CHAPTER THREE

Methodology

"I have not failed. I've just found 10,000 ways that won't work."

- Thomas Alva Edison (1847-1931)

3.1 Introduction to Chapter

This chapter reflects the operational phase of this research. It explains how the research concerns emerged within me from my field experience and how I carried out the research to satisfy my intellectual curiosity. My professional experience along with theoretical knowledge helped me to identify the gap in the existing literature in the field of Psycho-Oncology. This created an intellectual discomfort within me which prompted me to seek the most suitable methods to get appropriate answers to my research objectives. The conceptual map provided in this chapter integrates different concepts and sub concepts of the research and the lines of enquiry provide direction to my study. This chapter gives details about how the qualitative orientation of this research helped me in sampling and data collection process to collect rich data. Last but not the least; it describes the different phases of data collection and my personal experience as a researcher in the field.

3.2 Context of the Study

The seed of this research sprouted in my mind when I was 21 years old. My experience with women with breast cancer started with my field work placement as a student social worker in a multi-specialty hospital in Kerala in 2003. Since my specialization was in Medical and Psychiatric Social Work, I was placed in a multispecialty hospital in Kerala to learn the role of a Medical Social Worker in the Department of Oncology. But there was no Medical Social Worker or any such professional to look after the psychosocial aspects of the breast cancer experience of the woman and her family. Even from my first encounter with a woman who
was diagnosed with breast cancer, I was made aware that cancer is not only a medical disease of the body, but also has psychological, familial as well as social implications. I could witness women with their partners and significant others collapse at the time of diagnosis and they found it difficult to cope with the cancer experience. In the absence of a Medical Social Worker, I was given training by the doctor (Onco-Surgeon) on the clinical aspects of the disease such as identifying symptoms, risk factors, treatment and its side effects and I observed even the surgical procedures of mastectomy. With my experience in the hospital, I learnt that mastectomy involves removal of the breast from a woman physically as well as psychologically by a surgeon. Both the medical and surgical treatment of the disease is concerned only with the physical body and the removal of the disease. The psycho-social aspect of the illness remains untreated thereafter, leaving the woman after discharge from the hospital, to deal with the real experience of breast loss.

From my experience, I decided to conduct my research in three districts of Kerala, namely Ernakulam, Kottayam and Thrisur. Kerala is selected as a site for the study due to various reasons. Firstly I am born and reared in Kerala and have been associated with the field of breast cancer for the past 6 years and I am familiar with the field especially with the medical professionals of the hospitals in the three districts. Secondly I observed that there are no social workers in any of these hospitals and the social work profession itself is not recognized in hospitals in Kerala. I had an opportunity to observe and understand the activities of social workers with patients having cancer in the Tata Memorial Hospital, Mumbai. Thus I learned that the psycho-social experience of breast cancer must also be addressed in the hospital along with the medical help. Hence I decided to study in detail the lived experience of breast cancer and breast loss from the perspectives of women in Kerala. Thirdly, mother tongue plays an important role in explaining the lived experience of women and I am familiar with Malayalam, my mother tongue and the language spoken in the area of this study. Fourthly, the in-depth interviews with the participants of the study require considerable amount of time and resources, and I selected the three districts for my convenience due to familiarity and accessibility. Apart from all these, my interest and curiosity in the field of breast cancer encouraged me to select and work with women in Kerala.

3.3 Rationale

As mentioned in the introduction chapter, Kerala, the southernmost state in India is comparable to that of the most developed countries in the world in terms of its health indices.
But in the case of breast cancer experience the situation is different. The statistical data on breast cancer in Kerala provides clarity on this disparity. In Kerala, reliable data on breast cancer is available as per the Hospital Based Cancer Registry of Regional Cancer Centre, Trivandrum and the Population based Cancer Registry of Karunagappally\(^{10}\). In the age group of 35 to 64 years breast and cervix are the leading sites of cancer in all hospital based cancer registries, breast being first in Mumbai and Thiruvanathapuram, Kerala. The incidence of breast cancer in Kerala is increasing alarmingly even though the state has achieved proud health indices. According to the data available with the Trivandrum Cancer Registry, the prevalence rate in rural areas is 19.8 per 100,000 while in the urban areas, it is 30.5 per 100,000 (Kalavathy, 2006). When we compare this with the Hospital Based Cancer Registry Report (2004-2006)\(^{11}\), it is clear that the incidence rate of breast cancer of the state is at par with the all India rate.

Breast cancer is the most common cancer in urban India, but little efforts have been made to study the psychosocial aspect of patients with breast cancer (Khan et al. 2010). A few attempts have been made in the Indian context to comprehend and address the psychological and social needs of breast cancer patients (Pandey et al. 2000). The most significant fact is that, women do not experience breast cancer alone. Usually a network of family and friends who experience the social and emotional ramifications of illness surrounds them (Lewis et al. 1989; Northouse and Swain, 1987). The researcher had work experience with the breast cancer patients during their diagnosis and treatment days in one of the Multi-Specialty hospitals in Kerala as medical social worker. My professional experience reveals that the psycho-social needs of the woman and her significant others are not met adequately by professionals. I could observe doctors and nurses giving assurance to the patients that they would get relief from their physical hardships due to the treatment. But, they rarely addressed other issues such as concerns about changed physical appearance and sexual changes associated with the breast cancer experience.

### 3.4 Scope:

This study is focused on women with breast cancer and their psycho-social experiences in the context of mastectomy. A scrutiny of the chapter on literature review clearly indicates the

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\(^{11}\) Consolidated Report of Hospital Based Cancer Registries 2004-2006: National Cancer Registry Programme, ICMR, Bangalore, 2009
scarcity of indigenous knowledge in the Indian context about the issue. It also identifies gaps in the existing literature since there is contradiction among Indian and Western literature as well as in the Indian literature itself with regard to the experiences of women with breast cancer. Thus it tries to contextualize the lived experience of body image and sexuality in terms of breast loss in the personal as well as interpersonal life of married women in Kerala, India. The study is aimed at building a grounded theory which reflects field reality. The theory provides an interpretation of the data that reflects each individual’s experience and applies equally well across the entire data. Thus the study will have its contribution in two dimensions. The in-depth analysis of the experiences of the patients will enhance the knowledge base in the field of Psycho-Oncology, which will help address the psycho-social aspects of treatment. Contextualizing the experiences of breast cancer can be used for developing a culturally sensitive intervention package for helping women in similar social context. The in-depth analysis of the experiences in this study has retrospective nature starting from the symptom stage of breast cancer to the current phase of survival. Thus the intervention package can be used for helping women in both situations 1) women who are undergoing current diagnosis and treatment and 2) women who are in the follow up stage of the treatment. From my field experience of being a social work professional, the need of social work interventions in the field of Oncology is not yet recognized in Kerala. The researcher hopes that the findings of the study will be instrumental in bringing about a change in the scenario.

