the current study thus involved two levels: one that was socially oriented and one that was personally oriented. Symbolic interactionism, as a socially oriented concept, enables an understanding of how people see themselves, the world around them, and the two in relationship (Berger & Luckmann, 1966; Blumer, 1969). It further accounts for the experience of social roles and identities, which the individual embodies. The second level involved both constructivism and phenomenology, which framed our understanding of the personal interpretations of and meanings attributed to a cancer diagnosis (Gubrium & Holstein, 1999). These critical perspectives guided analyses relevant to the subjective experience of time, in the contexts of cancer, comorbidities, and aging, for this analysis.

Materials and methods

In this research, we utilized in-depth ethnographically-based interviews to identify and describe (1) patterns of meaning throughout the life course and (2) how new meaning was attached to illness experiences among older, chronically ill cancer patients (Black & Rubinstein, 2004; Rubinstein, 1995; Rubinstein, 2002; Maly, 2000; Spradley, 1979). On receiving approval from the Institutional Review Board of all sites, a total of fifteen men (*n* = 2) and women (*n* = 13), aged 65 years and older, were recruited to and enrolled in the study. The sample size of fifteen people is appropriate for a qualitative research project through which a major goal is to establish information specific to a particular phenomenon (Eisenhandler, 2008; Kvåle, 2007). Our sampling was based on a specific set of inclusion criteria: adults aged 65 or older; at least one pre-existing chronic condition self-reported as having a negative impact on a participant's daily life; Stage I–III solid tumor cancer diagnosis; and cancer diagnosis within the past year (excluding those with a previous cancer diagnosis within the past five years). We also assessed individuals for a willingness to participate, English speaking ability, local residence, and the ability to consent (as measured via the Mini-Mental State Exam or Verbal Fluency cognitive test). We did not further restrict the sample, to allow for maximum variation.

The final sample was represented by an average age of 78.47 years; 87% females; 80% White and 20% Black; and represented by the following cancer types: breast = 5; colon = 4; one each: brain, endometrial, esophageal, GIST, large B cell lymphoma, pancreatic, & stomach and stages: Stage I = 3, Stage II = 4, Stage III = 8, and one “unknown.” Informants had an average of 2.6 chronic illnesses. For the current analysis, we use case examples from five of the informants, which were chosen for the depth and clarity of their interview responses around the relationship of cancer and time. It is notable, however, that the major themes in this area were identified in all informants’ interviews.

Each informant was interviewed three times (1 to 2 h per session, held weekly for three weeks) using a semi-structured interview protocol (Britton, 2006; Rubin & Rubin, 2005). Interview questions were iterative, using an opening query or “grand tour” question designed to prompt intensive conversation and discussion of emergent topics (Britton, 2006; Holstein & Gubrium, 1995; Rubin & Rubin, 2005). The first interview collected a narrative history of each informant's life to date and served to establish an interactive context for the remainder of the sessions (Black & Rubinstein, 2004; Rubinstein, 1995; Settersten, 1999). In the second interview, informants were asked to talk about their health throughout their lives and through which we were able to construct individual health perceptions in the past and through the present (Greenstreet, 2006; Hollway & Jefferson, 2000; Lazarus, 1993; Lazarus & Folkman, 1984). Finally, in the third interview each informant was asked to “tell the story of your cancer diagnosis.”

After consent was obtained, interviews were audio recorded for later transcription and coding. Initially, a codebook was developed and codes were refined throughout the study to reflect areas of emergent importance (Berg, 2007; Richards & Morse, 2007). Twenty percent of the interviews were team-coded to ensure trustworthiness (Saldaña, 2012; Miles & Huberman, 1994). The use of codes in this data aided the development of overarching themes, such as meanings associated with time and its nuances (Miles & Huberman, 1994). Experiences, events, relationships, and meanings discussed by the informants were finally organized into themes, placing narrative data into subjectively meaningful categories (Maxwell, 2009; Miles & Huberman, 1994; Pope, Ziebland, & Mays, 2006; Rubin & Rubin, 2005). Analyses were aided by our interpretations of the interviews (as cases and as sets), so that the informants' meanings and lived experiences could be described, explained, understood, and justified on the basis of empiric data (Charmaz, 2006; Yin, 2014). Although time was an area of substantive interest, its examination was structured by the informants' concerns and definitions and its emergence as a major theoretical element was dictated by the informants' beliefs and concerns (Black & Rubinstein, 2004; Mishler, 1986).

