CARING PROCESS OF THAI WOMEN WITH BREAST CANCER RECEIVING CHEMOTHERAPY

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CARING PROCESS OF THAI WOMEN WITH BREAST CANCER RECEIVING CHEMOTHERAPY

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ABSTRACT

The purpose of this study was to explore the caring process of Thai women with cancer receiving chemotherapy and to explain the factors that influence this process. The research setting was the regional hospital in the lower northern part of Thailand and women's homes. The grounded theory methodology was used in the study. Data was collected from in-depth interviews of thirty women with breast cancer receiving chemotherapy, a member from each family of nineteen patients, and one nurse and one doctor providing care for these women. The women's physical examination, chart review, and observation were also used. Constant comparative analysis was used.

This study generated an evolving theory of the caring process of Thai woman with breast cancer receiving chemotherapy. It was composed of three phases. The first phase was the emerging of the caring process. This phase involved *a situation-induced need for care* and *emergence of care agents and ways of caring*. The second phase involved a *shift from care agents to non-professionals in family based-care*. The action in this phase is composed of *adjusting the quality of care for the loved one* and *deviance from the right ways of caring*. The last phase was a consequence of the shifting of care in the second phase. The care has *good outcomes* and *poor outcomes*. These outcomes were not only physical, but also psychological, consisting in the women's willpower to care for themselves, and what is here called *family strength*, the group strength draw into the women.

The factors that affected this phase are constraint on caring, promotion of care, and change in the setting of care.

Suggestions of this study: the care agents in the family should play a supplementing role. The health care system must be well planned to prepare the women and family. A continuing care system should be developed to help women and their family in the prevention, management, and alleviation of the suffering from chemotherapy. Finally, family felt happy taking the care agent's role and the women patients felt comfort and had desire to care for themselves.

KEY WORDS : CARING/BREAST CANCER/CHEMOTHERAPY/
GROUNDED THEORY/FEMINISM

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กระบวนการดูแลในผู้หญิงไทยที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด (CARING PROCESS OF THAI WOMEN WITH BREAST CANCER RECEIVING CHEMOTHERAPY)

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บทคัดย่อ

การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อค้นหากระบวนการดูแล และอธิบายปัจจัยที่มีอิทธิพลต่อกระบวนการดูแลในผู้หญิงไทยที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด สถานที่ศึกษาคือโรงพยาบาลศูนย์แห่งหนึ่งในเขตภาคเหนือตอนล่างและที่บ้านของผู้หญิงที่ป่วยเป็นมะเร็งเต้านม ระเบียบวิธีวิจัยใช้การวิจัยเชิงคุณภาพแบบการสร้างทฤษฎีจากข้อมูลพื้นฐาน โดยใช้ข้อมูลจากการสัมภาษณ์แบบเจาะลึกผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด 30 คน ครอบครัวที่เป็นผู้ดูแล 19 คน พยาบาลและแพทย์ที่ทำหน้าที่โดยตรงในการให้บริการแก่ผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัดอย่างละ 1 คน ร่วมกับข้อมูลที่ได้จากการตรวจร่างกาย การศึกษารายงานการเจ็บป่วยของผู้หญิง และบันทึกการสังเกต วิเคราะห์ข้อมูลโดยใช้การวิเคราะห์แบบการเปรียบเทียบข้อมูล

ผลการศึกษาพบว่า กระบวนการดูแลของผู้หญิงไทยที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด แบ่งเป็นสามระยะ ระยะแรกเป็นระยะการเกิดขึ้นของกระบวนการดูแล ประกอบด้วย การมีสถานการณ์ที่ทำให้เกิดความต้องการการดูแล การเกิดขึ้นของผู้ทำหน้าที่ดูแลและวิถีการดูแล ระยะที่สอง เป็นการเบี่ยงเบนของผู้ทำหน้าที่ดูแลไปสู่การดูแลภายในครอบครัวที่ไม่ใช่การดูแลเชิงวิชาชีพ ในระยะนี้ครอบครัวจะมีการปรับคุณภาพของการดูแลเพื่อคนที่ตนรัก และมีการเบี่ยงเบนของวิถีการดูแลไปจากสิ่งที่ถูกต้อง และระยะสุดท้ายเป็นผลที่เกิดขึ้นจากการเบี่ยงเบนของผู้ทำหน้าที่ดูแลในระยะที่สอง ประกอบด้วย ผลของการดูแลที่ดี และผลของการดูแลที่ไม่ดี โดยจะพบว่า มีความหลากหลายของผลที่เกิดขึ้นในด้านความสุขสบายด้านร่างกาย ความสุขสบายด้านจิตใจ การมีพลังอำนาจของผู้หญิงในการดูแลตนเอง และการมีความเข้มแข็งของครอบครัว โดยมีปัจจัยที่ส่งผลต่อกระบวนการดูแล คือ การมีข้อขัดข้องของการดูแล และการส่งเสริมการดูแล ร่วมกับมีการเคลื่อนย้ายของสถานที่ในการ ดูแล