3.5 Aim of the Study

In response to the above mentioned rationale, the researcher decided to conduct a study on “the Psychosocial Experiences of the Survivors of Breast Cancer: From Diagnosis to Two Years Post-Mastectomy”. The present study aims at generating a context based theory within the psychosocial experience of women survivors of breast cancer. The social and cultural context in which a woman lives has a strong influence on her experience of breast cancer in terms of body image and sexuality (Barni and Mondin 1997). As mentioned in the introduction chapter, the Kerala society gives importance to the physical appearance of the female body. In the patriarchal society, modern women are expected to be dressed up and maintain their body as per the needs and interest of modern men (Devika 2004). Breast cancer seems to provide a crucial vantage point to understand the implication of the body and particularly sexuality in the dominant conception of womanhood in Kerala. This is in an ideal position to explore the women’s psycho-social experiences of breast cancer since few studies
are conducted to contextualize the experiences despite an alarmingly increasing incidence of breast cancer in Kerala.

3.6 Objectives of the Study

The specific objectives and the research questions are the follows:

I. To explore the psychosocial experiences of survivors during their journey of breast cancer.

Research questions:

1. What are the major psychosocial experiences of survivors from diagnosis to the current stage?
2. What are the psycho-social factors that influence the diagnosis, treatment and post treatment life of women survivors with breast cancer?
3. What factors influence the psychosocial problems of women during each stage of treatment?

II. To examine the influence of mastectomy on the body image experiences of survivors with breast cancer.

Research questions:

1. How does the social construction of female body image influence the survivor’s perception of the experience of breast loss?
2. How do the experiences of body image influence the survivor’s day to day interaction and functioning with her spouse and family?
3. What are the coping strategies women adopt to deal with the perceived distress with regard to their body image?
4. What are the consequences of the strategies undertaken by the women?
5. What factors influence positive or negative coping with regard to body image experience?
III. To understand the influence of mastectomy on sexuality and sexual functioning of survivors with breast cancer.

Research questions:

1. How do experiences of body image influence the woman’s perception of her sexuality and sexual functioning?
2. What are the sexual changes that the women undergo due to treatment and mastectomy?
3. What are the consequences of these sexual changes on her sexuality?
4. What are the coping strategies women adopt to deal with the distress they perceived with regard to their sexuality?
5. What factors influence positive or negative coping with sexual changes?

IV. To explore the influence of individual and environment related factors on the experiences of survivors with breast cancer.

Research Questions:

1. How has the diagnosis of breast cancer and mastectomy influenced changes in the woman’s individual, familial and work related factors?
2. How do marital, familial, social and cultural factors influence the women’s experience of breast cancer?
3. What are the coping strategies women use to deal with the problems of breast cancer experience?
4. What are the outcomes of coping strategies and how do these outcomes vary among the individuals?
5. How do the above factors influence the woman’s current experiences with regard to her psychosocial contexts?
6. What are the individual and environmental factors which influence a woman either positively or negatively in her experience of breast cancer?
3.7 Theoretical Framework of this Research - A Summary

The proposed study aims at analysing the personal and interpersonal factors and conditions that influence women in assessing and dealing with the perceived threats of cancer (such as chance of survival, concerns about body image, sexual changes, functional roles and interpersonal relationship with others), the coping strategies these women undertake and the consequences of these strategies. For this, the researcher uses Susan Folkman and Richard Lazarus’s (Folkman & Lazarus 1980, 1988; Folkman 1984; Lazarus & Folkman 1984; Lazarus 2006) stress and coping theory as the conceptual framework guiding the study. These theories have been described in chapter 1.

3.8 Conceptual Map

A conceptual framework helps the researcher focus and binds the process of data collection; as a form of anticipatory data reduction, it is a form of pre-analysis, ruling out certain variables and relationships and attending to others (Miles and Huberman 1984). In the light of the theoretical frame work and literature, the researcher has developed a conceptual map, which explains how in this study a woman might experience the diagnosis, treatment and the consequences of breast loss on body image, sexuality, motherhood, and other social relationships. The conceptual map is represented in Figure 3.1
Figure 3.1
The Conceptual Map

Psychosocial Experiences

Maladaptive coping

Response of woman

Adaptive Coping

Intrapersonal / individual

Physical
Physical changes
Sexual changes
Stage of diagnosis
Age at diagnosis

Psychological
Disturbed body image and sexuality
Personal coping skills
Information / Knowledge base about breast cancer
Spiritual belief

Appraisal
Primary (threats) & secondary (resources)

Diagnosis & Treatment

Woman with Breast Cancer Symptom

Inter-personal / Environmental
Relationship with Partner,
Family,
Children,
Relatives and Neighbors
Economic condition
Ideal body image (Socio-cultural construction)
Professional support
Social stigma on cancer
3.8.1 Narrative of conceptual map

**Woman with symptoms of breast cancer:** A woman who doubts breast cancer due to any of the symptoms of cancer. The line of enquiry starts from the woman with symptoms of breast cancer. She will be anxious and disturbed when she finds a lump or abnormal nipple discharge or asymmetry in the shape of breasts, doubting whether it is a symptom of breast cancer. It may also be her partner who discovers this. Some women may not even consider the symptom serious enough to be cancer. She will be in a state of uncertainty till the proper medical diagnosis. Once the diagnosis is done, her experiences will be different.

**Diagnosis and treatment:** The diagnosis of cancer hits most of the women with a wave of shock, fright and denial. Each woman takes her own time to pull herself together and to deal with the realities of cancer. The news of the diagnosis itself can shatter a woman. She may think about consulting another doctor by denying the possibility of having breast cancer. She may not be familiar with the treatment such as chemotherapy, mastectomy, radiation, hormonal therapy and medications. She may be wondering, whether the surgery will cure her cancer, what she will look like after surgery, whether she will be able to continue with her job and contribute in manner that she used prior to diagnosis in roles such as a mother, wife, daughter, sister and so on.

**Interpersonal and Intrapersonal or Environmental factors:** For the most part, women do not experience breast cancer alone. She lives in her family surrounded by various social support systems. From the various researches conducted with cancer patients, the various psychological reactions to a disease are the following:

**Intrapersonal factors:** These are the personal characteristics of an individual. In this study the factors such as belief and trust in medical system, spiritual belief, age at diagnosis, and the treatment specific factors such as prognosis, onco-education, changes in her physical appearance (hair loss, breast loss, weight gain and other bodily changes), changes in her sexuality (confronting sexual changes such as breast loss, loss of sexual desire or urge, feeling of sexual attractiveness, range of sexual activities, fertility concerns, sexual enjoyment, communication between couples, and difficulties with sexual intercourse and orgasm), and personal coping skills (from her past experience of dealing with stressful situations and knowledge and experience of dealing with cancer can have a significant
impact on her experience with breast cancer). Internalized body image of woman as part of the socio-cultural life plays a vital role in her experience of altered body image due to breast loss.