Results

As noted, the experience of chronic illness and its effects on time were a major area of focus in this research. Issues of time occurred in many manifestations and, for virtually every informant, could be separated from neither the experiences of illness nor of age. Consequently, time and age existed for the informants in tandem and were thus implicit in one another, marking periods of time both surrounding and intrinsic to experiences of illness. *Illness Time* is used here to define the time from the awareness of either chronic or acute illness onset to the resolution of the illness period (i.e., formal end of treatment, declaration from doctor that the cancer had been successfully treated, or some other marker as deemed by the patient) (Charmaz, 1991). Illness Time was described and discussed by nearly every informant in his or her interviews, both directly and indirectly. This more active period of illness emerged as a manifestation of *Individual Time*, which we defined as time engaged in the course of daily living. Objectively, time is both linear in nature but operates in many dimensions simultaneously; it is both an internally and externally felt dimension (e.g., chronological versus subjective time). In view of the meaning of illness experiences, this research highlighted three main themes relevant to the experience of time as resulting from a new cancer diagnosis among the aged: (a) disruption found in individual biographical accounts as a result of fragmented time dimensions; (b) altered projections of a continuous sense of self into the future; and (c) modified treatment decisions resulting from a perceived altered life course and the finitude of advancing age.

Biographical disruption and fragmented time

For the individuals in this research, one critical element of time that emerged consistently in response to illness was the way in which time had become fractured and fragmented. This was necessitated by cancer's emotional and physical burdens, coupled with the uncertainty caused by the individual experience of illness. Restructuring time into smaller, more troubled pieces, this fragmentation was shaped by many dimensions: biographical time, routine time, treatment time, doctor days, chronological time, Illness Time, recovery time, etc. Where illness has fragmented the temporal flow of the life course, time itself cannot be divorced from the disruption that occurs to biography, thus severing the bridge between past and present.

Such a period of time seems to carry a symbolic load that differentiates the period, setting it aside from that which comes before and after it. Thus, time before illness is referred to here as the *Recalled Past* (Past Time); time marked by acute and penetrating illness and treatment is referred to as the *Perceived Present* (Illness Time); and the future as representing what was yet to come is referred to as the *Imagined Future* (Future Time). In this manner, time becomes an abstraction for individuals with cancer, whereby changes between periods are marked by uncertainty; this may be considered as *Anomalous Time*. These components of subjectively-felt time also map onto similar periods in which the informants are treating pre-existing chronic illnesses, either through daily pharmacy, doctors' visits, additional schedules, symptom monitoring, or frequent phone calls.

For many, Illness Time was seen as a necessary manifestation of the cancer experience and, with a few notable exceptions, pre-existing comorbidities did not bend, obscure, or re-define time in nearly as dramatic a manner as cancer. And though aspects of time seemed deeply embedded in overall illness experiences, temporality appeared distinctly defined by and changed as a result. Such a phenomenon as the fragmentation of time by cancer illness was discussed most pointedly in interviews with Jane Arnold (all names and locations have been replaced with pseudonyms).

Mrs. Jane Arnold was an 80-year-old White woman who had been diagnosed with Stage III endometrial cancer. Jane began early in the interviews describing the story of her cancer diagnosis, which had only occurred three months prior to our meeting. In the context of her story, there was evidence of how Illness Time, which had come to construct her Perceived Present, was singularly important to her individual narrative. Jane appeared to be disappointed by both the course of recovery, which was taking longer than she had expected, and the possibility that perhaps something additional was wrong that her doctors had not disclosed:

> Well, the reason I really went to the doctor was because I was at a restaurant having breakfast with my grandchildren and I felt this gush and I went to the bathroom and it was blood coming out of my vagina, really coming out of it. And I thought, ‘Well, this isn't right, not at my age, I shouldn't have this.’ ... So that's what I did, I went downtown and, uh, [the doctor] said, uh, she ‘Sees some cancer cells in one of [my] lymph nodes and that [I] should have a hysterectomy.’ ... I thought once she did the hysterectomy everything would be fine. ... I would go back to what [my husband and I] were doing [before I was sick] ... that would be the end of it. So I was a little surprised about that.

