

Breast cancer diagnosis: biographical disruption, emotional experiences and strategic management in Thai women with breast cancer

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Abstract In this article we draw on Bury's theory of biographical disruption to discuss the meanings of, and emotional experiences related to, being diagnosed with breast cancer among southern Thai women. Qualitative methods, including in-depth interviewing and drawing methods, were used to collect data from 20 women with breast cancer. The women perceived breast cancer to be a *rhok raai*; an evil or dread disease. They believed that breast cancer would lead to death. The disruption in their biography occurred when they detected abnormalities indicating breast cancer. The women's narratives revealed their chaotic lives upon this diagnosis and the news precipitated in them shock, fear, anxiety and loss of hope. Although they experienced chaos and disruption, the women cultivated strategies that helped them cope with their experiences by accepting their fate and adhering to Buddhist beliefs and practices. Through their narratives of biographical disruption, the women in our study offer healthcare providers knowledge that could lead to an appreciation of their needs and concerns. This knowledge is crucial for health professionals who wish to provide emotional support to women who have been diagnosed with breast cancer in Thailand and elsewhere.

Keywords: Thai women, breast cancer, biographical disruption, emotional experience, religious beliefs/practices, fate, hope, qualitative research

Introduction

Breast cancer is the most commonly occurring cancer among women throughout the globe (World Health Organization 2011). There has been a significant increase in the incidence of breast cancer in developing countries such as those in Asia (English *et al.* 2008, World Health Organization 2011). Women with breast cancer are affected both physically and psychologically. Breast cancer is an 'emotionally debilitating disease' that impacts on the lives of women of all ages (Banning *et al.* 2010: 307). It has been shown that women who are diagnosed with breast cancer are liable to much emotional debility, including anxiety, fear of dying and depression, and negative and suicidal thoughts (Al-Azri *et al.* 2009, Ching *et al.* 2012, Sprung *et al.* 2011).

Breast cancer is a leading cause of death in Thai women, and each year in Thailand approximately 190,000 women are diagnosed with the disease. Breast cancer has become a common

health issue among Thai women in rural areas (National Cancer Institute, Ministry of Public Health 2009, Phatthalung Provincial Health Office 2013). However, little is known about the experience of breast cancer among Thai women living in southern Thailand, particularly their emotional experiences upon the diagnosis of breast cancer and how they deal with it. In this article we aim to contribute to sociological knowledge by discussing the meanings of breast cancer and the emotional burdens among women with breast cancer in southern Thailand.

In writing about chronic illness, Bury (1991: 451) contends that sociologists not only need to recognise the problems or burdens that individuals have with their illness but also the positive actions that people take to deal with their health situation. Thus, we also examine in this article the strategic management (Bury 1991) that these women used to cope with their diagnosis of breast cancer.

Breast cancer diagnosis and biographical disruption

We situate our article in the notion of the biographical disruption of illness theorised by Bury (1982, 1991, 2001) and extended by Williams (2000). Based on Giddens's (1979) notion of a 'critical situation', Bury (1982: 169) sees illness as a 'major kind of disruptive experience'. Chronic illness, in particular, is 'precisely the kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted' (p. 169). Being diagnosed with a serious illness, such as breast cancer, can bring disorder to a woman's life (Bury 2001, Williams 2000). Inevitably, her sense of self-identity, daily life and quality of life are interrupted in many ways (France *et al.* 2013).

Bury (1982: 169, 1991) suggests that as a chronic illness unfolds, three disruptive events take place. First, the taken-for-granted assumptions about self, about the world and one's behaviour are disrupted. Bury refers to this as 'the breaching of commonsense boundaries' (p. 169). Often individuals would question what was going on with their lives. This stage requires paying 'attention to the bodily stages not usually brought into consciousness and decisions about seeking help' (p. 169). Second, the disruption necessitates 'a fundamental re-thinking of the person's biography and self-concept' (p. 169). This is when individuals ask 'why me?' (Williams 2000: 43). Third, disruption usually leads to the use of practical responses, and this involves 'the mobilisation of resources' (Williams 2000: 43). These resources may be physical, social, temporal, financial, medical or cultural (Williams 2000: 43). They are accessible to individuals in time of hardship. It is here, Bury (1991) contends, that individuals bring the meaning of illness and the setting in which it occurs into focus in their biographical disruption.

