The Impact of Narrative Nursing on Body Image, Disability Acceptance, and Psychological Hope Level in Young and Middle-aged Breast Cancer Patients After Surgery

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Abstract: *Objective:* To investigate the effects of narrative nursing on body image, disability acceptance and psychological hope level of young and middle-aged breast cancer patients after radical surgery. *Methods:* A non-randomized quasi-experimental study was used to divide 80 patients in the Department of Breast Surgery of a tertiary cancer hospital in Yunnan Province from October 2023 to September 2024 as the study subjects and the study subjects were divided into the intervention group and control group with 40 cases in each group. The intervention was performed within 1 month after surgery, and a total of 5 interventions were performed. The two groups of patients were evaluated by the breast cancer patients' body image self-rating questionnaire, the revised version of the Disability Acceptance Scale, and the Herth Hope Assessment Scale. *Results:* There were no significant differences in BISQ-BC, ADS-R, and HHI between the intervention group and the control group before intervention ($P > 0.05$). After the intervention, the BISQ-BC score of the intervention group was lower than that of the control group, and the ADS-R score and HHI score were higher than those of the control group, and the difference was statistically significant ($P < 0.05$). *Conclusion:* Narrative nursing can effectively improve the physical image level of young and middle-aged breast cancer patients, improve the disability acceptance and psychological hope level of young and middle-aged breast cancer patients, and help them vent their negative emotions, gain confidence in life, and improve their quality of life.

Keywords: Narrative nursing; Breast cancer; Radical surgery; Body image; Disability acceptance

1. Introduction

Breast cancer is the most common malignant tumor among women worldwide, with a peak incidence age of 45 to 54 years in China, and a relatively high proportion of young and middle-aged patients, showing a trend towards younger ages [1,2]. According to the Cancer Society data report [3], breast cancer ranks first with approximately 2.26 million new cases. Currently, the treatment of breast cancer is primarily surgical, with chemotherapy and radiotherapy as adjuncts. The overall treatment course is long, significantly affecting the patient's physical and mental health. Studies have shown that breast cancer patients experience psychological issues such as anxiety, depression [4], body image distress [4], and low mental health levels [5], with 50% to 67% of breast cancer patients experiencing body image disorders [6], which may persist. A good level of body image can help patients better cope with cancer, while a low level of body image can affect the physiological and psychological functions of breast cancer patients and their partner relationships, impacting their sexual life and marital quality [7], leading to social avoidance behaviors and psychological distress [8], significantly affecting the quality of life [9]. Therefore, early assessment of body image and the initiation of positive psychological interventions are crucial for helping young and middle-aged breast cancer patients post-surgery to accept themselves, improve their disability acceptance levels, and enhance their post-surgery quality of life. Narrative nursing refers to the practice where nurses listen to patients' personal experiences, absorb the essence of their stories, help patients reconstruct their life patterns, and then identify personalized medical and nursing points, implementing medical and nursing interventions for patients [10]. Currently, narrative nursing is mainly used in areas such as malignant tumors [11], stroke [12], and nursing education [13], but research on improving the body image levels of young and middle-aged breast cancer patients post-surgery is still relatively scarce. Based on this, this study applies narrative nursing to intervene in young and middle-aged breast cancer patients post-surgery, exploring its effects on improving body image levels, disability acceptance, and psychological states of these patients, with the aim of providing relevant reference data.

2. Objectives and methods

2.1. Study subjects

This study is quasi-experimental research, using a convenience sampling method to select 80 postoperative breast cancer patients who visited a hospital in Yunnan. The province from October 2023 to September 2024 as the study subjects. The 80 subjects were divided into groups according to different wards, with 40 cases in each group. Interventions were carried out within one month after surgery, a total of 5 times.

Inclusion criteria: (1) Age ≥ 18 years; (2) Diagnosed with breast cancer by pathological diagnosis and underwent a radical surgical plan; (3) Body image score ≥ 70 points; (4) Conscious, with basic reading and understanding ability; (5) Agreed to participate in this study.

Exclusion criteria: (1) Those who underwent breast reconstruction; (2) With other malignant tumors; (3) History of mental illness in the past. The study was approved by the hospital ethics committee (KYLX2023-181). There was no statistically significant difference in the general data of the two groups of patients ($P > 0.05$) (**Table 1**).