It was clear that Jane had hoped for a quick resolution to the cancer, telling the doctor to “do what you have to do.” But this quick resolution did not occur, lengthening the experience of illness, and thus the trauma of the present.

Common among the informants, a subtheme woven throughout Jane's narratives was the issue of age, which could not be clearly separated from the experience of time. Jane could not accept nor rectify having cancer in an area of her body that had so long divorced from her notions of self (in terms of reproductive identity). For instance, when her sisters needed to have hysterectomies in their menopausal years as a result of endometrial cancer, Jane had expected the same. Jane felt that once she had passed her reproductive years without endometrial cancer, that she had been given a pass on the cancer that had afflicted her sisters. She would thus question the timing of cancer in her life and time thus emerged as deeply interwoven throughout Jane's narratives:

> I thought ‘Well, how can this be, I'm 80 years old, how can I have cancer at 80 years old, how can I have a hysterectomy at 80, why didn't it happen when I was 50 or whatever.’ I have two sisters and they had a hysterectomy around that age and ... [I thought] I would be next. But it never happened.

As we discussed Jane's daily activities, she highlighted time, as it was before her cancer and compared it with the present. The way in which Jane described the changes in her life (“... we're doing much less than what we normally did ... because I'm tired and I really don't feel 100%”) was displaced from how she imagined this period of life would be. Indeed, her efforts to minimize this disruption by seeking continuity in life were thwarted. In speaking more with Jane, it became evident that she was having a great deal of trouble rectifying her cancer with pre-existing plans and ideas for the Imagined Future.

It was clear in many of the interviews that illness, particularly cancer, destroyed the temporal order people either work hard to maintain in their lives or that is naturally held in place by daily, unquestioned routines. For many, Illness Time most often was precipitated by an acute event, though it might also have followed months of more modest symptoms. Both are possible temporal flows that are disrupted by illness. Individuals thus “face the destruction of life itself, the destruction of the habituated, embodied self, as well as uncertainty about whether they have time left to create themselves anew” (Becker, 1997, p. 46). Older adults, in particular, might already feel that they face a temporal wall, and thus the acknowledgement of one's finitude precludes an enduring sense of Future Time.

The relationship between age, time, and illness becomes particularly complex as it involves multiple interactive and moving components. In fact, one of the hallmark features of this research is the way themes of time, meaning, and personhood are clearly layered on one another, framing their complex interrelatedness. This is exemplified by the ways in which biographical disruption, as a discrete event, cannot be separated conceptually from the tasks of maintaining a coherent self, which is a distinct entity relating to both meaning and personhood. One case, in particular, exemplified this and is presented here.

Mrs. Mary Burns was a 71-year-old African American woman who had been recently diagnosed with colon cancer and had a history of diabetes. A widow, she lived with two of her three children. Throughout the interviews, she would paint a visceral picture of how her body alerted her to the cancer. In this way, the cancer was at once an acute onset illness and a chronic illness, unfolding in unison. Undertaking to reconcile this complexity proved difficult for Mary as she described a poignant event in her cancer story:

> Um, I didn't have no warning. I, when I got sick I started hemorrhaging here [at home] ... and I heard, it was like a roar in my stomach, roooaarrr, somebody was in there digging out and I thought I had diarrhea, I went to the bathroom and I got up and looked back, the toilet was full of blood. ... So I walked down the hall, the hallways upstairs and my granddaughter was visiting me and she kept saying

> ‘Nana, what's wrong?’ and I'm sitting there and then by the time I got to my bedroom, was right over here, walked back down the hallway to the bathroom again, I said ‘Oh, no, not this.’ I really didn't know what it was because coming up toward this I thought it was my hemorrhoid, it was hard for me to go to the bathroom and I keep just saying my hemorrhoid is acting up but it wasn't a hemorrhoid, it was the tumor blocking ....

After Mary's gripping description about the acute onset of her cancer symptoms and the short time to diagnosis, she began a discussion about the effects of chemo and described having been thrust into the world of cancer and illness. Mary related episodes when she would awaken in the night and pace in the house to ease her feelings of sadness following her initial surgery:

> When I first came out the hospital, I was in bad shape. I had this crying habit. I would get up with my walker, I would walk from the front door all the way to the back door crying and [my son] would be right there and he didn't ... say a word, he just let me walk and cry. Then the next morning, I would ask him, I said, ‘Matt, did you see me walking and crying?’ He said, ‘Yeah, I heard you but I just let you walk it out.’ ... It just was a bad feeling would get me, like a nervous feeling would grab me and then I had to walk it off and cry it out.

