

“I do not Allow Myself to be Harmed, it is a Luxury; I have two Children who Need Me”: Remarks for Planning an Experiential Research Methodology in Women who have Undergone Mastectomy due to Breast Cancer

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Abstract

Breast cancer is a severe disease, which in combination with mastectomy poses particular psychosocial problems. After mastectomy, once the threat to life has been dealt with, intense psychosocial processes are caused to the woman who is trying to come in terms with the new body image, creating a new concept for themselves and their social identity, as women, mothers and companions. The woman's breast is connected with sexuality as well as motherhood and thus, mastectomy problematizes the very foundations of female identity. The goal of this research is to prove, through biographical interview, the lived experience of breast cancer utilizing the meaning of biographical disruption. This paper presents critical remarks for a qualitative research, in order to record with reliability the way women rearrange their life, reconstructing their identity after mastectomy. We suggest the use of narrative method, combined with a research planning based on Grounded theory and the meaning of “biographical disruption”.

Keywords: breast cancer, grounded theory, biographical disruption

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Introduction²

Cancer is a severe disease, which inflicts a large portion of the population. The severity of the consequences on the quality of life and the immediate life threat, is directly connected with the social and psychological level through representations and phobias. Apart from being a severe biological problem, cancer is closely linked with the way that we socially approach this disease which “stigmatizes” the patient or offer help, especially psychosocial. Beyond the biological issues and the side-effects following, cancer is also linked in a direct way with psychosocial needs which surpass the help offered by the scientific medicine. A noteworthy element, which should be further, researched and accentuated, is the dimension of lived experience of the disease. Such an experience encompasses the way in which patients handle the transition from health to disease and the opposite, and structure their daily life as well as their interpersonal relationships. Cancer, especially breast cancer and mastectomy, total or simple (tumor removal) cause severe upsetting to multiple levels. The surgical intervention modifies the body while it creates multiple side-effects to the way the individual female particularity is formed, as well as social identity. The appearance of breast cancer leads to the surgical “trauma” of the breast, its total removal or partial due to tumor removal; the breast is an organ linked biologically and symbolically with female identity, with reference to motherhood as well as sexuality.

The female breast, especially for the modern western societies, has been identified with the essence of sexuality (we can simply consider that breast augmentation and lift operations are a particularly widespread form of plastic surgery (Alexias et al., 2012)). Simultaneously, once it is a necessary means for the nutrition of the infant, it constitutes a substantial element of motherhood. Cancer and the consequent mastectomy are therefore “problematizing” two basic elements of constitution and structuring of female social roles thus contributing to a particular life situation in which the woman who “struggles” for her life, has to identify with and make compromises with her new self (Weisman & Worden, 1976; Landmark & Wahl, 2002).

At this point, it is obvious that the reliable recording and “in-depth” understanding of the lived experience of cancer and the way to adjust to this new life situation after mastectomy is gaining particular attention (Lerner, 2001; Lauver et al., 1995; Facione & Facione, 2006; Radley & Bell 2007). In

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this context, one of the objectives of the paper is to record a highly suggested methodology for conducting qualitative research, using biographical interviews, in order to accentuate and help understand the lived-experience dimension of breast cancer and mastectomy. The analysis of biographical interviews is suggested, based on: a) the Grounded Theory from the methodological point of view, and b) the analysis of biographical disruption concerning the basic theoretic guidelines.

The Grounded Theory has been particularly developed in the decade of 1960, especially by Strauss, Glaser and Corbin (Glaser & Strauss, 1971; Glazer, 1992; Strauss & Corbin, 1996, 1997). Grounded theory is a systematic methodology in the development of theory, which is based on data collection and analysis in a systematic method. It is one of the most popular suggestions for organizing a qualitative research (Kaufmann, 1996; Wainwright, 1997; Creswell, 1998; Coffey & Atkinson, 1996; Silverman, 1998; Travers, 2001; Savvakis & Tzanakis, 2004). This method refers to the gradual "building of a theory" in the field of qualitative research, once it requires the interconnection between the data collection and data analysis (for many social researchers the discrimination between "qualitative" and "quantitative" methods is only a matter of degree). The theory is not forced a priori on the data, it is not predefined and fixed, but it starts developing in comparison and combination with the data. Nevertheless, this process does not take place in a theoretical vacuum. It is integrated in planning the methodology, which requires a reference group and a generic methodological question, which guides the sampling. Moreover, the abovementioned guidelines require a clear, or at least flexible, theoretical orientation, a central question which is guided by a fundamental theoretical perspective.³