Within the interpretive sociology of chronic illness, Bury (1991) suggests that we need to pay more attention to the actions that individuals actively seek out to counter the impact of their illnesses. Bury proposes 'style' and 'strategy' or 'strategic management' as the means that individuals draw upon to minimise the impact of their illnesses. Style, according to Bury (1991: 462), signifies the way that individuals present and respond to salient characteristics of their illness. Style 'brings into focus variations in symbolic meanings, and social practices within different segments of the cultural order' (p. 462).

Generally, strategy represents 'the actions people take, or *what people do* in the face of illness' (Bury 1991: 461, original emphasis). In chronic illness, Bury suggests, that strategy signifies 'the actions taken to mobilise resources' (p. 462) in order to 'maintain a sense of hope for the future' (Williams, 2000: 44). Bury also refers to 'the range of resources' that individuals draw on in their adaptations in order to enhance their wellbeing, including medical resources. It is here that we wish to extend Bury's theory to include the culturally based

resources that the women in our study actively drew on in the strategic management of their biographically disrupted experiences of breast cancer diagnosis. In doing so, we bring together two areas of scholarship that have hitherto remained distinct: Bury's concept of biographical disruption and studies of religious practice among people with cancer.

We show in this article that the women who experienced disruption in their lives when they were diagnosed with breast cancer drew on medical resources to deal with the immediate threat of breast cancer. However, they also responded to these disruptions by adhering to a culturally based style and strategy (Bury1982) that helped them to cope with the diagnosis of breast cancer as best they could. They drew on Thai cultural and religious beliefs as their style and strategic management to mitigate biographical disruption and enhance adaptation (Bury 1991: 463). Our findings offer new understandings about how religious beliefs and practices are adopted as a source of meaning and emotional support in the context of these women's illness. These religious beliefs and practices have not been well understood in the area of breast cancer in general and in the Thai context in particular.

Methodology

We adopted a qualitative approach in this study since it allows us to learn about individuals' lives, stories and experiences (Bryman 2012, Liamputtong 2013). Qualitative researchers accept that, in order to understand people's experiences, we must attempt to understand the meanings and interpretations that they give to their experiences. This methodology is most appropriate when the researcher has little knowledge of the participants and their worldviews, and when the researcher wishes to work with marginalised and vulnerable individuals (Liamputtong 2007).

The research was situated in a feminist framework. In the feminist methodology, women and their concerns are the focus of investigations. One intention of feminist research is to undertake research that is beneficial to women. The ultimate aim is to 'capture women's lived experiences in a respectful manner that legitimates women's voices as sources of knowledge' (Campbell and Wasco 2000: 783). Feminist research calls for qualitative inquiry that is less structured and more flexible than that used in the positivist sciences. It allows researchers to look deeply into the experiences of people by giving them a voice and allowing them to express themselves (Grbich 2013).

The study involved 20 Thai women in southern Thailand. The study criteria included Thai women who had been diagnosed with breast cancer and had commenced or completed breast cancer treatments. A purposive sampling method was used to select key informants who met the study criteria and could provide rich data relevant to the purpose of our study. The number of participants was determined by a theoretical sampling technique which required recruiting to stop when little new data emerged (Liamputtong 2013, Padgett 2012). The characteristics of the women are as follows. A total of 11 women were less than 59 years old and nine women were over 60. All were Buddhist. Two were divorced, one was widowed and 17 women were married. Most of the women had only primary school education (12), six had finished secondary school education and two had higher education. Most women (13) were self-employed; mostly selling goods in the market or in shops. Two women were farmers and two government employees. Three women performed home duties. All women had to stop working during their treatment and most could not perform any heavy duties afterwards. All the women were mothers. In terms of income, 13 women had a family income of less than 20,000 baht (about £396) per month. Five had an income of between 20,000 and 29,000 baht. Two women had a family income of more than 30,000 baht. Most women (13) were diagnosed with a stage 1 breast cancer, two with stage 2, three with stage 3 and two with stage 4. In all, 13 women had