Life for Mary had been fragmented, defined by and constructed around cancer, and she desperately sought the normalcy that her Recalled Past represented. Mary finished our long talk about her cancer treatment saying: “This was the worst time of my life, I can't wait until August [when the chemo is finished].” Her ideas for the Future Time, her Imagined Future, were ones free of cancer and defined by ability, not a lack of it. As in the case of Mary, it became difficult with some of the informants to get a sense of the precise source of the disruption they were facing. Was it cancer, their comorbid chronic condition(s), their age, or was it the convergence of just two or more?

The Imagined Future and the continuity of self

Where illness represents a break in life's continuity, it manifests as a disruption to normalcy and personal identity thus becomes discontinuous and disconnected from previously understood or constructed notions of self. Nearly every individual in this research discussed a deep desire to either maintain or re-establish a stable sense of self and to avoid further temporal disruption, specifically following the end of Illness Time. Further, memory of the Recalled Past was intrinsic how the informants engendered a sense of who they were in Past Time and who they wished to be in Future Time. This appeared regardless of the extent of difficulties throughout the present. In short, the notion of a reconstructed self implicates memory as a key component of personal identity. For many informants in this research, personal values and ethos were greatly shaped by the past, fundamentally influencing responses to what would ultimately become staged assaults to the self from old age, chronic illness, and then cancer. One informant described such discontinuity and its role in constructing Future Time.

Margaret Foster was a 75-year-old African-American woman. Although Margaret had recently been diagnosed with Stage I breast cancer, she was a primary caregiver to her husband of 50 years who had suffered a major stroke and was partially paralyzed. Margaret related at great length many stories about her personal and familial history. Much of this pertained to her involvement with the Civil Rights Movement and a close relationship with Rosa Parks. This had greatly shaped who she had become as a person, her sense of self, and her ideas about the world: “... I will never take any wrong doings. The only time, uh, in high school I had ever been in trouble was when somebody had done, been unfair to somebody else or to me. And I stood up.” Having such a meaningful history, it was as though Margaret was primed with a strong sense of courage with which to face the hardships of her life. Thus, her recollection of the Recalled Past, times when she “stood up”, seemed to summon the strength that imbued her in the present.

In our talks, Margaret detailed a traumatic health episode a number of years prior that would first alert her to more serious health problems. She detailed having been on a school trip during her younger years as a schoolteacher. Alone in her hotel room, waiting to meet the school bus to return home, she never arrived. When friends arrived to her room, they found her in convulsions and she was rushed to the local hospital, where she continued to have a series of Grand Mal seizures in the critical care unit. At this point, Margaret slipped into a coma, but has a clear memory of the 23rd Psalm repeating in her head like a record: “Though you walk through the valley of death, I am with you.” The Psalm became meaningful to her throughout the years, serving as a point of encouragement through Margaret's most difficult and darkest times. The Psalm itself educed memories of Margaret's Recalled Past and her ability to withstand and recover from previous sufferings in life. It was as though the quote itself was temporally intrinsic to enabling Margaret to endure what she understood as temporary periods of suffering.

As the interviews with Margaret ended, we talked about the meaning cancer had for her. She talked about dealing with the existential question of “why me?” that cancer patients sometimes ask, entering into a conversation with oneself and one's higher power. At the basis of this was that “we're all subjected to everything and we have to be prepared and ready ... [that's] how I dealt with the ‘why me?’” Margaret appeared to seek her past to guide her, including her memories of times of strength. Our conversations with Margaret, and others, implicated the Recalled Past as preparing us to endure the Perceived Present and plan for the development of an Imagined Future. A further example of disruption time and plans for the future is the case of Edna.