Table 1. General information of the two groups ($n = 80$)

Project	Classification	Control group		Intervention group		Statistical value	P
		Mean ± SD / n (%)					
Age		46.8 ± 6.80		47.55 ± 5.66		3.429[a]	0.593
Nation	Han Chinese	37	92.5	29	72.5	5.541[c]	0.037
	Other ethnic	3	7.5	11	27.5		
Religious beliefs	Yes	2	5.0	1	2.5	0.346[c]	1.000
	No	38	95.0	39	97.5		
Current residence	City	27	67.5	36	90.0	4.731[b]	0.052
	Rural	13	32.5	4	10.0		
Educational level	Elementary school and below	12	30.0	11	27.5	4.675[b]	0.200
	Middle school	10	25.0	8	20.0		
	High school / Secondary vocational school / Vocational high school	11	27.5	6	15.0		
	Bachelor's degree or above	7	17.5	15	37.5		
Marital status	Married	35	87.5	39	97.5	4.216[c]	0.121
	Unmarried	0	0	0	0		
	Divorced	4	10.0	0	0		
	Widowed	1	2.5	1	2.5		
Occupational status	In service	11	27.5	15	37.5	1.001[b]	0.606
	Retirement	8	20.0	6	15.0		
	Unemployed	21	52.5	19	47.5		
Monthly per capita income	≤ 3000	7	17.5	7	17.5	0.971[b]	0.606
	3001-5000	18	45.0	14	35.0		
	≥ 5000	15	37.5	19	47.5		
Health insurance method	Urban and Rural Resident Medical Insurance	27	67.5	23	57.5	5.556[c]	0.135
	Employee Medical Insurance	13	32.5	17	42.5		
Disease staging	I	0	0	7	17.5	7.702[c]	0.096
	II	31	77.5	25	62.5		
	III	9	12.5	8	20.0		
Surgical methods	Radical improvement surgery	30	75.0	22	55.0	3.516[c]	0.061
	Mastectomy	10	25.0	18	45.0		

2.2. Intervention methods

2.2.1. Control group

Patients receive routine breast cancer specialized care, which includes health education and psychological counseling related to breast malignancy surgery and chemotherapy, conducted through a combination of oral and health education manual methods.

2.2.2. Intervention group

Based on the control group, narrative nursing is carried out. Nurses are required to actively listen to patients' stories throughout the work process and identify nursing points based on the content, reconstructing the meaning of the stories to effectively control patients' adverse psychological states [14].

(1) Formation of the narrative nursing intervention team

The narrative team consists of one national second-level psychological consultant and one medical social worker, responsible for theoretical and practical training; two deputy directors of breast surgery, responsible for formulating cancer treatment plans for patients under their care and assessing changes in their conditions, grasping key points of treatment; one master's supervisor, responsible for overseeing the implementation of the narrative nursing plan; one head nurse of breast surgery, responsible for coordinating the shifts of the narrative team members and organizing training and assessment for the narrative nurses; one graduate student who has undergone narrative training, who implements narrative nursing interventions based on the specific conditions of patients; and two duty nurses, who assist with routine care for both the control and intervention groups.

(2) Formulation of the narrative nursing intervention plan

The researcher reviews domestic and international literature related to "narrative nursing" and "body image," summarizes research progress, and formulates a plan based on the actual situation and nursing characteristics of the department.

(a) Implementation personnel: Each narrative nursing intervention is carried out by two nurses working together, with the narrative nursing personnel being the patient's fixed duty nurse (i.e., the narrative nurse in the narrative research group), facilitating trust from the patient;

(b) Implementation method: Conducted in the form of one-on-one, face-to-face interviews;

(c) Intervention time: Interventions are carried out twice, once before the patient's radical surgery, three days after surgery, before discharge, during the home period, and one month after surgery, with each session expected to last 20–30 minutes.

(d) Implementation location: The department interview room.

(3) Implementation of the narrative nursing plan

(a) Establishing trust relationships: After the patient is admitted, the patient is fully understood and recognized, and psychological counseling is provided. Guide the patient to speak freely and express themselves, and in communication, respond with smiles and nods without interrupting the patient, listen carefully and patiently to the patient's stories, and make positive and appropriate responses to the patient's stories, respecting the patient's privacy during communication. Establish a trusting relationship with the patient, allowing the patient to open up and share. Focus on understanding the patient's psychological state, personality traits, job nature, family background, and family relationships.