a family history of cancer but not breast cancer. All the women had a lateral mastectomy (10 on the left side and 10 on the right side). All women had access to treatment in their locality, including surgery, chemotherapy and radiation therapy (see Table 1).

Recruitment of participants was firstly carried out through our personal networks as members of Thai communities in southern Thailand. We initially contacted healthcare providers at

Table 1 *Participants' characteristics (N = 20)*

<i>Characteristics</i>	<i>Number</i>	<i>Percentage</i>
Age		
0–49	5	25
50–59	6	30
60–69	3	15
70–79	6	30
Religion		
Buddhist	20	100
Education level		
Primary school	12	60
Secondary school	6	30
Bachelor's degree	1	5
Master's degree	1	5
Marital status		
Married	17	85
Divorced	2	10
Widowed	1	5
Occupation		
Housewife	3	15
Self-employed	13	65
Farmer	2	10
Government employee	2	10
Monthly income (Thai baht)		
<10000	4	20
10000–19999	8	40
20000–29000	5	25
> 30000	3	15
Stage of breast cancer		
1	13	65
2	2	10
3	3	15
4	2	10
Period since diagnosis (year)		
1–5	8	40
6–10	6	30
>11	6	30
Family history		
Yes	13	65
No	7	35
Position of breast cancer		
Right	10	50
Left	10	50

primary health centres, where many women sought care after being hospitalised. A snowball sampling technique was also adopted to expand the number of participants (Bryman 2012, Liamputtong, 2013). Snowball sampling requires researchers to select a few initial research participants and ask them if they know others who meet the criteria for participating and who might be interested doing so. This technique is employed extensively in sensitive research with groups whose members are difficult to locate or may be unwilling to take part without reference to others in their own network (Liamputtong 2007).

We contacted the women by telephone to arrange interview appointments at their convenience. All the interviews were conducted by the authors (female, university lecturers) in the Thai language to preserve the subtlety of, and any hidden meaning in the participants' statements as much as possible (Liamputtong 2010). Both researchers have conducted research with Thai women in our previous projects. The women were asked several open-ended questions about the trajectory of their breast cancer. However, to obtain the data that we include in this article, the following questions were used to prompt the conversation and drawings:

1. When did you learn about your breast cancer?
2. What does breast cancer mean to you?
3. How did you feel when you were told that you have got breast cancer?
4. How did you deal with the diagnosis of breast cancer?

All interviews took place at the women's homes and at times that were convenient for them. Each interview took about one and a half hours and was audio-recorded for data analysis.

In this study we also used an innovative method involving drawing. Drawings show 'how people see the world in both its simplicities and its complexities' (Guillemin 2004: 275). The drawing method is a form of visual imagery which is beginning to be widely used with vulnerable people and for sensitive topics (Guillemin 2004, Liamputtong 2007). According to Guillemin (2004: 272), the drawing methodology provides 'a rich and insightful research method to explore how people make sense of their world'. It is, therefore, suitable for conducting research with vulnerable people (including women living with breast cancer). It is contended that vulnerable people tend to have difficulty expressing their emotions about, and understanding of, phenomena in conversations or in writing. Drawing may better assist them to express their feelings and tell others about the meaning of their illness and their condition. This method is often used to complement other methods, such as conducting in-depth interviews, to obtain insights into and an understanding of the participant's world (Guillemin 2004). In our study we found that many women felt it was easier to reveal their experiences with breast cancer by using pictures than by using words alone.