Mrs. Edna Barnes was an 85-year-old, African-American woman who lived on the outskirts of the city in a single-family home with her two sons and one daughter-in-law. She had Stage II breast cancer. Having been blind for approximately five years at the time of the interviews from advanced glaucoma, it was clear that Edna was highly reliant on her son and not fully accustomed to the lack of vision. The highlight of the first interview was that Edna stated clearly that she was not letting the breast cancer diagnosis get the best of her. She felt that she had to deal with things and move on, highlighting a sense of resiliency and a desire for continuity; she was clearly oriented in her Perceived Present and greatly desired to plan for her Imagined Future. With a history of cervical cancer in her younger years, Edna had perhaps been primed to handle the current diagnosis. It was at the third interview that she shared with us that her doctors recommended both chemotherapy and radiation, but that she had declined both after considering both potential outcomes and quality of life.

Edna's Imagined Future did not include what she believed could be suffering and debility. She instead hoped she would live to be “99 or 100 years old” and that she would feel as good then as she did now. Desiring continuity, Edna was avoiding any future disruption. Edna's Imagined Future was very much hinged on ideas of her Recalled Past and she seemed to deeply hope to one day regain her eyesight, breaking the lengthy cycle of disruption in which she currently found herself. It was unclear if this was in fact a possibility, given the advanced nature of her glaucoma, yet it was clearly something Edna hoped for very deeply. When asked about her breast cancer and having the tumor removed Edna was direct:

> And the doctor removed the lump in the breast and I haven't had any problems with it since they removed it but I don't, I just don't go for the chemotherapy and that, I said ‘At 85 I don't need it, I don't want it and if I go I'm just gone ... I'm not trying to die but I'm not going to be uncomfortable living either.’

We went on, moments later, to continue our discussion about Edna's future and what she imagined it might be like:

> Uh-huh, I'm pushing for at least 90 [years old] so I just hope to, to feel as good as I do now and don't get anything that's going to give me some misery because I don't want to be a burden, I don't want to be, you know, if, if something happens and I really start feeling bad I'm going to start saying a lot of prayers to be taken because I don't want to hang around. ...

Again, aspects of time and age filled the discussion. Edna portrayed an awareness of the illness experience as a function of both time and age and how this might affect her future. Certainly, Edna – and other informants in the study – had a sense that a life further disrupted by illness, specifically at an advanced age, was not worthwhile living.

Finitude in relationship to treatment decisions

The third major theme surrounded conceptualizations of finitude (or one's sense that time left is finite and that they are themselves finite and will ultimately cease to exist) and appeared to be related to the severity of the cancer diagnosis. Often, age and illness were comingled in such a way that their combination was essential in understanding the role of chronological time as directed by the illness experience, and as associated with experiences and meanings of aging, the aged body, and notions of the future (Baars, 2010a, 2010b; Heidegger, 1962). Analyses demonstrated how the comingling of differing aspects of time might affect treatment, altering thinking and decisions regarding treatment and, as a result, its associated outcomes. There was some notion among the informants that, because of advanced age and the possibility of “impending death,” treatment was neither a viable option nor a worthwhile pursuit. More clearly, because of the age range of this group, death was not a distant abstraction, but a distinctly close possibility with personal relevance.

Such an awareness of death translated into redefinitions of how the informants wanted to construct their Imagined Futures, which often did not include reliving current suffering and treatments for cancer and illness. Notably, suffering and the ability to withstand it in the future appeared to form the basis of fears of recurrence. Informants in this study thus sought to fill what might be their final years with a continuous sense of self that they sought from their healthy, Recalled Past. And although the Recalled Past might have included any number of less concerning comorbidities, informants appeared to have lived in relative peace prior to their cancer diagnosis. The case of Mary Burns, discussed above, is again particularly relevant here, as Mary had very clear ideas about the course of her cancer treatment, ideas regarding the meaning of age, and expectations for both the immediate future of Illness Time and the delayed Imagined Future:

> I've lived 71 years. Now if I was 50, it will have a great impact on me, but [at] 71 I've had a full lifespan. I do want to live to get 101 but that may not happen with that. I'm very, that really frighten me when they told me I had cancer. I said, ‘71, how am I going to get over this thing?’ And then when I went and talked to, the doctor interviewed me and my son, she said ‘I have patients 85 and they're doing fine,’ so that moved me to fight harder.