(b) External deconstruction of problems: Uncover meaningful and positive related events, discover the patient's strengths, improve the patient's negative attitude, adjust the patient's self-body image cognition, and help the patient face the disease positively. Problem externalization: Guide the patient to name the body image problems that trouble them, assist the patient in separating self-identity from physical appearance, and explain that the problem is not their problem, concretizing the problem, increasing the patient's sense of control over the problem, and focusing energy on solving the problem. Deconstructing the problem: Reconstructing self-identity. Through the patient's responses, dig out the underlying social

and cultural factors related to the patient's generation of this cognition and ideas, explain the root causes of the problem from the perspective of the cultural background in which the patient is situated, separate the patient from the problem, and view the problem from an objective perspective.

(c) Problem rewriting, external witnesses: Transfer the patient's positive self-evaluation to existing problems, and guide the patient to make decisions for themselves. During conversations with patients, if a deviation between the nurse's understanding and the patient's perception is detected, immediate self-reflection is made; and together with the patient, explore exceptional events, mainly exploring those successful, proud, beautiful, positive things in the patient's growth process, especially exploring the exceptional events where the patient overcomes internal feelings of disease stigma and recognizes their value.

(d) Treatment documents: The form of treatment documents is diverse, not limited to format, such as certificates, awards, messages, letters, etc., tailored to the individual. Using a sense of ritual to strengthen the patient's beliefs, and providing psychological support when the patient wants to give up. The above stages cover the entire narrative nursing interview process, with no clear chronological order, and the specific practical methods vary according to the nurse's communication with different patients.

2.3. Research tools

2.3.1. General information questionnaire

Based on the review of relevant literature and consultation with experts, a summary of general demographic information was made. This includes: age, ethnicity, religious beliefs, current residence, educational level, marital status, employment status, average monthly household income, medical insurance method, disease stage and grade, and surgical method.

2.3.2. Breast Cancer Patient Body Image Self-Rating Questionnaire (BISQ-BC)

Developed by Zhou *et al.* (2018) [15] based on the multidimensional theory of body image, it consists of 5 dimensions and 26 items. The 5 dimensions are: the social change dimension, behavioral change dimension, activity change dimension, role change dimension and psychological change dimension. The questionnaire uses a Likert 5-point scale, with a total score ranging from 26 to 130, where a higher score indicates more severe body image disturbance. The Cronbach's α coefficient of the scale is 0.90 (**Appendix C**).

2.3.3. Acceptance of Disability Scale-Revised (ADS-R)

This questionnaire was developed by Groomes *et al.* (2007) [16] and translated by Alvarez-Pardo *et al.* (2023) [17]. The scale consists of 32 items, using a Likert 4-point scale, with a total score ranging from 32 to 128. Scores from 32 to 64 indicate a low level, 65 to 96 indicate a moderate level, and 97 to 128 indicate a high level. The scale includes four dimensions: inclusion dimension (inclusion of the impact of breast loss), transition dimension (shift from comparative value to intrinsic value), expansion dimension (expansion of the value range), and affiliation dimension (affiliation to body image). The correlation coefficients between each dimension and the total scale range from 0.609 to 0.890.

2.3.4. Herth Hope Index (HHI)

Developed by the American scholar Herth (1992) [18] and translated and introduced into China by Zhao *et al.* (2000) [19] from China Medical University in 1999. The scale contains 3 dimensions, with a total of 12 items.

These include: positive attitude (items 1, 2, 6, 11), positive action (items 4, 7, 10, 12), and intimate relationships (items 3, 5, 8, 9). It uses a Likert 4-point scale, with a total score ranging from 12 to 48, where a higher score indicates a higher level of hope. The Cronbach's α of the scale is 0.87, and the test-retest reliability is 0.92.

2.4. Quality control

(1) Preparation stage: Narrative nurses receive narrative nursing training and assessment before starting narrative nursing work to ensure the effectiveness and homogeneity of narrative nursing;

(2) Data collection stage: Investigators are required to fully understand the questionnaire and distribute it using a unified standard instruction, with timely and deletion of questionnaires with regular answers and a missing rate of more than 15%;

(3) Entry stage: Double entry of results is implemented using EpiData 3.1 software, and inconsistencies are corrected by referring to the original patient questionnaires.

2.5. Statistical analysis

SPSS 27.0 statistical software is used for data analysis. Measurement data that conform to the normal distribution are expressed as mean ± standard deviation (SD), and count data are expressed as frequency and percentage. Comparisons between groups and within groups are made using two independent sample t-tests and paired t-tests. A P-value of less than 0.05 is considered statistically significant.