การศึกษาครั้งนี้มีข้อเสนอแนะว่า ผู้ดูแลภายในครอบครัวควรเป็นการเข้ามาเสริมในการทำหน้าที่ดูแล โดยบุคลากรสุขภาพต้องเตรียมผู้หญิงและครอบครัวเป็นอย่างดี และควรมีการพัฒนาระบบการดูแลอย่างต่อเนื่องเพื่อที่จะช่วยเหลือครอบครัวและผู้หญิงในการที่จะป้องกันปัญหาที่เกิดขึ้น สามารถจัดการกับปัญหา และบรรเทาความทุกข์ทรมานที่เกิดจากผลของการรักษาด้วยเคมีบำบัด ซึ่งในที่สุดจะทำให้ทำให้ครอบครัวมีความสุขในการทำหน้าที่เป็นผู้ดูแล และผู้หญิงมีความรู้สึกความสุขสบายและมีความปรารถนาที่จะดูแลตนเอง

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CHAPTER I
INTRODUCTION

Background and significance of the study

Breast cancer is a life threatening illness in women's life. It is the most common cancer and leading cause of cancer deaths in women throughout the world (Crane-Okada, 2001:13). It is second ranked in the incidence of cancer in Thai women, with cervical cancer being first (Phosuwan, 2002:413). The morbidity rate in Thai women is increasing from 14.6: 100,000 population in 1995 to 16.3: 100,000 population in 2001 (National Committee in Protection and Controlling of Cancer, 1999; Maipang, 2001:31). Moreover, the data from the Bureau of Health Policy and Plan, Ministry of Public Health, Thailand (1998:36) indicated that the incidence rates of hospitalizations in the northern part of Thailand had the highest rate at 23.17: 100,000 population.

The detection of breast cancer in the first stage cannot be considered early because the smallest of detectable cancers are about 1-centimeter diameter, have a mass one gram, and consist of about one billion cells (Lehne, Moore, Cosby & Hamilton, 1998: 1011). Therefore, women with breast cancer usually come to the hospital at least in the second stage of the illness. Especially in Thailand, eighty percent of women have a progressive stage of breast cancer at the time of diagnosis (National Committee in Protection and Controlling of Cancer, 1999), thus most of them required adjuvant chemotherapy after surgery (Anderson & Doyle-Mirzadeh, 1994: 434).

The systematic treatment with chemotherapy is a treatment starting within the first month after mastectomy. These procedures take a long time. It starts with at operation and then adjuvant chemotherapy or radiotherapy due to the stage of disease. Generally, The course of chemotherapy is a 6-12 month regimen, therefore a women's life pattern become disrupted from the frequent medical appointments every 21 days (Carpenter & Brockopp, 1994: 751). Additional to the long-term treatment, chemotherapy is a systematic treatment that enabled drugs to reach the site of the tumors as well as distant sites (Miaskoski & Viele, 1999:83). The utility of this regimen is to kill cancer cells that disseminated from the origin and it decreases the recurrent rate and improves the survival rate (Anderson & Doyle-Mirzadeh, 1994: 429). On the contrary, chemotherapy also destroys normal cells of the body such as bone marrow cells, hair follicle cells, gastrointestinal tract cells, and others cells. Chemotherapy has many unwanted side effects such as fatigue, nausea, vomiting, stomatitis, bone marrow depression, low white blood cells, hair loss, cystitis, thrombophlebitis, blurred vision, fatigue, chills, fever, itching, photosensitivity, nail changes, changes in menstruation, decreased vaginal discharge, loss of body image, effects to the fetus, and changing in sleep pattern as well (Carpenter & Brockopp,1994: 751; Goodman & Chapman,1993: 937-939; Otto, 1994: 499-503; Campbell , 1999:444). Moreover, these symptoms are progressively severe with increasing number of chemotherapy cycles (Longman, Braden, & Mishel, 1999: 909). These complications lead women to dread and face to the inability to take a role and they struggle from physical distress and emotional distress too. In this situation, women needed caring from other people.

In Thailand, the services of systematic treatment for women with breast cancer are located in the cancer centers. There are nineteen regional hospitals and eight university hospitals, which are located throughout all parts of Thailand.