In our research, the drawing method was employed during in-depth interviews. All participants were given a packet of 48 coloured pens and blank flip-chart paper for the drawing session. The participants were invited to draw their images of the meanings and experiences of breast cancer. When they finished drawing, we asked each to describe the image drawn. The descriptions were audio-recorded for data analysis.

Prior to the commencement of the study, ethical approval was obtained from the research ethics committees of Thaksin University and La Trobe University. Before making appointments for interviews, the participants' consent to participate in the study was sought. After explaining the study, the length of the interviews and the scope of questions, the participants were asked to sign a consent form. Each participant was given 200 Thai baht (approximately £4.00) as compensation for their time in taking part in the study. This incentive was necessary for such sensitive research, because it is a way of showing that the participants in the research are respected because of their knowledge and the time they gave.

The in-depth data were analysed using thematic analysis (Braun and Clarke 2006). This method of data analysis aims to identify, analyse and report patterns or themes in the data. Initially, we performed open coding, when the codes were first developed and named. Axial coding was then applied to develop the final themes arising from the data. This was done by organising the codes that we had developed from the data during open coding in new ways. Connections between categories and sub-categories were established. This resulted in themes, and these were used to explain the lived experiences of the participants. The themes that emerged are presented in the findings section. In presenting women's verbatim responses, we used pseudonyms to preserve confidentiality.

Findings

In the sections below the meaning and impact of the breast cancer diagnosis and how the women attempted to deal with it are presented and discussed.

Mareng dtao nohm means death: the meaning of breast cancer

Breast cancer was commonly referred to as *mareng dtao nohm* (cancer of the breast). Thus, the terminology the women employed for breast cancer was emotionally chaotic and embraced an immense level of threat to health (Drageset *et al.* 2011). The women perceived breast cancer as a *rhok raai* (an evil or dread disease). They believed that breast cancer would lead to death or shorten their lives (Lopez-Class *et al.* 2011). Sinjai (47-years old, stage 1 breast cancer) told us that:

The first thing that came to my mind was that I would die soon; that I would not live very long. Whenever there is a funeral at the temple, I always hear that the person died of breast cancer. There have been a few deaths lately and this makes me think that cancer is *rhok raai*, as it has destroyed so many lives.

Kaewta (55-years old, stage 1 breast cancer) shared a similar perception of breast cancer in her drawing (Figure 1):

I think of death. I will definitely die. I am drawing a temple with a triangular shape on the top. This is a symbol of death. I have a monk as well. I am thinking of a temple. I am going to die. I have to be alone. It is so sad.



Figure 1 *Thinking of death*

Chaos and despair: reactions to the diagnosis of breast cancer

The women first learnt about their breast cancer by themselves. The obvious signs of their biographical disruption emerged when they feel a lump in their breast by chance, for example, when having a shower. When this happened they felt anxious and stressed, and sought health-care advice as soon as they could (Bury 1982, 1991). Significantly, the diagnosis of breast cancer had a profound impact on the women. This impact was a trauma, a psychologically distressing event that individuals experience in confronting extreme adversities in life. Trauma often involves a sense of intense fear, despair and loss of hope (Bisson 2007).

All the women in our study expressed multiple emotional reactions to being diagnosed with breast cancer. Because women associated breast cancer with death and dying, and despite having access to medical care, they imagined that their lives would never get better. Their narratives reveal chaos that would lead to despair and loss of hope (Bury 1982 1991, Frank 1995). Sinjai (47-years old, stage 1 breast cancer) told us that she had no hope left on being diagnosed with breast cancer:

I saw my doctor about the diagnosis. He said that I had *mareng* [cancer], I fell to the ground straight away. I felt like I was fainting. Two nurses had to come to help me and told me to be strong. I felt *sin wang* [a loss of hope].