³ Grounded theory includes a number of systematic inferential guidelines, for the collection and analysis of data, aiming at the creation of a middle range theory, which will explain the data. The research is usually focusing on what people do and at several levels of meaning concerning their actions. These levels could include: (a) the explanations given by the participants for their actions, (b) their non-declared assumptions about them, (c) their intentions that led them to be involved in such actions and (d) the consequences of these actions on later acting and their interpersonal relationships. The coding procedure consists of three phases; the Open Coding, the Axial Coding and the Selective Coding. In constructing of a category, the beginning entails description and property explanation, definition of the circumstances under which the category takes place, is maintained and changed, description of the consequences and accentuation of the relation between the particular category and the rest (Glaser & Strauss, 1971; Glazer, 1992, Strauss & Corbin, 1996, 1997).

Thus, in our research, the basic analysis categories, as will be presented later on, have been developed in the above framework of Grounded Theory and will serve the understanding of the narrative interviews of sufferers from breast cancer and undergone mastectomy, in the context of biographical disruption and an attempt to redefine their social identity as women.

Exploring broken lives

Some life events, such as the death of a familiar person, the medical confirmation of a severe or chronic disease, the definitive or long-lasting relocation to a different country, a divorce, the sudden disruption of a promising career and several other, similar to a certain extent, violent events seem to lead to a virtually mandatory rearrangement of the personal goals into new areas for action. In all the cases, where the individual is forced to interpret an objective event as a “cut in time” and disruptive to his personal history, which in turns leads the person to a series of radical redefinitions of the “world of familiarity”, we can speak about biographical disruption

(Bury, 1982, 1986, 1991, 1997, Anderson & Bury, 1988, Williams, 2001, Brown & Harris, 1989, Carricaburu & Pierret, 1995, Crawford, 1994, Hyden, 1997, Kelly & Field, 1996, Kleinman, 1980, 1994, 1995; Turner, 1992, Williams et al., 2000).

We can define “biographical disruption” as an objective event, which is registered in the biographical path of an individual and is experienced subjectively as a “cut” in biographical time, while it is connected with the disruption of the structures of everyday life, the withdrawal of all the expected elements and the relativity of the available resources of social knowledge. The biographical disruption is virtually never a static and one-track event, but it can take multiple, differentiated subjective meanings. Additionally it is not a sole event, yet it is composed by a series of events, which gain a subjective feeling of comprehensiveness for the individual, marking a crucial marker in the history of life and a means of comparison and general assessment of the whole biography.

It seems that most of the times biographical disruption as well as its recognition by the individual himself, lead to fundamental contradictions at the level of constitution of subjectivity. The person is forced to recur constantly to two discrete and partially contradictory areas of constitution of subjectivity, that is to two different horizons of interpretation of the personal story (Gadamer, 1975). The diagnosis of the disease and its institutional management are elements that lead the individual to an essential for himself distinction of the lived experiences, to a biographical “before” and “after” and

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to an almost forced split of the biographical time. (Corbin & Strauss, 1987; Glaser & Strauss, 1968). The individual, in each narration of the personal story, is forced to rehabilitate this biographical disruption, to handle in a narrative context the “unusual”, “unexpected” as well as “devastating” situation (Brown & Harris 1989; Hazzard, 2000; Helgeson et al., 2007; Kayser & Sormanti, 2002).

The presentation of a consistent narrative story presupposes to take into consideration the whole personal story, that is the biography as a regulatory framework. Additionally, the narration of the personal story includes in its own structure the attempt to present of a positive self-image. In cases of narrators that carry experiences which caused a biographical disruption, such in the case of women with breast cancer, this complete and internally consistent story gets questioned, resembling this way high-risk situations (Radley, 1999; Radley, 2002; Wilkins, 1993).