In the lower northern part, there is a regional hospital that provides services for women with breast cancer. Its service covers about a four million population in six provinces. The rate of hospitalization in this regional hospital nearly equals others in Thailand which have women with breast cancer in 1998 and 1999 as 342 and 391 respectively (Jaipat, 1999:41; Jaipat, 2000: 40). Evidence supports this service from the data of a chart review in this hospital during April, 1999-February, 2000 indicated that there were 135 women with breast cancer. Women who received chemotherapy was 74.82 %. In this chemotherapy group, about 14 % dropped out before the required chemotherapy was completed and about 11% had a delay in treatment due to a low white blood cell count.

Traditionally, chemotherapy was given in the inpatients unit and health care providers in the hospital cared for side effects. The doctor prescribed the necessary medications of chemotherapy and its schedule. Prior to giving the chemotherapy, women's white blood cells must be tested to see if it shows an acceptable level, higher than 3,800 cells per cu.mm, chemotherapy is given to these women. Methochopamide mainly treats nausea and vomiting from the side effects of chemotherapy. However, this chemotherapy has severe side effects and this standard drug failed to prevent nausea and vomiting in the women (Johnson, Moroney & Gay, 1997: 51). At this time, chemotherapy is given by a daytime service. The women come to the hospital to receive intravenous chemotherapy in the first and the eighth day of each cycle. After receiving intravenous chemotherapy at the hospital, the women receive the next appointment and return to their homes to take oral chemotherapy for days 1-14. They receive information about the diet they should take, how to manage nausea, vomiting and other unwanted side effects at home. With this information, it was concluded that there are many women who face the struggle of chemotherapy and they have difficulty in dealing with it. Moreover, the health care teams do not know what happens with the women while they are at home after they received their chemotherapy.

In addition, when the phenomena was explored from the women, their family, and the health care team, the preliminary data indicated that all of the women suffered from side effects of chemotherapy. Moreover some of them had complications, could not take oral chemotherapy, could not work, and could not manage their daily life. It can be analyzed that this service is changed because of the changing policy of health care services. Most of hospitals must control the cost of care, the length of stay, and they have a limited number of health care personals. These are the constraints of the facility, time, and health care personnel. The desirable outcome is only emphasized on diminishing the disease at the end of the treatment. Thus, the health care teams do not know what happens with the women while they are at home after they received their chemotherapy.

It can be analyzed that the above situation happens because of three reasons. The first is there are limitations of facilities and a shortage of health care expert teams. There is only one doctor whom must be responsible for women with breast cancer receiving chemotherapy. He must responsible for other patients that require surgery too. Moreover, there is only one nurse whom must be responsible for women with breast cancer. It is an unqualified ratio of patients to nurses. The second is lack of continuing care for these women facing side effects at their home. The women receive chemotherapy at the hospital then they go back to their home. Therefore, many side effects emerge when they are at their home. They have no somebody for consultation. The last reason is the effects of a hierarchy system in a Thai culture on the health care service. Within a patriarchal perspective, the medical paradigm values the health care team as experts who take the position in all decision making in the health care service. This system is outcome evaluation and disease management. The doctor judges every thing for the clients with limited participation from the nurses, client, and client's family. Clients may be perceived as not know how to manage cancer cells. Side effects of chemotherapy may be less concern than treatment schedule.

The hierarchy system in Thai culture creates a linear relationship between superior and subordinate. It is remarkable in the health care system. Doctors are very superior, nurses are less superior to doctors and clients are subordinate people, especially in rural parts and low socioeconomic clients especially women. Thus clients accept the prescription of the superior as things they must follow. Nurses are also influenced by the hierarchy system in that it does not provide the best caring method. In this situation, the clients dare not to ask questions and be informed. They must have patience and suffer from the illness by themselves. The doctors and nurses do not always have time to listen to the questions. From a feminist researcher perspective, she found that health care providers always exercise their authority, do not listen and answer the formal questions (Sindhu,1992).

Additional, a critical review of the previous research in caring of women with breast cancer receiving chemotherapy indicated that most studies used teaching methods for symptom management (Smith, Holcombe & Stullenbarger, 1994: 1205). The research report about women receiving chemotherapy for breast cancer in Thailand mainly deal with concepts and variables that the researcher was interested in, such as self care and adaptation (Kongchum, 1996:56; Thongtanunam, 1998:91; Kaveevivitchai, 1993:73-74). Some of the research is about interventions that were created by the researcher (Chinsawangwatthanakul, 1995:72; Soivong, Hanucharurnkul & Ratanatharathorn, 1996: 5). Some of the research is about developing self-care (Chotanakan, 1996:108-109). Most of the research in Thailand are mainly about women in the urban areas. Studies about women living in the disadvantaged areas are not found. These women have access to limited personnel and care services. Therefore, the caring process that is appropriate to these women should be explored.