3. Results

3.1. Comparison of BISQ-BC scores for body image between two groups of patients

After intervention, the BISQ-BC scores of the intervention group patients decreased compared to before intervention, and the BISQ-BC scores of the intervention group patients were lower than those of the control group, with a statistically significant difference ($P < 0.05$) (**Table 2**).

Table 2. Intra-group comparison of body image (BISQ-BC) scores before and after intervention between the two groups (points, mean ± SD)

Project	Classification	Before intervention (*n* = 40)	After intervention (*n* = 40)	*t*	*P*
BISQ-BC	Control group	105.90 ± 5.07	104.50 ± 5.22	1.329	0.192
	Intervention group	104.33 ± 7.76	60.98 ± 7.68	23.089	< 0.001
Related psychological changes	Control group	33.08 ± 3.03	32.75 ± 3.06	0.483	0.632
	Intervention group	33.18 ± 3.69	17.18 ± 3.46	19.634	< 0.001
Related behavior change	Control group	29.45 ± 2.22	29.23 ± 2.79	0.411	0.683
	Intervention group	28.78 ± 3.93	19.95 ± 3.84	10.080	< 0.001
Related role changes	Control group	22.25 ± 3.28	22.08 ± 2.14	0.291	0.711
	Intervention group	21.33 ± 2.60	12.78 ± 3.76	12.483	< 0.001
Behavioral change related to the subject	Control group	13.68 ± 2.30	13.35 ± 1.70	0.780	0.744
	Intervention group	13.20 ± 2.77	6.95 ± 2.36	10.493	< 0.001
Related social changes	Control group	7.45 ± 0.96	7.10 ± 1.53	1.595	0.119
	Intervention group	7.85 ± 1.21	4.13 ± 1.87	9.618	< 0.001

3.2. Comparison of ADSR scores before and after intervention in two groups of patients

After intervention, the ADSR scores of both groups of patients increased compared to before intervention, and the ADSR scores of the intervention group were higher than those of the control group, with a statistically significant difference ($P < 0.05$) (**Table 3**).

Table 3. Intra-group comparison of ADSR scores before and after intervention in two groups (points, mean ± SD)

Project	Classification	Before intervention ($n = 40$)	After intervention ($n = 40$)	t	P
ADS-R	Control group	79.33 ± 8.51	92.10 ± 4.91	-7.680	< 0.001
	Intervention group	77.58 ± 8.39	101.98 ± 5.23	-15.598	< 0.001
Expand dimensions	Control group	26.38 ± 2.43	28.23 ± 2.84	-6.037	< 0.001
	Intervention group	27.20 ± 2.35	30.85 ± 2.55	-6.803	< 0.001
Inclusive dimension	Control group	20.68 ± 3.93	25.28 ± 2.30	-0.841	0.406
	Intervention group	19.85 ± 4.51	29.15 ± 2.32	-11.206	< 0.001
Transform dimensions	Control group	20.75 ± 3.54	25.65 ± 2.80	-0.548	0.587
	Intervention group	19.93 ± 4.70	27.85 ± 2.08	-1.216	< 0.001
Subordinate dimension	Control group	11.53 ± 1.99	12.95 ± 1.63	1.429	0.161
	Intervention group	10.60 ± 2.31	14.13 ± 2.51	-6.794	< 0.001

3.3. Comparison of HHI scores between two groups of patients before and after intervention

After intervention, the HHI scores of both groups of patients increased compared to before intervention, and the HHI scores of the intervention group were higher than those of the control group, with a statistically significant difference ($P < 0.05$) (**Table 4**).

Table 4. Intra-group comparison of Herth Hope Index (HHI) scores before and after intervention in two groups (points, mean ± SD)

Project	Classification	Before intervention ($n = 40$)	After intervention ($n = 40$)	t	P
Herth	Control group	33.40 ± 2.74	33.85 ± 3.62	-0.845	0.403
	Intervention group	33.85 ± 4.45	43.18 ± 2.49	-11.031	< 0.001
Positive attitude	Control group	10.35 ± 1.72	10.03 ± 1.64	1.428	0.161
	Intervention group	10.70 ± 2.13	14.23 ± 2.49	-8.602	< 0.001
Positive action	Control group	11.75 ± 0.93	12.03 ± 1.29	-1.317	0.195
	Intervention group	12.18 ± 1.30	14.58 ± 1.24	-9.055	< 0.001
Intimate relationships	Control group	11.30 ± 1.36	11.80 ± 1.74	-1.612	0.115
	Intervention group	10.98 ± 2.03	14.38 ± 1.06	-9.365	< 0.001