Alcharee (74-years old, stage 1 breast cancer) talked about feeling despair when she was told that she had breast cancer:

I sat and cried. My husband came in and said that it would be healed as many people survive breast cancer. I went into my room and stayed for hours as I believed I would die. *Rhok mareng* has no chance of cure. I felt that I would not be able to get better but die. I could not eat anything for weeks after being diagnosed.

Their feelings of despair were so strong that the women wanted to die upon hearing the words breast cancer from the nurse who conveyed the message from the doctor about their illness:

When the nurse told me, I wanted to die in front of her. It was a very bad feeling, so sad. My tears suddenly fell. I was crying all day and all night. I didn't know if I would survive. I felt



Figure 2 *Feeling lost and frightened*

like I had no energy to walk . . . no energy in the body . . . I could not raise my arms and legs . . . I just cried and cried. I was very sad. (Sangchan, 66-years old, stage 1 breast cancer)

Sangchan's drawing of her feelings is shown in Figure 2. She drew a picture of a nice flower and her face. She explained that the flower symbolised a beautiful life but she was feeling lost and frightened.

Women describe their fear of breast cancer:

When the doctor told me that it was *neuua raai* [dangerous/evil tissue], I was so frightened that I forgot everything. I left my handbag, my patient's card and everything on the doctor's table. I did not expect to hear that I had breast cancer at all. The nurse had to call me telling me to go back to fetch my stuff After I got home, I could not eat anything for 3 days and only slept and cried . . . I had no *gam laang jaai* [emotional strength] left in me. (Jitpat, 42-years old, stage 1 breast cancer)

Some women recalled being paralysed by the shock they felt on hearing the term breast cancer spoken by their doctor:

I became paralysed because my brain stopped working. It could not take anything in and I did not know anything afterwards. I just sat there. My eyes were wandering. The doctor kept saying things and I could only nod or shake my head. I could not *tham jaai* [accept it] when the doctor told me about my condition. I then had to walk out of the doctor's office, but the doctor called me back in. (Pimjai, 56, stage 1 breast cancer)

The feeling of hopelessness was also common. Chinda (53-years old, stage 1 breast cancer) had two episodes of breast cancer. She told us about her feelings when she had the first operation to remove one breast:

The doctor said I have got *neuua raai* [a tumour] in my breast. At first, I did not think too much about it but when I left the hospital I felt so helpless. I started to cry. The nurse walked me to the front of the hospital and I was crying. People asked me who had died; I said no one died but I kept crying all the way out of the hospital.

Feeling hopeless led to suicidal thoughts by some women. Chinda had two operations to remove the cancer cells from both breasts. When a carcinoma was discovered in the second breast, she wanted to commit suicide:

With the second diagnosis, I thought of committing suicide by hanging from my neck or using a gun. I was feeling so hopeless. I had already had one breast removed but why did it affect the other breast? The doctor told me after the first operation that there was no trace of the bad cells of breast cancer in me. I thought it would not come back, but it did.

It is essential to point out that most women did not expect that breast cancer would affect them, even those who had the history of cancer in their families. Their narratives revealed their adverse emotional reactions when being diagnosed with breast cancer because it was sudden and unexpected news to them (Al-Azri *et al.* 2009, Drageset *et al.* 2011, Montazeri 2008, Shaha *et al.* 2008). It is not surprising to witness the shock these women experienced:



Figure 3 *Feeling despair*

It was unbelievable, you know . . . I didn't think this could happen in my life. When I knew I had breast cancer, I was shocked . . . I could not walk, could not hear anything, could not sleep or even eat. It was like my legs were cut off completely. I wanted to be alone . . . I only thought I would die soon. I have no hope of surviving. (Sinjai, 47-years old, stage 1 breast cancer)

Sinjai described her feelings of despair and loss through a drawing in which she was crying (Figure 3). In it she showed how sad and lost she felt.