The above situation of health care services for women receiving chemotherapy energized the researcher to tried to find ways to develop better care for women. To study what is going on when women receive chemotherapy, how the treatment and caring process develops from the grass-root level could be a good angle. The experience of women, their families and health care providers can provide valuable information. The advantage and disadvantage of the caring process at present can be a lesson as well as a key to develop quality in the caring process for these women.

Research questions

This study had the following research questions:

1. What was the caring process of Thai women with breast cancer receiving chemotherapy?
2. What were the factors that influence the caring process of Thai women with breast cancer receiving chemotherapy?

Purpose of the study

The purpose of this study was:

1. To explore the caring process of Thai women with breast cancer receiving chemotherapy.
2. To explain the factors that influence the caring process of Thai women with breast cancer receiving chemotherapy.

Definition

Caring process for breast cancer women who received chemotherapy referred to all of the special activities that included everything which health providers, women, and families do to care, manage and maintain for continuing all the process of chemotherapy treatment.

Expected outcome and benefits

This study aimed to explore the caring process of Thai women with breast cancer receiving chemotherapy and explain the factors that influence this process. Therefore, the expected outcome and benefits are as follows:

1. This information provides knowledge of what was going on in caring process for Thai women with cancer receiving chemotherapy. Such an understanding can be used to develop an appropriate caring system for these women with breast cancer.

2. Health care providers could use the content of this finding to decrease the hindering factors and increase the facilitating factors in this caring process for the quality of caring.

Summary

In this chapter, the background and significance of the study, the purpose of the study, research questions, and expected outcomes and benefits are presented. This study aims to generate an evolving theory of the caring process of Thai women with breast cancer receiving chemotherapy. The expected outcome and benefits were knowing what was going on in the caring process for Thai women with cancer receiving chemotherapy which the administration of the health care system should develop an appropriate caring system for these women with breast cancer. Moreover, health care providers could use the content of this finding to decrease the hindering factors and increase the facilitating factors in this caring process for the quality of caring. They also could develope a guideline to collaborate the care among these women, their families and health care providers.

CHAPTER II

LITERATURE REVIEW

In this chapter, the empirical and conceptual basis for the present study will be described. This literature can be used to stimulate theoretical sensitivity by providing ways of approaching and interpreting data. It can be used as secondary sources of data, question stimulation, direction in the selection theoretical sampling and supplementary validity.

To generate an evolving theory for women, the researcher analyzed the literature in three sections. The first section focuses on women's health that includes: Illness with breast cancer of women, the treatment development, medical treatment in women with breast cancer, chemotherapy for breast cancer, the consequences of chemotherapy, and caring for women with breast cancer from a feminist perspective. The second section demonstrated the health care system for women with breast cancer receiving chemotherapy in a research setting. The last section focuses on the conceptual base.

Women's health

This section is composed of a critical review of women and health. The researcher needs to reflect in the significance of women's health and the rights of women. It demonstrates the illness of women with breast cancer and treatment development. The medical treatment for women with breast cancer includes chemotherapy, the consequences of chemotherapy, and the caring for women from a feminist perspective.

The boundary of women's health is not conditioned by the definition of health that World Health Organization (WHO) defined. WHO states that health is a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity (WHO cited in Cook, 1994:1). In addition to women's health, this must reflect on the health care services and the processes which support women to regain, maintain and attain health within their well-being of physical, spiritual and psychosocial context.

Women's health is an important issue as related to 1) Women's health has been widely recognized as a human rights. Women must have rights to control their body and decision making by themselves. Women must have choices in health care services and be able to access information. 2) Women's health is significant because it means health in the family and society. Most of the women have responsibility to their family's health and some of them take roles for the health of the social population. 3) Women are the producers in the family and society. 4) Women's health is at risk from the consumer's system because of the illusion in advertising, the false attitude and value in medication and the lack of information for decision making. 5) Health care systems can not provide appropriate services for women. These disadvantages effect women's health (Archawanitkul & Boonmomgkol, 1996: 4-5). Thus, consideration in women's health must be related to a women context. This includes the physical environment, individual factors, and relationship between women and others. Whenever women are faced with breast cancer and the consequences of the treatment, women's health are certainly effected (Bruenjes, 1994 :23).