**Interpersonal factors:** The interpersonal or environmental factors include her relationship (before and after treatment) with partner, family members, children, relatives, neighbors, her economic condition to deal with the treatment specific demands, her family relationship and communication (for example whether her concerns about the symptom can be disclosed in the family), the personal as well as psychological support that she can utilize, her empowerment status in the family in decision making in the treatment, role functioning in family and society, the cultural aspect of body image in her society, values and attitudes toward illness as such and specific diseases prevalent in the patient’s social milieu (social stigma attached to the disease, her experience of social stigma such as shame, guilt, discrimination from colleagues and so on); belief about delivery of medical care and practitioners; economic consequences of illness for patient, the professional support she could enjoy during the course of her treatment and the physical aspects of environment in which she lives during her illness.

**Diagnosis and treatment related factors:** It means factors such as prognosis, stage of disease, side effects of treatment (such as chance of infertility), chance of survival, and the subjective meaning they have for the woman in relation to her breast cancer history, knowledge, values.

**Appraisal:** Stressful experiences are construed as person-environment transactions. When woman hears that she has breast cancer there may emerge a situation of stress through the primary appraisal, since the disease can be fatal (life is at stake), of her functional roles such as mother, wife, daughter, and professional relationships the other possible stakes. She analyzes each aspect of her personal, familial and social life to detect whether any of them is involved or at threat due to her diagnosis and treatment. If harm or threat is anticipated, it leads to secondary appraisal, appraisal of resources to cope with the threats. She engages in assessing possible resources from her personal as well as interpersonal systems. An important point to be noted is that her perceived stakes of threat can later serve as potential resources for her (for example the threat she perceived on her functional role as a mother may later be turned as a resource when her children provide her psychological as well as functional support during treatment and recovery).
Adaptive Coping: If she perceives that she can use the available resources, either individual or environmental or both, to overcome stress, it leads to healthy and effective coping of the situational demands.

Maladaptive coping: When she perceives that her resources are not enough to cope with her demands, it causes stress and she fails to cope with the demands of the situation and this results in maladaptive coping.

All these processes constitute her psychosocial experiences with breast cancer.

3.9 Assumptions of Research Methodology:

Methodology refers to the broad philosophical orientation or paradigm that guides a research study and researchers are expected to select a research paradigm that is congruent with their beliefs about the nature of reality (Mills, Bonner and Francis 2006). Denzin and Lincoln (2000), a research paradigm contains the researcher’s ontological, epistemological and methodological premises, and a basic set of beliefs that guide the entire study. The Table 3.1 gives a brief description about the philosophical positions of the researcher.

**TABLE 3.1**

Assumptions of Research Methodology

<table>
<thead>
<tr>
<th>Ontology</th>
<th>Epistemology</th>
<th>Method</th>
<th>Logic of enquiry</th>
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<tbody>
<tr>
<td>Women perceive a threat to their selves (existence, femininity, functional roles and social relationships) in their experience with breast cancer.</td>
<td>Constructivist standpoint gives the researcher an opportunity to reduce her bias and acknowledge the experience of the participants to perceive that women construct their reality subjectively by</td>
<td>Multiple methods of data collection such as in-depth interviews, telephonic interviews, and observation.</td>
<td>Inductive logic for generating and confirming theory, and constantly comparing data through constructive and interpretive analysis that leads to theory that emerges from the data (deduction – propositions/hypotheses about the relationships</td>
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of meaning depends up own their pre-cancer life experiences, personal as well as interpersonal resources available, resilience and personal coping skills, and the consequences of the current coping strategies.

| attributing meaning to their lived experience. |
| - Constructivist paradigm provides order and structure to the collection and analysis of data, while accepting changes in the emerging relationships within the data, leading to theorizing. |
| Simultaneous data collection and analysis until saturation of categories based on the core phenomenon. |
| within the categories of data). |

### 3.10 Research Design

The research design is exploratory in nature. It seeks to find out how women move along in the experience of breast cancer, what meanings they give to their actions, and what issues concern them. It helps us understand and explore the experiences of women with breast cancer. Here the researcher is looking at processes and linkages of the experience that the woman goes through during the illness process. The study is interested in building a context specific theory following grounded theory, one of the streams of qualitative research, from the data itself rather than from a pre-disposed hypothesis. Also the results of the study cannot be generalized to the population. The qualitative orientation of the study attempted to reveal the experience of women in her natural setting. It tries to contextualize the lived experience of breast cancer and breast loss in the context of contemporary Kerala.
3.11 Qualitative Research Approach

According to Creswell (1998: 15) "A qualitative study is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting”. The emphasis is on the understanding of the social world through the examination of the interpretation of the world (field reality) experienced by the participants. This interpretivist stand provides insight into the participant’s experiences of the world and thus makes the study more meaningful (Strauss and Corbin 1993). For this research, I focused on understanding the actual experiences of women and the psycho-social processes involved in their experience.

3.11.1 Rationale for selecting qualitative approach: Qualitative inquiry is designed to explore, understand, and describe the experiences of the participants under investigation in their own words (Lincoln & Guba 1985). I adopted a qualitative approach in sampling, data collection and analysis to explore the lived experience of women with breast cancer in the context of their psychosocial experience of breast loss. The main advantages of following qualitative approach are the following:

- The interpretive character of the approach helped me to examine the rich experience (data) of women from their own perspective. It helped me in the analysis part, since I followed Grounded theory approach which is one of the methods of qualitative research. Data collection and analysis happen concurrently and I stopped collecting further data when the categories reached saturation, the point where no additional experience arised from analysis. Hence I could cover the whole range of experiences from the perspective of the participants which has resulted in the formation of the context based theory. The theory is thus formed from the field reality and experience of the participants. Both complement each other. To facilitate the discovery of new knowledge, the researcher puts aside as many assumptions as possible and takes a fresh, creative look at the phenomenon under study (Woolley, Butler and Wampler 2000).

- The uniqueness of each data could be maintained for the study since each individual reacts to the diagnosis and treatment of their breast cancer differently. There were participants who represented two extremes of experiences or perceptions. For
example, one participant who was scared of surgery hid her symptoms for two years till she got too tired to breathe, while another woman at her first encounter with the symptom consulted the Oncologist doubting breast cancer and underwent treatment. Thus I could include each and every experience from their perspective. The qualitative approach pays attention to the idiosyncratic as well as pervasive, seeking the distinctiveness of each data.