The narration “snags” constantly on the event of the diagnosis and the evolution of the disease provoking this way a contradictory speech. The multiple, as well as radically different, horizons of constitution of subjectivity lead to multiple scopes, which often interfere with the consistency of the narrative and lead to contradictions. The presentation of “self” is founded on antithetical dualisms like “before-after”, “here-there”, “in-out”, “top-bottom” and “good-bad”, narrative artifacts, like concealment, deliberate/oriented argument, emphasis and retrospective interpretation of life. The changes on the level of constitution of subjectivity are reflected on the narrative practices which reveal the struggle of the individual to bridge the gap and assure the consistency and stability of his identity (Savvakis & Tzanakis, 2006).

In all cases, the biographical method is a fruitful research technique in order for these narrative practices to be illustrated, recorded and become the conceptual means to understand historical forms of experiencing equivalent stressful events, such as breast cancer.

Biography, self and narration

The biographical narrative plays a decisive role in interpreting the past, especially in cases of biographical disruption. It is thus, a highly recommended tool to understand the way breast cancer and the consequent therapeutic interventions lead to a re-organization of the horizons of life. The biographical approach is a form of a free and open, yet not entirely impulsive and unstructured, discussion and has been established as one of the most accepted techniques of qualitative research in social science. In this technique, the narrator is prompted by the researcher to narrate a period of his life or

usually his life entirely. The narrator restructures actions or events, which happened in the past, from a starting point in the present. In biographical interview, the narratives hold a major part but other techniques such as descriptions, evaluations, theories, justifications are also included; these techniques are frequently especially revealing and refer to the way the narrator interprets (Bertaux & Kohli, 1984; Angrosino, 1989; Denzin, 1989; Penneff, 1990; Stanley, 1993; Evans, 1993; Atkinson, 1998; Chamberlayne et al., 2000; Hollway & Jefferson, 2000; Ferraroti, 2003).

Usually, the particular research technique is constituted by three phases:

- a) The first narrative phase. This is the basic narrative part of the interview during which, once the narrator accepts to take part in the process, he starts in a more or less extensive narration which reaches a point or a situation of his current phase of life. The researcher, has to follow attentively, in an encouraging manner and unabated interest
- b) The second narrative phase. In this phase, the researcher invites the narrator to cover and explain the gaps and queries concerning the narration of the previous phase and to clarify unclear events and imprecisions, asking questions which bring about new narrations.
- c) The phase of open questions. In the end of the interview the researcher asks all kind of questions and asks for assessments, evaluations and views of the narrator on all the matters of interest checking if all the issues concerning the research have been covered.

Grounded theory and biographical method can find common places in two points: (a) concerning sampling, i.e. the choice of narrators and (b) concerning the manner of conducting the interview especially of the last two narrative phases where the interviewers' intervention is stronger. Particularly in the second phase, the recognition of the narrative gaps from the interviewer, the silence and the emphasis, as well as the questions which are established in order to cover the abovementioned gaps, are largely based on the analysis of the narratives that preceded; either from the same person (in case of consecutive interviews) or other informants. Grounded theory and Biographical method are more immediately linked in the third phase of the narratives, which is guided by the questions of the interviewers. The third narrative phase of a biographical interview takes place on the basis of flexible interview guidelines which are modified during the process of research once new questions arise.

In our research, whose presentation follows, we used the above technique once the formulation of the basic questions demanded the immersion of the researcher in the subjective narration of the ideas,

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experiences and reactions of each individual. Such a technique accentuated the means that were put into use for the restructuring of the narration and the practical organization in reacting against the biographical disruption caused by the occurrence of breast cancer. The fundamental question remained unchanged during the research in order to secure the comparability of the narratives. Nevertheless, additional questions and the interviewers' communication manner were modified according to the progress of the analysis of the preceding narratives.⁴

The purpose of the research was to record life stories of married women suffering from cancer so as to understand the means of dealing with the particular disease and to shed light on the functions/fields which are affected by the disease as well as observe the general biographical trajectory of each participant. The research was based on biographical interviews, in a sample of 14 women diagnosed with breast cancer and having undergone mastectomy, aged 45 to 55 years old, who participated in self-help processes giving and receiving voluntarily psychological and moral support. The research took place in Attica, mainly in Athens, Greece, during 2004-2009. The purpose of the research was from the beginning, the understanding of the way breast cancer and mastectomy affect their way in life, their biographical trajectory.