Illness with breast cancer of women

Breasts are very significant to women because it is a symbol that reflects to women's characteristics. In childhood, the breasts of boys and girls are similar. When adolescence occurs, the development of women and men have significant differences, especially physical characteristics. Women's breast have increasing developments by stimulation from the follicle stimulating hormones and lutinizing hormones from the pituitary gland. This stimulates the ovaries to produce estrogen hormone that stimulates the growth of breast mass and mammary glands. Moreover, there is another hormone, progesterone that stimulates the growth of mammary ducts for lactation for a baby. In conclusion, estrogen is responsible for ductal growth, whereas progesterone is required for the development of lobules, the actual milk-producing structures (Ellerhorst-Ryan & Goeldner, 1992: 824). A woman's breast tissue changes throughout her lifetime. Most of this changes are benign and occur with their menstrual cycle (Williams, 1997: 197). Although the primary physiologic function of the breast is lactation, it is often associated with femininity and sexuality (Allen & Oberle, 1996: 83; Balon & Wehrwein, 1997:349). Therefore, the breast are also attractive in women for many centuries. The illness from breast cancer is the process that effects women's health. This process has many risk factors that can or can not prevent them.

1. The factors that can not prevent:

1.1 Family history of cancer

Women with a family history of breast cancer in a first-degree relative (mother, sister, or daughter) have a relative risk of 4.0-6.0 times greater than that of general women (Hamolsky & Facione, 1999: 427). Moreover, women in a western culture have an increased risk to breast cancer more than women in an eastern culture (Crane, 1994:92).

1.2 Age factor

Early onset of menarche (before age 12) and late menopause (after age 50) are each associated with an increased risk of breast cancer by a relative risk factor of 1.5 and 2 times greater than that of general women respectively.

2. The factors that can prevent:

2.1 The age at childbirth

The age of women at birth of first child before 20 years has relative risk of 1.5 times greater than the age of women at birth of first child after 20 (Crane,1994: 93).

2.2 Exogenous hormones

The result from the health care services for birth control policy lacks information about the consequences of oral contraceptives that affect women to breast cancer in a relative risk of 1.5 times greater than that of general women. This information helps women in their decision for using or not using this contraceptive for birth control. Moreover, postmenopausal women receive exogenous hormones from estrogen replacement therapy that has been available. This regimen has been used to manage the menopausal symptoms of hot flashes and dyspareunia secondary to atrophy vaginitis (Crane, 1994:95). Most studies have shown a 1.5 increased risk for breast cancer if the hormone replacement therapy is taken for more than 5-10 years.

In Thailand, the health care system is more concerned in the curative process than health promotion. Moreover, family planning, and maternal and child health remain the biggest requirements in health care services (WHO, 1999: 3). There are insufficient services in breast cancer detection and women have less opportunity to access these services, especially the women in rural areas.

2.3 Diet

The possible association between dietary fat and breast cancer risk was suggested when epidemiological studies noted a difference significantly. A higher intake of fat has been associated with higher rates of breast cancer (Ellerhorst-Ryan & Goeldner,1992: 827 ; Caplan, Sallis & Patterson, 1993: 249).

2.4 Stress

Women face more stress than men. They have responsibility in working in and outside their homes for their families' financial stability.

The treatment development

From the significance of the breast, the social construction and treatment development of women with breast cancer can be looked at from 3 eras.

1. The Victorian Era: Women as Madonna/Whore

This time period was characterized by the view that women are ruled by their bodies. They were seen as unstable and inherently weak (Thorne & Murray, 2000:143). The women were excluded from social situation. The development of breast cancer was considered to be connected with the internal pollution of women. This pollution comes from industrialization and the inherent emotional frailty of women. From this physiological relationship, breast cancer develops. This separates women from men medically. Thus this "women's disease" arose as a new specialization in the male medication profession. Indeed, the medical profession has more power and authority than women. In this time the specialty of women's diseases has emerged. However the treatment was not an adequate response to women as related to their culture. This culture provides women to have a specific role in the family. Therefore, the treatment was gruesome, including manual investigation, leeching, injections and cauterization of their breasts (Thorne & Murray, 2000:145).

By the last decades of the nineteenth century, there was an evolution in treatment from the scientific knowledge basis. William Halsted, an outstanding professor of surgery at John Hopkins University, introduced the “supra-radical” mastectomy as the standard treatment for breast cancer. This surgery was the only choice in cancer treatment for women at this moment. Halsted advocated removal of the entire breast, the lymph nodes, the muscles of the chest wall, and all surrounding fat tissues (Yalom, 1997:229). The procedures “leaves the women with a sunken chest, restricted movement on one side of their body and, frequently, a painful chronic condition called ‘milk arm,’ caused when lymph fluid fails to circulate properly and accumulates in the arm” (Thorne & Murray, 2000:145). However, in the early 1900s, the physicians made the relationship between breast cancer and reproductive system, and in 1920s they discovered estrogen. Although they are not sure why there was a connection, the operation to remove the ovaries caused remissions and tumor regressions in nearly half of the women with breast cancer. The consequences of this treatment had no regard to femininity and body image and lead to hormonal imbalances in women receiving oophorectomies (Throne & Murray, 2000:147). In 1930s after the discovery of radiation therapy, this was also used to treat breast cancer (Yalom, 1997:231). The treatment of breast cancer was more based on scientific knowledge by using rationalist in connection with knowledge. However, males in the medical profession did the diagnosis and treatment of this era. The cause of breast cancer was thought to be women’s inner pollution and the treatment was to excise the offending parts.