- Qualitative approach gives flexibility. The research problem is a sensitive issue and hence the researcher needs flexibility in the use of methods and tools. One participant was quite shy to discuss about her experience of sexual changes after mastectomy. She was cooperative in the in-depth face-to-face interview and presented her experience in all other areas except sexual changes that she had undergone after mastectomy. She even revealed that she was too shy to disclose the issue openly. She attempted several times, but she could not open up. Then I tried telephonic conversation over face-to-face interview, she could open up confidently. Since I had built a purposeful rapport with her, I understood her unwillingness to explain a sensitive issue during a face to face conversation. Recognizing this, I relied on a telephonic interview in which she explained how she had experienced sexual changes and how it affects her relationship with husband. Telephonic interview is an accepted method of data collection in qualitative research. For example, Sturges and Hanrahan (2004) reported the results of a comparative study of face-to-face interviewing with telephone interviewing in a qualitative study. Since comparison of the interview transcripts revealed no significant differences in the interviews, they concluded that telephone interviews can be used productively in qualitative research. According to Sweet (2002), qualitative researchers should not rely exclusively on the face-to-face interview, as the telephone interview can be an equally valuable data collection approach.

- Purposeful personal relationship / rapport needs to be established in order to elicit data. I could build an effective personal relationship with my participants. I conducted home visits and the interviews were done at their home. This helped the participants feel at ease and open up without any hesitation. When the analysis commenced and when I found gaps in the existing data, I could go back to them and even collect further data through telephonic conversation.
• Since the research concern is a sensitive one, the informed consent of the participants needs to be obtained and confidentiality was ensured. I explained the nature, objectives and expected outcome of the study in my first encounter with the participants. They were given the freedom to withdraw from the research at any time if they feel uncomfortable. But all of them participated till the end of my analysis and I even shared the preliminary findings with them.

• Though the data collection was time consuming, I could elicit rich data from the field which enhanced the emerging theory. Data collection process and analysis took place together and both lasted for one year and two months.

3.12 Grounded Theory

Grounded Theory being one of the streams of qualitative research is a powerful research method for collecting and analyzing qualitative research data. It was developed by the sociologists Glaser and Strauss (1967). Even though Grounded Theory emerged during 1960s it is still not widely used and properly understood and practiced by researchers in various professions.

The basic assumptions followed in grounded theory research are following (Dey 2004)

• the objective of grounded theory research is to generate or discover a theory which is field based rather than testing ideas formulated in advance of data collection and analysis;
• grounded theory follows ‘theoretical sampling’ method to test or refine new ideas as these emerge from the data;
• the researcher has to set aside prior theoretical assumptions to allow the field based, context specific theory to emerge which must represent the reality;
• different methods of data collection followed in grounded theory are in-depth interviews fieldwork, observations, and documents;
• data analysis is flexible and systematic as well and begins as the first data is collected. It proceeds from “open coding” (line-by-line and paragraph-by-paragraph coding for identifying codes and categories) through “axial coding” (relating categories to sub-
categories and understanding its properties) to theoretical coding around an emerging coherent relationship between categories;

- data analysis proceeds through identifying categories and connecting them through constant comparison;
- further data collection (or sampling) is based on emerging concepts;
- these concepts are developed through constant comparison with additional data and the categories developed offer meaningful interpretation of the phenomena under investigation;
- grounded theory provides pointers to how to bring the research to a successful conclusion. Data collection can be stopped when no new concepts emerge since categories reach theoretical saturation.

3.12.1 Advantages of using grounded theory in this research

The following points serve as the foundation for Grounded Theory in my research

- The history of Grounded Theory itself reiterates its significance in health sector, especially in cancer. Because the founders of Grounded Theory methodology used it for the first time among patients who are in their terminal stage of cancer (Glaser and Strauss, 1965).
- Flexibility of methods to collect data which can be used by the researcher adds advantage to eliciting adequate information. Since the researcher is free to follow iteration (freedom to step back to any of the previous stages and continue the research from there), I could revise my inclusion criteria during data collection and simultaneous analysis and proceeded further data collection from there. In the beginning I did not plan to collect data from women who do not have children. But once I started data collection and analysis, I discovered that childlessness is an important factor which determines perception of diagnosis and recovery. So I decided to include women without children too.
- The therapeutic nature of interviews allowed the participants to reveal their problems and experience of distress which they may not even revealed to their close relatives or any other health professionals. The feeling that somebody is there to listen to them gives them consolation in their survivorship. Though I did not offer any direct
supportive counseling or any other interventions, mere listening to their experience enabled many women feel better.

- Interviews require a close relationship between the researcher and the researched to elicit such data from the researched. Sensitive issues like breast cancer and breast loss can be handled carefully in Grounded Theory methodology. Women confessed that they never discussed about their sexual changes due to the disease and the doctors were neglecting all other issues except their medical condition that is cancer.

- By using qualitative Grounded Theory approach, I could expand the scope of data gathering. Even though I had an interview guide, the interview was interactive in nature and was informal. My next question was prompted by the current answer of the participant. I was free to ask the relevant questions which were not included in the interview guide and thus it enriches data collection. It helped me to collect the entire range of experiences of women.

- I could identify the saturation in the categories since I was doing the analysis along with data collection and thus I was able to collect rich data with sufficient time.

### 3.13 Inclusion Criteria

The participants were selected according to the following criteria.

- Only married woman within the age group of 30 – 45 years who underwent mastectomy two years before the period of study in hospitals with the Department of Oncology in Kerala.

- Only those participants (survivors) who have completed two years mastectomy life.

- Only those participants with first time diagnosis and treatment for breast cancer.

### 3.14 Exclusion Criteria

- Those women who are suffering from other pre-existing chronic physical illness, epilepsy and organic mental disorder or from any pre-existing psychiatric illness.
3.15 Sampling Procedure

Since this research is based on Grounded Theory approach, I used theoretical sampling\textsuperscript{12} method (Glaser and Strauss 1967) for data collection which uses the principle of divergence and saturation.\textsuperscript{13} Theoretical sampling means sampling on the basis of concepts that have proven theoretical relevance to the developing theory. The term theoretical sampling is coined by Barney Glaser and Anselm Strauss in 1967\textsuperscript{14}. In Grounded Theory, the analysis begins immediately with the first interview and also guides for further data collection, choosing new participant to compare with ones that have already studied by the researcher. The number of participants or the sample size cannot be stated at the outset of the research; and can only count up at the end of research (Strauss 1997).

In this research, the first interview transcript is read line-by-line and paragraph-by-paragraph, looking for incidents and facts, and is coded for anything and everything that seems potentially relevant. The coding is very detailed and time consuming, yet critical since it offers all possibilities for the researcher to systematically conceptualize the data. Through constant comparative analysis, the substantive codes are then developed into categories, and categories are finally integrated into the emerging theory. The criterion for judging when to stop sampling the next participant pertinent to a category is the category’s theoretical saturation. Saturation means that no additional data are being found to develop properties of the category.