The research followed the basic principles of theoretical sampling, oriented to the concept of biographical disruption. The criteria of sample selection were the following:

- a) Mastectomy (radical or simple) as part of a therapeutic intervention for breast cancer.
- b) The intercession of a reasonable period of time after the completion of therapeutic interventions, meaning mastectomy, chemotherapy and potentially radiotherapy, without metastasis.
- c) The participation in self-help groups, of exchanging moral and psychological voluntary support in people suffering from the same disease.
- d) Marriage or the existence of children.

⁴ The initial question was the following: "We are interested in known the way that these women encounter breast cancer and understand the consequences that this disease brings about in their lives. For this reason we would like to hear you tell the story of your life, from the time you were born up until today". The questions of the third phase were focused on the special interests of the research meaning the recording of "changes" in the field of everyday life and their evaluation from the interviewees - narrators themselves.

- e) The age being on decade before or after 50 years old.
- f) The low or middle social class.

The purpose was to record the restructuring of life which is “forced upon” by the occurrence of the disease, especially concerning sexuality and motherhood. The lack of metastasis allows the anew planning of the future while the presence of a life-threatening disease, on the verge of the productive age, forces a radical reflective thinking about the body, the self and the values of life. The common cultural background (individuals of low or middle socioeconomic class, living in the city) was deemed necessary in order to accentuate the common elements of the narrative restructuring of the experience of the disease.

An important criterion in selecting the sample was the intercession of a reasonable period of time between the surgical intervention of mastectomy and the participation in self-help groups, receiving and giving moral as well as psychological support. Before they were in position to participate in voluntary groups of support for individuals suffering from breast cancer, these women followed an educational course of a relative organization. This way, the women who participated in the research have experienced the painful experience of the disease and therapy and also have experience in participating in groups of psychosocial support making them able to reflect on their experience with cancer having been given all the potential chances to restructure anew their life. We wanted to study how biographical disruption is restructured narratively and the means to record it in this particular context (Katakis, 1989; Hamel, 1993). Following the principles of grounded theory, we sought after the analysis to take place gradually and each new interview happening after the previous ones had already been transcribed and analysed.

Consequently, the process was constituted of three phases. The first was the pilot phase which concerned contacts with professionals in anti-cancer hospitals and associations of women with breast cancer in Athens, where we recorded using semi-structured interviews, their assessments for the basic parameters of handling and psychologically supporting patients during therapy. Additionally, in the same places we performed “in vivo” observation in order to perceive the basic parameters in the relationship of women suffering from cancer and professionals. The initial stage of the research aimed at the familiarization of the researchers with the object of study and its particularities, especially in the level of formulating relationships and recording the psychological status and needs of women suffering from breast cancer.

These interviews were dynamic, and every information stemming from the interview was constituting a new context of performing the next one, offering deep knowledge of the object of study. The purpose of the interviews

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was for the researchers to gain “in vivo” knowledge of the phenomenon which was only known to them through covering the necessary bibliographic references. Using these interviews, the theoretical concepts were operationalised and gained their experiential dimension.

Simultaneously, because of the fact that the interviews took place in the hospital, usually at the waiting room before the patients would undergo radiation therapies, we used the method of participant observation detecting behaviors, reactions and emotions of both the patients and the staff. These observations were systematically recorded after the end of the visit in a diary where together with the event that had impressed us, we would also refer to the suitable theoretical context or connect which could explain the particular behavior.