2. Postwar Era: Women as Masochist

This era was following the second world war. It was considered the husband’s duty to satisfy his wife, and women were expected to act in ways that encouraged and supported continuing sexual relations. The women still had to fulfill the role as “the angle in the house” and “a good person in the family”. Their lifestyle was menial labor and sexual humiliation. They had less authority than men and their breast were used to serve men’s pleasure.

During this era, the beginning of chemotherapy was applied. Chemotherapy was discovered by the exploration of mustard gases at Maple City, Italy. They noticed that many soldiers receiving exploration had atrophy of the lymph nodes and bone marrow hypoplasia (Gross & Johnson, 1994). The first drug to be used for its cytotoxic effects in treatments of cancer was nitrogen mustard. This knowledge was used for chemotherapy development (Luken & Middleton, 1995:78). At the same time surgery was used with the same method as the supra-radical mastectomy and oophorectomy. It was the standard of treatment for breast cancer in this era.

Chemotherapy was a heritage of the war or a sunny side of the atom in this era. The National Cancer Institute, established by an act of the United States Congress in 1937, began specific research programs to develop and test new chemotherapy agents (Miaskowski & Viele, 1999: 83). The research of chemotherapy began from this point. In 1943 at Yale University, they administered the first chemotherapy for lymphoma patients. Most of them were male patients (Bonadonna, 1993: 2127).

3. Contemporary Era: Feminist and Activism

This era focuses on the development process of diagnosis, decision making for treatment, and consideration for the life of women with breast cancer. There are many grants for research. The advancement of chemotherapy knowledge was based on the knowledge of the cell theory. Early developing chemotherapy found that after using chemotherapy the patients might have disseminated cancer. During 1950 –1970, they hypothesized in cell kill hypothesis that calculated the amount of chemotherapy by the exponential growth combined with drug resistance. The study was continued for many decades. The result discovered much chemotherapy. The connection with this knowledge, the medical profession suggested that chemotherapy must be used in combination of drugs to kill cells in every stage of the cell cycle. For an effective cure, the chemotherapy must be used during the cell cycle and continued for many cycles (Knoft & Durivage,1993: 227). As a result, 1975 was the year that started combination of chemotherapy.

In trails of chemotherapy, there were continuing developments and there were advances in type of chemotherapy, timetable, combination and the route of administration. In present, the medical profession suggests that chemotherapy is essential for adjuvant therapy in women with breast cancer. This regimen must be used within 30 days after surgery.

In this era, there was surgery development from the supra-radical mastectomy to the modified radical mastectomy. This was used from 1960 to the present. This procedure leads to less physical deformity and more movement of the arm. Moreover, another procedure was breast conservative therapy that is used in young women whom reject to have removal of their breast (Chindavijak, 1995: 75).

However, in this era the breast maintains the symbolic of attractiveness to the satisfaction of men likewise the postwar era. The medical profession takes a major role in treatment development. The problems of treating breast cancer are useful resources for oncologists, medical researchers, fund-raising, support and educational services, and private anguish (Thorne & Murray, 2000: 153). This affects women to have significant informational resources but the knowledge is not always used with integration of the information.

Medical treatment in women with breast cancer

In this section, the literature related to treatment and the consequences of chemotherapy will be discussed. It is well known that the medical profession develops new knowledge for effective treatments based on the knowledge of biomedical. There are numerous types of breast cancer. For example, ductal cancer, found in the cells of the ducts, is the most common type of breast cancer. Another cancer that begins in the lobes or lobules is called lobular cancer. Treatment depends on the type of breast cancer and stage of the disease. Two women with the same type of breast cancer may have different treatments and a different prognosis because one has a more advanced stage than the other.

The staging of breast cancer is according to the extent of disease, which includes size of tumor, nodal involvement, and distal spread. This clinical staging is useful in determining the treatment approach and defining the natural progression of the disease. The most widely used staging system is the tumor-node-metastasis (TNM) system which is advocated by the American Joint Committee on Cancer (AJCC) (Balon & Wehrwein,1997: 359). This system is relatively complicated and can be simplified in term of the most critical components, that is, whether or not the nodes are involved and whether distant metastases are known to be present.