The researcher sees similar instance over and over again, becomes empirically confident that category is saturated (Strauss 1997). I collected data from thirty two participants. The saturation of all categories was observed in the analysis of the twenty seventh interview. All categories for interpersonal and intrapersonal factors (mentioned in the conceptual map) influencing the experience of breast cancer, appeared to repeat after twenty fourth interview except spiritual coping and influence of social stigma. The twenty fifth interview has

\textsuperscript{12} Theoretical sampling : Kathy Charmaz in ‘Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis’ describes theoretical sampling as the process of data collection for generating theory whereby the researcher jointly collects, codes and analyze the data and decides what data to collect next and where to find them in order to develop theory as it emerges.

\textsuperscript{13} Principle of saturation: Ian Dey, in the article Grounded Theory, in ‘Qualitative Research Practice’ (Seal et al., 2004) describes Principle of saturation as pointers to bring the research to a successful conclusion. Data collection stops when categories reach theoretical saturation, that is when further data no longer prompts new distinctions or refinements to the emerging theory

\textsuperscript{14} Glaser and Strauss (1967), in ‘The Discovery of Grounded Theory’ mentioned the importance of theoretical sampling in a grounded theory approach to discover categories as well as their properties and to find out interrelationships into a theory.
resulted in the formation of another subcategory of ‘relying totally on spiritual faith’ under the category of spiritual coping (one of the internally oriented coping strategies). No other participant reported an experience of relying totally on spiritual faith even with eight additional interviews with different participants. Also no additional experience emerged under the category spiritual coping. So with the twenty fifth interview, the category spirituality found saturation. The influence of social stigma (which comes under the major category of intervening condition – ‘cultural tagging and binding’) finds a new subcategory called ‘bearing the tag of cancer patient” with the twenty seventh interview. No additional data emerged for any of the categories with the analysis of five more participants. All other categories attained saturation within the twenty fifth interview itself. These participants had undergone breast cancer treatment in five hospitals in three districts of Kerala namely, Ernakulam, Thrissur and Kottayam during 2008-2009.

3.15 Principle of Divergence

The adequate theoretical sample is judged on the basis of how widely and diversely the researcher chose the participants for saturating categories of the theory (Strauss, 1997). In order to include all possible experiences of breast cancer, I used the principle of divergence\textsuperscript{15} to select cases. For this I must be familiar with my participants to know their similarities and differences. I received official permission from the hospitals and thus I collected secondary data about the participants from their case files. Since I had field experience, I approached both surgical and medical Oncologists to get a brief description about each participant. I sat with the doctor during his outpatient consultation to identify and to get familiarized with the participants during their follow up. I selected those participants who satisfy the inclusion and exclusion criteria of the study. The doctor gave a detailed description about each participant, since he knew them personally and introduced me to the participants. That really helped to get an entry and build a meaningful rapport with the participants quickly. I then revealed the nature and purpose of my study and sought their permission for interview at their homes as per their convenience. Only one interview was conducted in a hospice since one participant was admitted there due to metastatic lung, skin and stomach cancer.

\textsuperscript{15} Principle of divergence refers to the selection of comparable and contrasting cases in the selection of samples for the theory to emerge.
3.15.1 *Rationale for divergence in this research*: Theoretical sampling procedure uses the principle of divergence to ensure the selection of participants who represent an entire range of experience (selecting cases within two extremes of experiences until it reaches a saturation point where there is no experience left out to select as a different case).

I could maintain principle of divergence using the following variables:

3.15.2 *Sample characteristics*

*Age*: I am interested in studying the body image experiences and sexuality concerns of women in the context of breast cancer. So I selected women within the age group of 30 to 45 years since the treatment results in medical menopause which has direct influence on sexuality. Before starting data collection I planned to include women within the age group of 25 to 40 years. But I could not find any participant who was married and completed two years of mastectomy life below 30 years of age. So I selected women within the age group of 30 to 45 years.

*Support from partner and family*: All the characteristics except support from family and the importance of children were obtained from the case files in hospitals or patient records. As I started analyzing the data after the first interview, there emerged different codes for family support (one of the intervening conditions). Once I came to know about the family dynamics of many participants I could collect data from participants whose family support range from great support to no support at all. The analysis of the participants who had good family support generated categories (for example: ‘post cancer desirability’) which contrasted with the categories (example, ‘solitary survivorship’) developed for the participants who had low or no support from family members. Thus I was able to include the categories with participant’s perceptions of full to no family support in their cancer experience till this divergence reached saturation. This enabled me to understand the experience of a woman when she is supported as well as neglected during her hardship with cancer experience. I therefore did not have to exclude any of the participants due to this criterion.

*Children*: I planned to include women with children during the initial phase of my data collection. It gives me an idea that they need to live for their children at any cost and were ready to take any sorts of treatment. This created a curiosity within me - do infertile women also have the same experience? So I interviewed women without children and I came to
understand that the presence of children plays an important role in the perception of diagnosis and recovery. So I included women with and without children.

**Economic background:** The economic background plays an important role in the cancer treatment. Costly medicines for chemotherapy can reduce the side effects of treatment to a great extent. The participants who could afford foreign costly medicines had comparatively less side effects than that of poor participants who could afford only local affordable medicine. The economic status of the participants is classified on the basis of the monthly income of their family as reported by them. Accordingly the participants are classified into low, middle and high income family on the basis of the Income Tax Slabs\(^{16}\) that were existing for the year 2008-2009. The income categories are as follows:

- \(< 12500 – low income family\)
- \(12500 – 25000 – middle income family\)
- \(> 25000 – high income family\)

**Religion:** To understand the effect of religious beliefs on cancer experience I included women from Hindu, Christian and Muslim religions. These are the predominant religious groups in Kerala. The state has a population of around 33 million, with 56 per cent following Hindu religion, 25 per cent Muslims and 19 per cent Christians. Followers of other religions are an invisible minority in Kerala\(^{17}\).

**Educational background:** The participants ranged from 7\(^{th}\) stand educational qualification to Post graduate level.

**Occupational status:** Both working and non-working (salaried and non-salaried) women are selected for this study. I also included a woman who is the only earning member of the family.

**Stage of Diagnosis:** It ranged from early stage (stage I) diagnosis to stage III diagnosis, with and without metastasis.