4. Discussion

4.1. Narrative nursing can effectively improve patients' body image levels

Narrative nursing refers to patients narrating their experiences and stories, with nurses helping them to reconstruct

the meaning of their illness and life stories through their narratives. In the process of narration, nurses experience the patient's mental state, physical manifestations, and psychological changes on multiple levels, to achieve holistic nursing. The purpose of narrative nursing interventions is to enhance patients' self-awareness, analyze and affirm their positive strengths, and recognize the efforts patients make in overcoming difficulties, psychological issues, facing and conquering illness; through storytelling and conversation, nurses uncover potential psychological issues, provide positive guidance, and stimulate the patient's inner strength. In the narrative process, the patient is the protagonist in solving problems, while the nurse is a collaborator and guide [20]. Nurses, as listeners, get close to the patient's life story, focusing on the internalized problems of the patient and externalizing them, transforming the patient's anxiety and unease into something objective, enhancing the courage to face problems; additionally, by helping patients find overlooked highlights and the positive forces behind them, patients are made to realize that they have the resources and abilities to solve problems, their potential and positive traits, and provide new choices, making them aware of the possibility of a new life, thus building confidence, seeing hope, and changing the patient's actions and self-identity [21]. The results of this study show that after the intervention, the body image scores of the intervention group were significantly lower than those of the control group, consistent with related research findings [22].

4.2. Narrative nursing can effectively improve patients' disability acceptance and psychological hope levels

The results of this study show that after implementing narrative nursing, the ADSR scores and psychological hope levels of the intervention group were higher than those of the control group ($P < 0.05$), indicating that narrative nursing can better improve patients' ADSR and psychological hope levels. The reason may be that narrative nursing combines humanities with medical care. When patients feel understood, they experience a profound sense of satisfaction, which also has a multiplier effect on improving patients' disability acceptance. Narrative nursing improves the confidence of patients with breast absence after radical breast cancer surgery through reasonable interventions, reducing the patient's sense of stigma. Narrative nursing can guide patients to open up channels for expressing negative emotions through storytelling, reducing the patient's self-imposed emotional burden, and allowing patients to actively explain and decompose the huge stressor of "cancer diagnosis," reducing the patient's psychological stress level [23]. The narrative nursing implemented in this study required nursing staff to respect and listen to the stories behind each issue related to the patient, listening to the patient's stories with an attitude of equality and respect, while encouraging them to narrate their diagnosis and anticancer experiences, allowing patients to vent negative emotions, promoting patients' acceptance and adaptation to the disease [24]. Psychological hope, as a protective psychological resource, plays a key role in cancer patients' stress responses to pressure and crisis events. The premise for patients to adapt to life after being diagnosed with cancer is to accept the disease; a high level of disease acceptance not only helps cancer patients better adapt to the disease but also contributes to improving patient treatment compliance, prognosis, and quality of life [25]. Through patient narratives, nursing staff can fully understand the patient's situation and physical and mental state, grasp the key points of nursing, deeply explore the crux of the patient's current problems, and then adopt targeted nursing measures based on the patient's situation, externalizing the patient from the negative emotions of cancer, viewing the problem objectively, effectively improving the patient's psychological hope levels and disability acceptance.

5. Conclusion

Narrative nursing can effectively improve the body image of patients with breast absence after radical breast cancer surgery, increase patients' disability acceptance and psychological hope levels, reduce the psychological distress and stress levels of patients with breast absence after radical breast cancer surgery, improve patient treatment enthusiasm and rehabilitation outcomes, and is worthy of clinical promotion. However, this study also has certain limitations:

(1) This study only selected patients for investigation of body image levels one month after surgery and conducted narrative nursing interventions. Breast cancer treatment is a long and tortuous process, during which the patient's negative emotions fluctuate with changes in the condition. Future studies can track patients at multiple time points for body image levels and trigger narrative nursing interventions on time and their application value;

(2) This study only selected patients from one medical institution, and there is still a limitation in the representativeness of the population in terms of medical resource distribution and regional social differences. Future research can consider expanding the scope of sample distribution, extending the follow-up time, and accurately identifying the long-term body image symptoms of patients with breast absence after radical breast cancer surgery, providing a reference for the development of more comprehensive narrative nursing intervention measures.

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