During the second phase, we contacted an Association of Women suffering from Breast Cancer aiming at conducting interviews with women who participated in the Association while offering voluntary help to other patients as we had already defined in our sample. Firstly, we interviewed the psychologist of the Association using the technique of semi-structured interview in order to record the “specialist’s” opinion on the psychology of these women. Afterwards, the psychologist was used as a key person with a view to encouraging the participation of these volunteers in the research process once there was established already a trusting relationship between these women and the psychologist. At this point it is worth noting that the particular group of patients, as referred in the bibliographic references, is unwilling to participate in any research and publicize the lived experience of the disease. Consequently, the “specialist” was used as an intermediate to secure the access to this group which had deep firsthand experience of the psychological status of the women with breast cancer.

When a volunteer consented to have a discussion with us, we arranged an appointment for the interview, and since we informed her about the subject of the research, the confidentiality of her personal data and the procedure for carrying out the discussion, we would start the process of recording the biographical-narrative interview in order to explore the volunteers’ self-concept regarding to breast cancer and its effect on her life. All the interviews were conducted deliberately at the Association and not at the hospitals.⁵ The environment at the Association is not connected with therapeutic interventions and negative experiences while at the same time carries the feeling of supporting the other. After the procedure of each

⁵ The duration of the interviews lasted between 45 and 75 minutes. In some cases that was considered necessary, we contacted again the narrators to clarify important elements of the interview.

interview was completed, it followed its transcription, the composition of the biographical trajectory and finally its analysis, which included, in the following order, description, abstraction and thematic analysis in order to conduct conclusions.

During the third phase, after the categories of analysis which framed the basic theoretical orientation towards the concept of biographical disruption were formed, eight additional biographical interviews were conducted. The conduction of these interviews was completed only after we did not get any new feedback regarding to the questions we had set and the categories that emerged and formed (theoretical saturation).

Ethical issues

This study followed the standards for the conduct of good qualitative research as described by Elliot et al (Elliot et al., 1999). In this study triangulation, an attempt to increase reliability and validity of qualitative results was pursued by using the three researchers involved in this study to analyse the data separately in order to ensure that the identified themes were in accordance with the interview material. In qualitative research it is also important to consider ways to achieve stability and credibility of the data in order to increase its trustworthiness, for this reason the text was read multiple times to achieve stability (Weber, 1990; Krippendorff, 2004) and discussed by the two researchers to strengthen its credibility (Weber, 1990; Graneheim and Lundman, 2004). The analyzed data was compared and jointed together in order to derive a final table of themes.

The first ethical issue that we faced is in relation to the turmoil caused by the research procedure to the life and psychological state of women suffering from breast cancer. To encounter this sensitive issue, we chose for our sample women that take an active part in self-help groups, therefore they were willing to talk about their lived experience. Also, by using the biographical method, narrators were able to choose the content of their narration, that is to refer only to facts that they wanted and ignore whatever troubled them. For the second ethical issue, regarding to the publication of the narrators' names, we chose to maintain anonymity during the process of the interviews. At any case, after our assurance that all ethical rules will be followed accordingly, it was asked from the narrators to give their informed consent on the recording and analysis of the interviews. Their consent was recorded as well before starting the interview.

Analysis process of the narrations

The conduct and analysis process of each interview included the following steps:

- a) Recording. After we confirmed the participants' consent to conceal any data that would reveal their identity, we used a digital recorder in order to achieve an accurate recording of their narration. It's worth mentioning that during the interview, the researchers were keeping notes about the participants' reactions to the questions or any other reaction (e.g. physical) could be worth noting.
- b) Questions – Interventions. During the interview, the researchers, when necessary - mainly during the second and the third phase of the interview, as described above- intervened by making clarifying questions.
- c) Transcription. After the interview was completed, the recorded data was transcribed and coded.
- d) Biographical trajectory. After the transcription of the interview, the biographical trajectory of each narrator was recorded which consists of the objective data of her biography (Bertaux, 1997; Riemann & Schutze 1991; Humprey, 1993).