\(^{16}\) [http://financeminister.in/Modified+income+tax+slab](http://financeminister.in/Modified+income+tax+slab)

\(^{17}\) Cited from: [http://www.kerala.gov.in/index.php?option=com_content&view=article&id=2818&Itemid=2263](http://www.kerala.gov.in/index.php?option=com_content&view=article&id=2818&Itemid=2263), retrieved on 18/05/11
3.16 Principle of Saturation (Data Collection Procedure)

Once I gained familiarity with the study participants and after building a professional rapport with them in the hospital I sought their permission for the interview at their homes. I selected the first participant who is a housewife and has two children. This interview helped me understand her experience as a housewife and a mother in the context of breast cancer and breast loss. Then I interviewed another woman who is working and enjoying a very active social life. She also has two children. This threw more light on the body image experience of a woman in the context of her social life. These two episodes gave me an insight into the significance of the presence of children in their perception of cancer diagnosis and recovery. Thus I selected the third participant who had no children (she can never be a mother in her life) and she was 44 years of age. Childlessness provided another experience where she found no hope and no meaning to live further and this perception prevented her from early diagnosis even though she confidently assumed that she had breast cancer based on her symptoms. She delayed her diagnosis intentionally hoping to die without taking treatment. This necessitated me to select the experience of a childless woman who is young to explore the possibility of any difference in the experience. This gave me another experience of hope since she had hope and trust in her fertility and treatment that she would be a mother in her life though she had lost her one breast.

Thus keeping the principle of divergence in mind, I selected women with different experiences with the above mentioned sample characteristics. This procedure allowed the theory to germinate and grow by continuously moving backwards and forwards between ideas and data. Thus with theoretical sampling I could work with my participants who had comparable and contrasting experiences. Saturation of several categories occurred towards the end of the data collection and with the twenty seventh interview, all categories found saturation since no new data emerged from further interviews. In order to ensure that no experience was left out I conducted five more interviews but that did not result in new data.

3.17 Geographical Area

Patients from those hospitals that have a Department of Oncology in Ernakulam, Thrissur and Kottayam districts of Kerala were selected for the convenience of data collection. The participants also reside in these respective districts.
3.18 Time Dimension:

Those patients who underwent mastectomy during May 2008 to February 2009 in the oncology departments of the above mentioned hospitals. All participants must have completed two years of mastectomy life. The data collection process lasted for one year and two months with simultaneous data analysis.

3.19 Social Dimension:

The social concerns of the study include the perceptions of the body image experiences of the woman as a member of the society. The social construction of femininity is related to her experiences in body image disturbance due to breast loss. She has to live in the system to which she belongs during her diagnosis and treatment and after the treatment phase of her life. The study deals with her body image aspect of the disease in the context of breast loss. This in itself indicates the social aspect of the treatment. The stigma attached with the society towards cancer in general and especially breast cancer and breast removal is the social dimension of the study.

3.20 Economic Dimension:

The economic status of the participant has an influence on diagnosis and type of treatment. If she is economically well settled, she can opt for costly chemotherapy medicines which results in less physical side effects. Also if she can afford a breast reconstruction, it would reduce the psychological distress of mastectomy. If she is the only bread winner in her family, the economic burden will be another issue in her treatment and her future. It may double the problem.

3.21 Political Dimension:

This includes the decision making power or the stand of the woman in the diagnosis, treatment and her future life after treatment. It includes whether she is empowered and educated enough to reveal her doubt to her partner or significant others regarding a lump in her breast and the need for a proper diagnosis and treatment for the same. It also encompasses the choice of treatment. If the diagnosis is done in the first stage, then she can opt for breast conservation surgery which is comparatively more expensive than mastectomy. Her financial
independence and empowerment decides all these. It is determined largely by the degree of patriarchy of her family or the society in which she lives.

### 3.22 Psychological Dimension:

The psychological experience of losing a breast is complex. One may be wondering, whether the surgery will cure her cancer, how she will feel after surgery and about her appearance. The diagnosis of breast cancer and its treatment has a significant impact on the woman’s physical functioning, mental health and her social well-being (Pandey et al. 2005).

### 3.23 Research Settings

Five Hospitals with a Department of Oncology in three districts (Ernakulam, Thrissur and Kottayam) of Kerala were selected to get participants for the study. A brief description of the hospitals is given below.

- **Hospital A** is a super specialty hospital with international standards located at Kochi in Kerala, India.
- **Hospital B** is a multi-specialty Hospital located at Kottayam District.
- **Hospital C**, at Thrissur is a charitable institution aimed at treatment and management of Cancer in Central Kerala.
- **Hospital D**, at Ernakulam is a super-specialty hospital with 1050 beds with a reputed medical college, nursing college, nursing school, para medical courses, diploma programmes for doctors, super-specialty departments in almost all branches, modern investigative and therapeutic equipments and facilities and specialized social service departments.
- **Hospital E** is an 800-bed multi-specialty hospital in the town of Angamaly, Eranakulam District.
3.24 Method of Data Collection

The researcher used in-depth (unstructured open-ended) interviews and observation for data collection. The following description provides the rationale behind the selection of this particular method and how it helps in rich data collection.

According to Silverman (2006: 112-118), in-depth unstructured interview is the most widely used qualitative method of data collection since it generates emotionalist as well as constructivist knowledge by addressing the research concerns. Both the emotionalist and the constructionist view interview as experiencing subjects who actively construct their social world. It is concerned with the subject behind the person – the lived experience of the researched. Thus it provides authentic insight into the participant’s experience instead of positivist interviews which is based on random selection of respondents and administration of standardized questions with multiple choice answers which can be readily tabulated (Silverman 2006: 118). Through in-depth interviews both the researcher and the researched participate actively and engage in mutual construction of meaning. This research is aimed at generating knowledge of the above two kinds and hence in-depth interview was selected as the principal method of data collection.

From the literature review it was clear that majority of the studies were conducted with standardized scales and the personal experience of breast loss left least explored in detail (refer literature review chapter). The Quality of Life Questionnaire is highly culturally sensitive and also does not provide the actual lived experience of participants. Since this study aims to understand breast cancer experience from the perspective of women, the researcher requires the participants to speak from within rather than responding to readymade questions prepared prior to the interview. Breast cancers being a sensitive issue, the interviews were conducted at the participants’ home. It tried to explore the lived experience of breast cancer through retrospective personal in-depth interviews with women. The interviews explored the subjective meaning women attached to their breast cancer experience and helped me to understand the context. The researcher needed to build an effective rapport with the participant in order to elicit their inner feelings. It depended upon the quality of time the researcher spent with the participants and the professional skills of the researcher.
I would like to explain the advantage of using observation and in-depth interview in my research by quoting an incident with one of the participants. She was talking about her body image concerns as part of her treatment. When she talks about her hair, she started crying. She was crying in such a way that she found it difficult to talk. There was a long silence. In between she was telling “I …had…long…hair, thick hair…but…you know… I lost…I lost it forever”. Suddenly she went inside to her room and returned with her two photographs. They were the photographs that she took on the day before chemotherapy treatment began. She posed her long hair towards her front and smiled in one photograph. The other she took with her husband and daughter posing her hair towards the front. She started explaining how much she valued these photographs. She was not satisfied with her verbal explanation on her concern about hair loss as “I had long thick hair, but I lost it forever”. She felt that her verbal explanation could not bring out her lived experience of hair loss and hence she produced before me the photographs. She added “Nobody can understand my feelings. You know, how much I value these snaps, I loved my hair, but I lost it. I never ventilated my grief and concern on hair loss even with my husband and daughter. They cannot understand what I am actually suffering. ... they want me to be happy always that I am alive even after confronting a fatal disease. But nobody can understand me. I am not what I was before ...I really mean it. Nobody can understand what I am undergoing”. This particular incident highlights the significance of her hair, the meaning it has in her life which she could not verbalize and hence she showed pictures which helped her convey her feelings. The therapeutic nature of the in-depth interview provides a proper ambiance to explore the lived experience of hair loss. It was a catharsis and she felt relieved after that. She could ventilate her inner feelings and emotions with me that she could not share even with her significant others. This is due to the effectiveness of the rapport that I could build with her. I could win her confidence and through in-depth interview I could gather rich data by capturing such subjective experiences. In qualitative research, the person of the researcher has special importance. Researcher and her communicative competencies are the main instruments of collecting data (Flick 1998). I used various techniques such as probing, paraphrasing, and summarizing and more than that I was an active listener in the interviews.