This system corresponds stage 0- carcinoma in situ, stage I- localized disease only, stage II – axillary nodal involvement pathologically, stage III-more advanced locoregional disease without distant metastasis, and stage IV- distant metastases are present (Goodman & Chapman,1993: 928-929; Crane,1994:102).

From this knowledge development, the staging of breast cancer is significant information that the medical profession uses for standards in selecting the proper treatment, which can be composed of surgery, radiation, hormonal therapy and chemotherapy. The treatment for women with breast cancer depends on the staging as follows: (Chindavijak, 1995: 75)

The treatment of stage I is composed of conservative therapy or modified radical mastectomy, and combined with adjuvant chemotherapy or hormonal therapy.

The treatment of stage II is composed of modified radical mastectomy or conservative therapy (tumor not larger than 4 cm. and node not clinically palpable), and combined with adjuvant chemotherapy.

The treatment of stage III is composed of preoperative neo-adjuvant therapy or preoperative irradiation therapy, and combined with modified radical mastectomy or radical mastectomy and using systemic therapy after surgery.

The treatment of stage IV is composed of palliative surgical treatment for locoregional and metastasis, and combined with systemic therapy.

Although, the cancer treatments available today are essentially those that have been available for 50 years: surgery, radiation, and chemotherapy. Some people refer to it as “slash, burn, and poison” as some embittered patients have called them (Langellier & Sullivan, 1998: 76; Thorne & Murray, 2000:153). There are the others prognostic makers that are used for treatment. Those are estrogen and progesterone receptor status, p53 protein and c-erb B_2 oncogene (Charilertsak, 1993: 126; Charilertsak, Purisa & Punyammalee, 1994: 72).

1) Estrogen and progesterone receptor status (ER/PR), since 1971, is a biomedical assay that has been available to analyze breast cancer (Crane, 1994:104). They help to predict whether a woman’s tumors will response to endocrine therapy and that the tumor will follow a more indolent course (Fisher, Osborne, Margolese & Bloomer, 1993: 1718).

2) P53 protein is commonly found in breast cancers that arise in women who do not have evidence of a family history of this disease (Bartow,1999: 1039).

3) C-erb B_2 oncogene or HER-2/neu is part of a group of membrane surface proteins associated with epidermal growth factor receptors. Data suggests that HER-2/neu may be useful as a prognotic factor in evaluating clinical outcomes and as a predictive factor in determining how well a patient will response to chemotherapy and antiestrogens (Mautner, Scjmidt & Brennan, 2000: 189).

Chemotherapy for breast cancer

Chemotherapy is frequently used for the treatment of breast cancer. It may be used before or after surgery due to the stage of disease. The purpose of treating cancer cells with chemotherapy is to prevent these cells from multiplying, invading, and metastasizing to distant sites. Unlike surgery or radiation therapy, cancer chemotherapy is a systemic treatment that enables drugs to reach the site of the tumors as well as distant sites (Miaskoski & Viele, 1999:83). This regimen kills cancer cells that disseminated from the origin and it decreases the recurrent rate and improves the survival rates because breast cancer is systemic disease and it can effect other body systems (Anderson & Doyle-Mirzadeh, 1993: 429). The biologic basis of cancer chemotherapy rests on the understanding of the cell cycle. The cell cycle is the sequence of steps that both normal and cancer cells use to grow and replicate. It involves five phases that are designated as G_0, G_1, G_2, and M. The G_1 phase is primarily directed at RNA and protein synthesis and has the greatest variability in length, from 2-3 hours to several days. The second phase or S – phase is the phase of DNA synthesis. The time of this phase appears relatively constant, ranging from 8-30 hours. The third phase G_2 – phase is the phase of cell production. The necessary factors that are essential in cell division are produced. It usually lasts a brief period of time. The forth phase or M – phase is the phase of cell division. This is also a relatively short phase of the cycle, 30-90 minutes. The other phase is G_0 phase, often called a resting or dormant phase. It represents the time the cells are out of the cycle but have the potential to reenter (Knoft & Durivage,1993: 273; LeMone & Burke, 1996: 306-309;Miaskoski & Viele, 1999:84).

Most of the chemotherapy drugs can be grouped together based on whether they exert their cytotoxic effects during a specific phase of the cells or are predominantly in the dormant phase. In contrast, cell cycle-nonspecific drugs theoretically are more likely to be effective against cancer cells that are not in a state of rapid cell division (Miaskoski & Viele, 1999: 84; Otto, 2001: 644).