The role of age was deeply interwoven in how individuals processed not only their ability to withstand various treatments, but also their perceptions of time as affected by experience. Future Time must necessarily incorporate notions of the present and the past in order for individuals to make decisions about the trajectories for their future. That is, people do not make choices without some guidance, which typically is provided by prior personal experiences. If personal memories, which are largely based in time, are negative, then individuals are not likely to repeat the same choices, especially under a specific sense of finitude and impending death. The older cancer patient, then, represents a unique treatment population for future care needs and treatment decisions. Like others in the sample, Mary Burns had fears about the possible future recurrence of her cancer, fearing her aged body's ability to withstand treatment:

> I, if it, if, if cancer flare up again, I would have to think twice about taking the chemo and stuff, I would just let it go on its own really. Because I think age has something to do with the treatment, too, not something to do with it if — I feel like if you're younger, because I look at the way my son and my daughter took theirs, it didn't affect them the way it affect me. They didn't stop going.

Mary's fears of the future, coupled with her fears of death, were deeply ingrained in her thoughts of and intentions for future care. And though Mary had clearly described her fears of the future, none were as salient regarding as the case of Ruth Martin.

Ruth Martin was an 83-year-old European-American woman who lived alone in a large, retirement community. She was deaf in one ear, in addition to having a variety of other chronic illnesses. When we met, she had been recently diagnosed with Stage III pancreatic cancer and felt that she probably did not have long to live. Ruth had faith in her Higher Power, Jesus, and had given up imagining the future to what she believed was already decided for her. When we met it seemed that she knew very deeply that she would not be alive much longer; she had accepted that reality. Ruth poignantly described feeling closer to death as “just a feeling that she had,” yet it approximated something like a premonition:

> Yeah. In the last couple of weeks I feel closer to death. ... It's just a feeling. ... I mean, you know, I hurt, I have pains in my chest. It hurts to breathe, um, I know I have a heart condition, I know I have a blockage in the bottom of my heart. I've had two infarctions ... But I live life to the fullest that I can.

Approximately six months after her interviews, Ruth passed away. Her awareness of dying and the meaning of it throughout her experience of Illness Time were profound. For those touched by serious illness, it seems that some intrinsic aspect of the illness experience projects into Future Time and specifically shapes one's own sense of finitude. That is, the meaning of illness appears to shape how one thinks and believes about their Imagined Future, in questioning their continued existence and the possibility of the future itself.

Conclusions

A central question this article addresses is: What is the effect of a new cancer diagnosis in later life notions of the future? The experience of time was a major theme of this research that emerged relative to illness and age, and occurred in a variety of manifestations. It is notable that time could neither be separated from the experience of illness nor from the experience of age, which existed concurrently and were implicit in one another. This confounding of age and time was especially the case in relation to cancer diagnoses, but less so in connection to other comorbidities. In fact, several informants discussed options for their cancer treatment at the time of the interviews and in the future both in relation to age and their projections of the body's ability to “withstand treatment.” In this area, we believe that our research will better inform health care practitioners about how age and time become meaningful components of decisions about cancer treatment in later life. In short, do individual patient perceptions about future time impact treatment-related decisions and how?

Intrinsic to the experience of illness, individuals appear to push away and “other” disease, a foreigner to one's identity and thus a source of disruption. As a result of this othering, individuals attempt to maintain a stable identity and a continuous sense of self now and into the future. What is distinct about cancer is its meaning load. The meaning of cancer itself appears to differentiate it from other chronic illnesses that may have existed prior to the cancer diagnosis. For many of the informants, chronic illnesses held prior to the cancer diagnosis had been folded into the individual life and, in many ways, normalized as an expectation of the aged self. Cancer, through dint of this cohort's upbringing, was instead conceptualized as a “death sentence” that made it at once both an acute and chronic condition. Thus, the “unseenness” of cancer left many of our informants questioning the current status of their health and course of the future and time itself.

One critical characteristic of time that consistently emerged from the narratives was the fragmentation that resulted from the corrosive demands of illness. Though periods of time are undoubtedly linked to one another, the all-encompassing nature and emotional power of the cancer experience appeared easier to rectify with notions of identity and self when placed within a fragmented context of the illness experience. This reconciliation occurred as the cancer diagnosis changed significantly the way the informants thought about themselves and their lives. More precisely, time became fragmented into smaller pieces that were experientially more manageable for the transitions of self throughout and beyond illness: the Recalled Past (Past Time), the Perceived Present (Illness Time), and the Imagined Future (Future Time). Acute experiences of illness were quarantined in the present and how people thus contended with disruptions to individual biography emerged as an important finding.