Narrative recording of the biographical disruption

Breast cancer is a potentially fatal disease which is connected with various collective representations (Henriksen & Hansen, 2009). Breast cancer which requires total or simple mastectomy, induces additional problems since it affects the organ which is connected with femininity, not only from the viewpoint of maternity but also of sexuality (Lam & Fielding, 2003; Spiegel, 1999). Therefore, this fact induces important identity issues to women who undergo mastectomy since they are forced to create a new kind of somatization (Csordas, 1994). The absence or even the partial amputation of breast creates questions regarding to the constitution of their social identity, leading to a new self perception. As the analysis of the cases that were recorded through biographical-narrative interviews showed, breast cancer has indeed the following effects on the biographical course of the sufferer:

- a) Biographical disruption, threat of the feminine identity and its confrontation.
- b) Renegotiation of the relationship with self.
- c) Redefinition of values and priorities, in a reflective context of self interpretation.

- d) Renegotiation of relationships with others.
- e) Mobilization and active participation in volunteering.

The basic idea of grounded theory approach is to read (and re-read) a textual database (such as a corpus of biographical narrations) and “discover” or label variables (called categories, concepts and properties) and their interrelationships. The ability to perceive variables and relationships is termed "theoretical sensitivity" and is affected by a number of things including one's reading of the literature and one's use of techniques designed to enhance sensitivity. What we would like to propose, as our basic methodological suggestion, is how this general methodology could be based on the concept of biographical disruption, which is used as a basic framework for the theoretical sensitivity, in order to investigate deeply the lived experience of breast cancer, through the narrative reconstruction. The issue is to connect the essential points of the grounded theory with the central hypothesis that breast cancer causes biographical disruption, which is recorded in a narrative way.

It has been argued that the way by which the situations of biographical disruption are illustrated is based on typical narrative patterns, which primarily relate to (Savvakis & Tzanakis, 2006):

- a) Dualisms, mainly chronological and local: the separation of biographical time, that is the biographical disruption and the emergence of multiple and at the same time contradictory horizons of constitution of self can be detected in dualisms like “then-now”, “before-after”, “here-there”, which intervene significantly in the biographical narration and evince at least two central viewpoints of self interpretation (“before I was..”, “after the cancer everything has changed....”, “at the hospital I understood that...” etc.).
- b) Emphasis: a biographical disruption is a permanent bet during the process of narration. The narration of its creation leads to iterative references at the crucial moment of the disruption, since the presentation of the self, during the interview, forces to repetitive reflection of the crucial and decisive “event”, the presupposition to understand the current situation, the permanent reminder that “before this” everything used to be different.
- c) Concealing: In other cases, the stressful life events which threaten the united self-image and hinder the attempts of recognition, the imperative of a positive identity, lead to obstinate concealing. The permanent concealing of decisive as well as distressful events or life periods (mastectomy, sexual problems, stigma, loss of employment

etc.) suggest an active element at the narration of similarly lived experiences.

- d) "Hysteron Proteron" narration: Often, since the concealing seems to be impossible judging from the structure of the narration, the individual follows a particular narrative practice of reversing the chronological or the "rational" course of the narration. When the narration leads the narrator to a key point, which seems to quash the attempts of the individual to recognise a positive self-image, he chooses to interrupt the narration course by using a "parenthesis". The parenthesis includes arguments, excuses or data and information, with which the narrator aims to an a priori interpretation of the distressful or negative for the self-image narration that is following (e.g. "when I entered the operating room... but first I should tell you that a few years before...").

Analyzing the recorded narratives of the individuals that have these experiences focusing on the morphological particularities of the narration, we are able to record and analyse the particular contents of the disruption, the means of self-defence and through these, the general social practices that the individuals develop in order to deal with the disease and the biographical disruption.

Our sample is not just cancer patients but individuals who are considered to have survived, hence it is more likely that they adopt a positive attitude (they are the ones that made it). Additionally, they attend psychotherapy and moral support groups as well as self help groups. Therefore, we can assume that they have developed a specific "equipment for self" which tends towards:

- a) The reconciliation with the disease
- b) The attitude that you have to talk about it; "not to sweep what hurts you under the rag"
- c) The focus on the positive sides of this distressful experience.