Strategic management: dealing with the diagnosis of breast cancer

Despite the chaos and despair they experienced on diagnosis, the women cultivated some strategies (Bury, 1982, 1991) that helped them to cope with their diagnosis. Many of the women focused on promoting their emotional wellbeing by acknowledging their fate and following religious beliefs and practices.

Accepting fate: emotional strength

Most Thais believe in fate. When they experience illnesses they are likely to accept them as their fate (Liamputtong *et al.* 2012, Ross *et al.* 2007). Belief in fate is based on the assumption that an individual's fortune and misfortune are determined by the combination of their *gam boon* and *baap* (merit and demerit). This is known in the literature as the concept of karma. One meets one's fate as a result of one's actions in the past. There is nothing one can do against fate. It is one's *cha dtaa gam* (destiny) to meet fate. Although breast cancer was a frightening experience to the women, most women accepted their fate. This is a style (Bury 1991: 462) that the women in our study used as their adaptation to their diagnosis. They believed that if they had been destined to live with breast cancer, the illness would happen to them:

I did not feel too frightened when the doctor said that I had breast cancer. I could *tham jaai* [accept it] as I think that if I was intended to have breast cancer then I would have breast cancer. If I don't get better, then I will die. If I think about it, then I will be too stressed about my life. I tell myself to keep to my own *cha data gam* [fate] and not think too much about it.
(Manee, 67-years old, stage 1 breast cancer)

Some women accepted living with with breast cancer because they had already lived much of their lives. If they were destined to die from it, this would not be too difficult to accept:

I could *tham jaai daai* [accept it]. Otherwise, it would be too difficult to deal with. I am now 70-years old and have already lived more than half of my life. I did not think too much about it. (Penpan, 70-years old, stage 1 breast cancer)

For some women who had lived through other kinds of adversity, although breast cancer caused great chaos and feelings of despair, the difficulties they had already helped them to deal with breast cancer better. Although it can be suggested that these women saw their biographical disruption resulting from the diagnosis of breast cancer as reinforcing the disruptions they had already experienced (Williams, 2000: 52), they also saw it as part of their fate, that they had to accept and live through:

I have experienced too many difficulties in my life and I have lived through this breast cancer. Whatever happens to me, I will live through it. I am not too upset about it. (Soraya, 75-years old, stage 3 breast cancer)

Among these women, accepting fate is inextricably linked to their Buddhist beliefs. In Thai culture, Buddhist beliefs play an important part in dealing with suffering of all kinds, and for the women in our study it was their emotional suffering. Buddhism pervades the whole of Thai life, and has had a deep influence on the Thai mode of thinking and behaving (Mulder 1985, Pornsripongsa *et al.* 2014). The basic idea of Buddhism is the belief that life is suffering. Suffering deals with the problems of life which are conditioned by birth, old age, sickness and death, since all things in this world are subject to change and decay and therefore do not last (Falk 2010, Paonil 2003, Pornsripongsa *et al.* 2014, Ross *et al.* 2007). According to Buddhism, sickness is a natural phenomenon (Paonil 2003, Pornsripongsa *et al.* 2014). The women in our study believed that their disease was part of the life cycle in the Buddhist way: *geert gaae jep dtaai* (birth, old age, sickness and death). One must accept this cycle:

I think that, as a human being, once we have been born, one day we will die. So we have to *taam jaai* [accept] this. Whatever we have, one day it will end. This is my belief. I think illness like mine is common. It does not only occur to me. We all have to go through *geert gaae jep dtaai*. One day it will be our turn; we will become sick and die. (Rasri, 76-years old, stage 4 breast cancer)