To be sure, the Perceived Present, or Illness Time, might be defined by a more literal and personal experiences of cancer. That is, the main activity of the sick person becomes the integration of cancer into the folds of the individual life context, one's overall health maintenance, and long-term cancer recovery (Whittemore & Dixon, 2008). Hence, survival of disease and the weight of the Perceived Present becomes an object of focus for each person, which arises out of necessity to meet the demands of disease treatment and management. From these time demands, surviving present Illness Time took on an immense weight for our informants, hinged on hopes of recovery. As such, Past and Future Time, positioned in the periphery, receded as each individual attempted to deal with illness management and various identity tasks central to present experiences of illness. Arthur Frank (1995) talked about such a relationship of illness in dislocating the relation of the whole that comprises Past Time, Present Time, and Future Time. He suggested that “the present is not what the past was supposed to lead to, and whatever future will follow this present is contingent [on what happens now]” (p. 60). Thus, as the acute onset of chronic illness begins to fade over time, so then does Illness Time fade into a less acutely defined period. This approaching of the end of Illness Time may thus usher in a period of Anomalous Time, during which the two sets of time overlap. For the informants in this study, Anomalous Time persisted throughout the last bits of follow-up care during which the patient was not actively being treated, but was not yet out of the constant purview of his or her doctors.

Though these conclusions emerged from our data, it is clear that the fragmenting of time is not an isolated phenomenon relevant only to cancer. One of the clearest discussions of this phenomenon is found in the seminal work of Kathy Charmaz's (1991) *Good Days, Bad Days*. Charmaz discussed how, within the experience of illness, time does in fact become fragmented by the ill person; notable dates (e.g., diagnoses, the end of treatment, anniversaries, and similar occasions) are used as markers for the beginning or end of specific periods of time. In her research, the end of Illness Time (such as when treatment is finished) might also mark the beginning of one's Imagined Future (which hence becomes the new Present Time). Charmaz stressed that chronically ill men and women divided their lives into periods of illness versus non-illness, which would include flare-ups and remissions. Simply, a person could experience repeated episodes of Illness Time whereby life could become fragmented any number of times as a consequence, marking Future Time as uncertain. In a sense, Charmaz's notion of non-defined time permeates the borders of Illness Time, much like what we have defined as Anomalous Time. Essentially, Anomalous Time has been used throughout this article to describe time when the informants have gone undiagnosed and marked neither as ‘sick’ nor as ‘well.’ Anomalous Time was a period without any strong temporal markers and through which the informants felt unguided in their illness experience.

From the present study, it is clear that dimensions of time are central to individual experiences of illness. Time does in fact become fragmented as a result of the chronic illness experience, specifically that of cancer. As a result of this fragmentation, the ways in which people sustain a sense of self and personal identity to see them through both Anomalous and Illness Times may be likened to “survival mode.” That is, holding on permits individuals to see themselves through what some informants likened to a tragedy and what others simply wanted to wish away. Thus, through the destruction of the natural progressive ordering of time, a sense of uncertainty seems to define periods of chronic illness — making the future highly uncertain and ill-defined. We suggest that cancer intentionality is based in part on efforts to sustain the self throughout other such periods of Anomalous Time. The findings highlighted in this article present an opportunity for future research that includes an investigation of the ill-defined period of Anomalous Time. That is, what marks this time as experientially different and how do people sustain a stable sense of self through such periods? Perhaps most relevantly, we must seek to understand how personal decisions related to cancer treatment and health behaviors are directly affected by such uncertainty. In closing, we believe our research lends evidence for future contributions in the field of psychosocial cancer research that more precisely explore issues of time and aging as co-occurring phenomenon that include both the individual and cumulative effects of myriad psychosocial factors.

Acknowledgments

We thank the Agency for Healthcare Research and Quality for their support of this research (R36 HS020177-01).Wewould like to acknowledge the contributions of Dr. Ilene Browner and her staff at the Johns Hopkins Center for Geriatric Oncology, as well as Dr. Kathy Helzlsouer and her staff at Mercy Medical Center and the Cancer Prevention and Research Center. Susan M. Hannum, Ph.D. additionally thanks the Johns Hopkins Bloomberg School of Public Health and, specifically, NCI for their support provided through the Cancer Epidemiology, Prevention, and Control Postdoctoral Fellowship (T32 CA009314).

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