Equally important to the verbal communication is the facial expressions of feelings and body language articulated by the participants. Non-participant observation was used along with in-depth interviews to supplement the spoken experience. Non-participant observation implies that the researcher not only ‘hears’ but also ‘sees’ the experience of the participants. It does
not require the researcher to be member of the participants social context rather I could observe their actions, body language and facial expressions in their own natural settings. Thus I could witness and understand how the women managed to cover their physical changes from others. Some displayed their concern by wearing a saree and asked me to notice the difference between two breasts. Some women wanted me to touch their mastectomized breast to feel the emptiness, while others showed their padded brassieres which they call ‘the most important equipment to go out’, for some others it was their artificial wig.

For one participant, information about sexual changes was elicited using a telephone interview. This was chosen as the participant preferred to talk over the phone than communicate her experiences in a face to face interview. This created a sense of trust and comfort as she not only knew the researcher, but also felt assured that this was a safe medium of communication. This also helped to control her embarrassment while addressing such intimate issues.

With the help of in-depth interviews, I could provide space for the participants to share their experiences and thus they directed the study based on their views, perceptions and emotions.

3.25 Interview Guide

The interview guide includes topics about pre-diagnosis, diagnosis, treatment and recovery phases. Though my next probes come from the current answer of the participants the interview guide really helped me to cover all possible aspects and not to omit any area of research interest.

3.26 Pilot study

The researcher conducted a pilot study with two participants and it gave her clarity on conceptual map. In both the cases, intra-personal as well as inter-personal factors contributed to the perception of one’s experience with breast cancer. The interview guide that was developed by the researcher covered all aspects of the experiences in the pilot study.

3.27 Data Collection Experience

Even though there was no written contract as informed consent, each participant cooperated meaningfully. None of the participants withdrew from the study once they were informed
about the purpose and nature of my study. Rather they all were quite enthusiastic and happy to reveal and share their experience for such a purpose. Many participants were of the opinion that, “if my experience would enrich your study, I am quite happy to share with you” There was no time limit in the interview and each participant took her own comfortable time. Each interview lasted for at least two to two and half hours and every woman was interviewed twice. Only four of them were interviewed for third time since the first two interviews with them did not elicit complete experience. There was no monetary remuneration provided to the participants. The data collection process lasted for one year and two months. The below mentioned chart will explain the process involved in the data collection.

3.28 Phases in data collection

Table 3.2 gives a detailed description of the different stages of data collection of the research.

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
</tr>
</thead>
</table>
| • Studying the case files of the participants in the hospital.  
• Identification of the research participants who satisfy the inclusion and exclusion criteria.  
• Discussion with the doctor about the participants who were selected to know about their background in detail. | • Sitting with the doctor in his OP sessions during the follow up of my participants to get acquainted with them through the doctor.  
• Getting familiar with them and making purposeful professional rapport with the help of doctor  
• Getting permission from the participants for the interview at their homes and getting clarification about the geographical location of their houses for accessing them | • In-depth interview with the participants and the real data collection experience.  
• Transcription and translation of interviews  
• Data analysis and data collection till the point of saturation.  
• Filling the gap in data through telephone interview since I could build and maintain effective rapport. |

TABLE 3.2

Phases in Data Collection
3.29 Data Analysis

Various steps in the data analysis process are the following:

3.29.1 Translation and Transcription

All the audio-recorded interviews were translated from Malayalam to English and then transcribed. This was done using a computer and further data were stored electronically. The entire process was done by the researcher in order to retain the essence and meaning of the original interview. I maintained field notes of the observations and other meaningful communications (the photographs showed by participants to express their concern, how women become more cautious to hide their head and body when an outsider happens to come, the facial expressions to show their physical discomforts such as pain) which could not be audio-taped.

These translated interviews were used to make case narratives and identified the emerging, codes, concepts and categories. These will be dealt in detail in the next chapter of this research. The initial phase of analysis that is (word-by-word and line-by-line) coding of the interview transcripts were done in computer with the use of ‘ATLAS.ti’\(^\text{18}\), scientific software. Apart from the initial coding, all analysis was done manually by the researcher using a computer.

3.29.2 Data Analysis Process: Data analysis commenced with data collection. Grounded theory method of data analysis by Strauss and Corbin (1990) was used by the researcher.

The steps in the analytic process are grouped into five stages which are outlined in Table 3.3. Though the stages in the table represent a linear process, the data analysis was a series of overlapping steps that were revisited at different points.

\(^{18}\) ATLAS.ti, Visual Qualitative Data analysis, Version: Win 5.0 (Build 60), Educational Single user license, 2003-2010 by Scientific Software Development, Berlin All rights reserved.
<table>
<thead>
<tr>
<th>Stages</th>
<th>Procedure</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Listening, translation and transcription of interviews</td>
<td>To create a data base for managing and analyzing data</td>
</tr>
<tr>
<td>2</td>
<td>Substantive coding (line-by-line, paragraph-by-paragraph) and developing theoretical notes.</td>
<td>Breaking the data to identify emerging codes</td>
</tr>
<tr>
<td>3</td>
<td>Compiling codes under similar heads and grouping similar codes into concepts and subcategories</td>
<td>Integration of codes and abstraction of data into concepts and categories</td>
</tr>
<tr>
<td>4</td>
<td>1. Constant comparison (compare and contrast) of codes and categories until saturation.</td>
<td>Discovering and building categories to capture ideas and document emerging categories or themes.</td>
</tr>
<tr>
<td></td>
<td>2. Memo writing on categories and identification of theoretical codes.</td>
<td>Conceptualizing the relationship between codes and categories for the development of field based grounded theory following the paradigm model (Strauss and Corbin 1990).</td>
</tr>
<tr>
<td>5</td>
<td>Mapping of categories and description of the story line.</td>
<td>Visual representation of the relationship of categories based on the core phenomenon and its relationships with other categories such as causal conditions, context and intervening conditions, strategies and consequences of the strategies.</td>
</tr>
</tbody>
</table>
Grounded theory provides procedures for developing categories of information (open coding), interconnecting or correlating the categories (axial coding), building a story line that connects the categories (selective coding) and ending with a discursive set of theoretical propositions (Strauss and Corbin 1990).