Religion as emotional support

Their religion gave many women moral support throughout the process of living with breast cancer. Although their religion could not cure their breast cancer, it provided these women with emotional support. The women observed many Buddhist practices in their everyday life to minimise the impact of the diagnosis. Practising meditation and praying to the Lord Buddha and well-known monks were other means used to deal with the chaos and despair they experienced on being diagnosed with breast cancer. Meditation and prayer were perceived as strategies that could optimise the way they coped with living with illness and trying to follow a peaceful life (Ariyabuddhiphongs 2009, Paonil 2003, Ross *et al.* 2007). Religious observations became daily routine practices for these women:

Nang samaathi [do meditation] makes me sabai jai [content] ... with everything ... *Nang samaathi* and *suaat mon* [chanting/reciting Buddhist texts], without doubt helped me a lot. We are Buddhist, we can bring the Buddhist principles into practice. They could also stop



Figure 4 *Meditation practice*

the spread of the disease. I pray to the Buddha to help me and wish for my good health.
(Sinjai, 47-years old, stage 1 breast cancer)

Thaya (52-years old, stage 1 breast cancer) agreed:

Meditations can relieve my worries a lot. I do this every day as it helps to reduce some fears and I may live longer, I think. Practising Buddhist meditations makes me *sabaai jaai* [relieved] and often it can reduce suffering. Figure 4 shows Thaya's drawing of meditation practice.



Figure 5 *Almsgiving*

Alms-giving (providing food to Buddhist monks) was another common strategic practice among the women. This is a common practice that most Thai people follow in their daily lives (Ariyabuddhiphongs 2009, Falk 2010). All participants believed that the act of alms giving would provide them with great merit. In Thai culture, merit (referred to as *boon*) and merit-making (*tham boon*) are perceived to be good deeds that lead to a better life, and less suffering in life (Falk 2010, Ross *et al.* 2007). The women believed that merit-making would make them strong, give them strength to fight their disease, and stop their breast cancer from developing further to advanced stages. Barnyen (44-years old, stage 4 breast cancer) told us: 'I give alms every day. I feel good when doing this because I can gain merit. Merit will help me live longer, I believe'. Barnyen also drew an image to explain her way of promoting health (Figure 5).

While drawing the picture Barnyen elaborated:

I go to the temple regularly, especially on the important religious days, to *tham boon* [make merit]. I believe that if I continue to do good things, good things will return to me. I feel that I have strength when doing it. So I hope this way may help me to live longer, too.

Discussion

Being diagnosed with breast cancer was a traumatic experience for many women (Drageset *et al.* 2011). The diagnosis of breast cancer generated a number of emotional responses such as chaos, despair, anxiety, fear and hopelessness (France *et al.* 2013). This makes women with breast cancer 'emotionally vulnerable' (Elmir *et al.* 2010: 2532).

Armstrong and Morris (2010) contend that cancer has been considered as an evil and an invincible predator that can destroy lives. Thus, breast cancer is often perceived as equivalent to death (Lopez-Class *et al.* 2011). This can be clearly seen in how the women in our study constructed the meaning of breast cancer. A diagnosis of breast cancer can trigger thoughts of death and dying in the patient (Avis *et al.* 2004). The women in our study also thought of death and dying on being diagnosed with breast cancer because they believed that they would die soon. Thus, it is not surprising that breast cancer was truly a dreaded disease.

The women's narratives showed that their lives were disrupted when they learnt about their breast cancer (Bury, 1982, 1991). This disruption occurred when they became aware of the signs and symptoms of the disease. This was the beginning of the 'chaotic state' in their lives (Ching *et al.* 2012: 252); they started to realise that their lives would be disrupted in significant ways (Bury 1982, 1991, France *et al.* 2013, Williams 2000). The diagnosis of breast cancer created further emotional burdens among the women. Often, the news of their breast cancer was sudden and precipitated shock, fear, anxiety, disbelief and loss of hope. It was a particularly stressful time for them (Elmir *et al.* 2010: 2532).