Additionally, through this "attitude", which is illustrated at corresponding narrative practices, appear the following social practices:

- a) Through volunteering, the disease transforms to an experience filled with mobilization and assistance.
- b) Breast absence becomes the means which contributes to the constitution of a new identity positively defined.
- c) The disease leads to individualization, reflection and eventually to a new self representation.

Our basic suggestion is that we should not only record the typical narrative practices as referred above (dualisms, emphasis, concealing and "hysteron proteron" narration), but also to investigate the forms they take, what sense they make, the representation of the disease that use, which identity strategies they serve (Serdedakis & Tsiolis, 2000; Rose, 2007). Our aim through biographical-narrative interview is not to achieve an objective biographical reconstruction. That would be unrealistic since during a biographical interview, memory, context, ideologies, research question and in general the "quality" of the relationship between narrator and researcher always function like a canvas on which the life course is illustrated and the "important" points of the personal story are chosen (Riessman, 1993; Serdedakis et al., 2003). Only if we consider the historical analysis of the narration as central methodological choice, emphasizing at the same time on comprehending the strategies of the narrator, we can comprehend the individual's attempt to present and at the same time defend himself, most of the times without being completely aware of it.

Therefore, in case the narrator uses dualisms we should not just record it but also explore the contradistinction. In our case the narrators contrasted their previous "bad" self, who "had no limits", "got nervous for no reason" and pursued "wrong objectives", to their new self who follows a healthy way of life, avoids habits like smoking or drinking and in addition cares to keep a safe distance from the others and maintain a new identity free of "pointless stress" and "shallowness of everyday life".

In our case, "emphasis" on the disease, which is illustrated at the biographical narrations, is based upon the reproduction of a psychological idiolect (set of boundaries, stress control etc.). Emphasis seems to be a result not only of the dramatic effects of the disease but also of the "psychologization" and the ideology of a fragile self that accrues from psychotherapy and the participation in self help groups. Thus, it is demonstrated in this case that the interventions coming from professionals play a significant role in identity management of the seriously ill patients (Morgan & Thomas, 2009).

The narrative practice of concealing takes also a particular form in our case. What is concealed most of the times, or at least is degraded, is the grief and despair that accompany the diagnosis and treatment as well as the fear of death. And this is due to the fact that these patients are considered to have survived, according to statistical prediction models, and in this exact way the patients themselves perceive their situation despite the standard preventive examinations they undergo regularly. It is what the current situation allows to exile, to relegate.

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One thing to note is the relatively degraded role of the preposterous narration in the biographical narrations of our sample. This narrative practice, which often derives from stigmatization, appears not only because these women “have made it” so there is no need to justify the biographical disruption, but also because they have “worked on” the relationship with the disease and they have talked about it over and over again. It is the kind of story as well as the involvement which takes place in groups that set aside this typical narrative practice (self help, psychological, emotional support groups and assistance to other sufferers groups).

Conclusion

This combination of grounded theory and biographical method as well as this way of treating the recorded narratives, led us to our basic conclusion regarding the narratives of the women of our sample. The disease leads to a compulsory individualization which de facto imposes reflection. The sufferers, after they had undergone the experience of their disease which is threatening directly their life, in an attempt to organize their defence means against cancer and create a sense of continuity with their life before, revise their relationships with others, what they describe as “their attitude towards life”, assessing social conditions from the point of view of the individual that “realizes that each moment is valuable” due to the short and not guaranteed nature of life. At the same time, they reconstruct their past assuming that their previous behaviour contributed to the occurrence of cancer (Alexias, 2008). The most important is that in order to restore a sense of biographical continuity they even attribute to the disease positive meanings.

The reflection, the psychological support and the ideology that accrues from the self help groups lead to the recognition of a necessity of what is referred as *self work* (Fischer-Rosenthal 2000; Little et al., 2002; Radley, 2009; Tzanakis, 2014). The self is regarded as malleable and is perceived by using moral and psychological terms based upon a normativity that aims to its protection and health. This self representation affects decisively the way the sufferers narrate their life story which is based on a reproduction of psychological idiolect that resembles what Giddens calls reflective self as a central characteristic of the late modernity (Giddens, 1991).

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