In the open coding phase, I analyzed the texts (transcripts, field notes of observations) for possible categories of information emerging from the text. The interview transcripts were read line-by-line and paragraph-by-paragraph and were coded. The coding was very detailed and time consuming, yet it enforced the researcher to open all possibilities in the data for a field based grounded theory. Line-by line and paragraph-by-paragraph coding are followed by focused coding where similar codes are clustered under common concepts and similar concepts were clubbed to form subcategories and categories. Thus reduced the number of codes derived from the analysis. This does not reduce the essence of the data rather it decided which initial codes make the most analytic sense to categorize the data that represents the process or action in the emerging grounded theory. The categories are composed of various subcategories called “properties” that represent multiple perspectives about the categories (Creswell 2007). Each category was saturated through constant comparative\(^{19}\) method to see that no new information or perspective can be added to the category to provide further insight. This process is followed by axial coding through which there established relationship between categories and subcategories by specifying the properties and dimensions of a category in the form of a story line.

For the purpose of convenience, I divided the analysis chapter into three main parts (with different sections) and each part clearly narrates their lived experience starting from the symptomatic illness to the current stage of their day to day living. Logical diagrams (Strauss and Corbin 1990) are provided in each section explaining the analytic thinking that shows the evolution of the logical relationships between categories, and their subcategories in terms of paradigm features.

\(^{19}\) Creswell in his book, *Qualitative Inquiry and Research Design: Choosing among five approaches* (2007: 64), mentioned that “data collection in grounded theory is a “zigzag” process: out to the field to gather information, into the office to analyze the data, back to the field to gather more information, into the office and so forth”. Thus data collection and analysis happens simultaneously to saturate categories through theoretical sampling. “This process of taking information from data collection and comparing it to emerging categories is called the constant comparison method of data collection in grounded theory”.

90
Accordingly in the axial coding process, the open coding categories are classified under causal conditions 20, central phenomenon 21, context 22, intervening conditions 23, strategies 24 and consequences 25 following the coding paradigm of Strauss and Corbin (1990). The template for coding grounded theory (Cresswell 2007: 171) in the study is given in the following Figure 3.2:

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**Figure 3.2**

**Template for Coding Grounded Theory**

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20 Causal conditions refer to the events or incidents that lead to the occurrence or development of a phenomenon.
21 The central idea, event, happening, about which a set of actions/interactions is directed at managing or handling, or to which the set is related (Strauss and Corbin 1990).
22 A context represents the specific set of properties that pertain to a phenomenon; that is, the location of events or incidents pertaining to a phenomenon along a dimensional range. It is also the particular set of conditions within which the action/interaction strategies are taken to manage, handle, carry out, and respond to a specific phenomenon (Strauss and Corbin 1990: 101).
23 Intervening conditions are broad general conditions either facilitating or constraining the choice of strategies taken by the participants (Cresswell 2007; Strauss and Corbin 1990).
24 Action or interaction carried out by the participants is directed at managing, handling, carrying out, responding to a phenomenon as it exists in contexts or under a specific set of perceived conditions. It is processual, evolving in nature, purposeful or goal oriented and can be either a failure or a success.
25 Outcome of the strategies undertaken by the participants; it can be intentional or unintentional.
3.30 Ethical Considerations:

3.30.1 Informed consent: Obtaining informed consent from research participants is central to ethical research practice. There was no written consent but oral contract. The purpose, nature and aim of the study were explained to each participant. It also assured that their participation is voluntary and the participants had the right to withdraw at any stage of the study if they feel uncomfortable. The risks of participating in the study was explained to the participants; they include giving ample time ‘to talk’ for collection of data which might hinder their personal work or rest. The benefits of participating in the study were also elucidated; they include, the therapeutic nature of the interview where they can share their innermost concerns with the researcher, their contribution to knowledge generation and theory building and thus an intervention package.

3.30.2 Confidentiality: The information given by the participants will be ensured anonymity and confidentiality. The data will not be used for any other purpose other than research. Breast cancer being a sensitive issue, the researcher ensured participants that the data will be destroyed once the research is over and the names and the addresses of the participants will not be used anywhere even in the thesis. The names of the participants are disguised in this manuscript.

3.30.3 Role of researcher: The researcher did not undertake any social work intervention with the participants. Though the purpose of the interview was to elicit information on breast cancer experience, three participants found it difficult to control their emotions. They experienced the interview as a chance to ventilate their problems. Since the interviews were conducted at their homes they felt comfortable in expressing their pent-up emotions. They enquired about counselling service and expressed the need of professional assistance in dealing with their problems. Instead of providing a direct intervention, I referred them to a colleague, who is a counselor for providing psychological support.

3.31 My Personal Experience as a Researcher:

I started going to hospitals in three districts of Kerala, in the month of May 2010. I was granted permission from five hospitals and I went through the files of the patients who had undergone mastectomy in the year 2008 – 2009. From these files I identified the participants who satisfied the inclusion and exclusion criteria of the study. After identifying my participants, I conducted a personal meeting with the medical as well as the surgical
Oncologists to get acquainted with the participants. All the patients need to come to the hospital once in three months for follow up till they complete five years of mastectomy. I took three months to identify and get familiarized with the participants. I interviewed my first participant in the month of August 2010 and the process went on till I reach saturation. The qualitative orientation and the theoretical sampling enabled me to gather rich data from the field. I translated and transcribed the first interview. The coding process began with a line-by-line coding and focused coding. The first analysis itself produced more than three hundred codes. But when the data collection and analysis proceeded I could group similar codes under common heads and identify categories. Since the data collection and analysis happened together, the gaps in the collected data could be identified easily and that enabled me to go back to the participants to fill in the gaps. Though the process was time consuming, I could enjoy doing it and I am satisfied that I could do justice to my research by providing rich data from the field reality. I took one year and two months to finish data collection and analysis process.

3.32 Conclusion

This chapter attempts to provide the reader the context of the research concerns, objectives, research questions and reasons for selecting qualitative approach and grounded theory methodology. The research paradigm along with ontological, epistemological and methodological assumptions of the study clarifies the philosophical orientation and the standpoint of the researcher. I have explained the principle of divergence and saturation which serve the basis of data collection, analysis and thus the field based grounded theory evolved from this study. Descriptions and template for grounded theory analysis have provided adequate detail for support the process of analysis which will be dealt with in the subsequent chapters.