In their research with individuals with a spinal cord injury, Smith and Sparkes (2005) found that when individuals have lost hope, then believe that their lives are effectively over. Freeman (2003: 81) calls this 'narrative identity foreclosure'. Smith and Sparkes (2005: 1102) suggest that these individuals feel that they are unable to 'move creatively into the future'. However, this experience was relatively absent among the women in our study. Although they experienced loss of hope when they were diagnosed with breast cancer, most of the women cultivated strategies that helped them to cope with their illness (Bury 1982, 1991). We have demonstrated in the article that their strategies included accepting their fate and following Buddhist beliefs and practices. According to Wyke *et al.* (2013), responses to illness are com-

plex and multiple. Although the women felt despair and lost hope at the beginning, most gradually came to accept their condition, and some found ways of coping more quickly than others.

Religious beliefs and practices act as a buffer against misfortune and as a means to cope with adversities in life, including illness (Belding *et al.* 2010, Koenig *et al.* 2012). Religious faith has also been shown to enhance the 'social and functional well-being' of individuals living with breast cancer (Lopez-Class *et al.* 2011: 725). In their research with Lebanese women, Doumit *et al.* (2007) suggest that belief in God was an essential strategy for coping with the diagnosis of breast cancer. In the same way, African American women with breast cancer relied on religious support as their principal coping mechanism (Davey *et al.* 2012).

Among Thai people, Buddhism provides a semantic and spiritual framework for making sense of stressful life events and illnesses, and for managing them in times of difficulty (Falk 2010, Lundberg and Rattanasuwan 2007, Ross *et al.* 2007). In our study, religious beliefs and practices played a significant role in women's attempts to cope with breast cancer. They utilised Buddhist teachings about the cycle of life to move towards understanding and acceptance of the diagnosis of a dreaded disease. They practised meditation to free their minds from morbid preoccupations with the increased risk of early death, and followed traditional practices of 'making merit' to improve personal karma and the hope that their life might become better in the future (Ross *et al.* 2007).

We wish to point out that a significant number of southern Thai women are Muslim. Just as religious support was helpful to the Buddhist women, it may also help those from other faiths, such as women from an Islamic background. However, as our article did not include Muslim women we are not in a position to confirm this.

Conclusion and implications for health care

Women who were diagnosed with breast cancer viewed breast cancer as a traumatic loss of personal identity. This signifies the need for healthcare providers to provide emotional support to these women. While experiencing chaos and despair, the women in this study looked for strategies whereby they could manage their emotional experiences and deal with the diagnosis of their breast cancer better. Many women relied on their emotional strength and adapted their religious beliefs and practices to deal with their health condition. We argue that it is essential that healthcare providers should have a better understanding about women's needs and concerns. This could ensure that culturally appropriate health care is provided to Thai women living with breast cancer in southern Thailand and women elsewhere.

Specifically, it is crucial that healthcare providers understand the emotional experiences of women with breast cancer and their particular needs and concerns following their diagnosis (Drageset *et al.* 2011). From a feminist standpoint, we suggest that healthcare providers need to respond to the individual embodied experiences and needs of women with breast cancer (Elmir *et al.* 2010). Our findings also suggest there is a need to provide psychosocial counselling and support to these women (Mehnert and Koch 2007). Healthcare providers are in a very good position to assist women to deal with a negative life event like living with breast cancer (Drageset *et al.* 2011).

Methodologically, narratives of biographical disruption of illness provide a means for understanding how individuals experience illness (Bury, 1982, 1991, 2001, Frank 1995, Williams 2000). Narratives enrich an understanding of illness which may lead to good relationships between healthcare providers and women with breast cancer (Thomas-MacLean 2004).

Through illness narratives, the women in our study offer healthcare providers knowledge that could lead to an appreciation of their needs and concerns. This knowledge is crucial for health professionals who wish to provide emotional support to women who have been diagnosed with breast cancer (Landmark *et al.* 2002). This knowledge could also be used as evidence for the need for developing emotional support interventions for women with breast cancer.

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