1. Cell cycle specific drugs (CCS) are agents that are most active against cells that are in a specific phase of the cell cycle. An example of this group is the antimetabolites.
2. Cell cycle non-specific drugs (CCNS) are agents that are most active against cells that are not in a specific phase of the cell cycle. Examples of this group are alkalyting agents, nitrosoureas, and antibiotics etc.

In breast cancer treatment, chemotherapy usually includes a combination of drugs. They are given directly into the vein or orally. Once the drugs enter the bloodstream, they travel to all parts of the body in order to reach cancer cells that may have spread beyond the breast. Therefore chemotherapy is considered a systemic form of breast cancer treatment. It is given in 4-6 cycles of treatment followed by a recovery period (Knoft, 1991: 447; Miaskowski & Viele, 1999: 449; Maipang,2001:37; Otto, 2001: 646).

1. Standard CMF chemotherapy contains cyclophosphamide, methotrexate and 5-fluorouracil. Cyclophosphamide is given by the oral route for 14 days. Its dose is 100 $mg/m^2/day$, three times per day. Methotrexate is given by the intravenous route on the first and eighth day. Its dose is 40 $mg/m^2/day$. 5-fluorouracil is given by the intravenous route on the first and eighth day. Its dose is 600 $mg/m^2/day$. Treatment is repeated every 21-28 days for 6 treatments.
2. CMF regimen in node-negative women is cyclophosphamide, methotrexate and 5-fluorouracil. Cyclophosphamide dose is given orally. Its dose is 600 $mg/m^2/day$. Methotrexate is given by the intravenous route. Its dose is 40 $mg/m^2/day$. 5-fluorouracil is given by the intravenous route. Its dose is 600 $mg/m^2/day$. Treatment is repeated every 21 days for 12 treatments.
3. CAF regimen contains cyclophosphamide, doxorubicin and 5-fluorouracil. Cyclophosphamide is given by the oral route for 14 days. Its dose is 100 $mg/m^2/day$ for three times per day. Doxorubicin is given by the intravenous route on the first and eighth day. Its dose is 30 $mg/m^2/day$. 5-fluorouracil is given by the intravenous route on the first and eighth day. Its dose is 500 $mg/m^2/day$. Treatment is repeated every 28 days for 6 treatments.

4. FAC regimen contains cyclophosphamide, doxorubicin and 5-fluorouracil. Cyclophosphamide is given in the dosage of 600 mg/m^2 by the oral route on the first day. Doxorubicin is given in the dosage 60 mg/m^2 by the intravenous route on the first day. 5-Fluorouracil is given by the intravenous route on the first and eighth day. Its dose is 600 $mg/m^2/day$. Treatment is repeated every 21-28 days for 4-6 treatments.

5. AC regimen contains doxorubicin and cyclophosphamide. Doxorubicin is given in the dosage 60 mg/m^2 by the intravenous route on the first day. Cyclophosphamide is given in the dosage 600 mg/m^2 by the oral route on the fifth day. Treatment is repeated every 21 days for 4 treatments.

6. A→CMF regimen contains doxorubicin 75 mg/m^2 by the intravenous route on for 4 cycles. After that, it is followed by cyclophosphamide 600 $mg/m^2/day$, methotrexate 40 $mg/m^2/day$ and 5-fluorouracil 600 $mg/m^2/day$. This treatment is repeated every 21 days for 8 treatments.

The consequences of chemotherapy

As the chemotherapy helps to prevent distant metastasis, the consequences of chemotherapy affect women with many problem side effects. The problems include psychosocial, financial, and role development. The side effects of chemotherapy depend mainly on the drugs the patient receives. As with other types of treatment, side effects vary from person to person.

1. The side effects of chemotherapy

In general, chemotherapy not only affects the cancer cells but also it affects the normal body cells, especially the cells with rapid growth. The types of chemotherapy used have different side effects that affect women's bodies.

1.1 Cyclophosphamide, endoxan, cytoxan, or neosar represent the same drug. It is an alkalating agent. It effects every phase of the cell cycle, therefore it can be called a cell cycle nonspecific drug. The mechanism of action is how it interacts with DNA and the essential factors in the cell life. Finally, it induces cells to mutation and destroys the cell.

After taking this drug orally it can change to the active form in the liver. This process can change to another substance that influences the catalyst in the liver. The half-life of this drug is 6-12 hours. 25% of the drug is excreted from the body in 8 hours. The side effects are as follows: (Germ, Carvalho, Wittes & Allegra, 1995: 84; Otto, 1994: 499-503; Lehne, Moore, Crosby & Hamilton, 1998: 1014-1017)

1.1.1 Acute toxicity is severe and frequently with nausea and vomiting. Mechanism of nausea and vomiting in women who receive this chemotherapy is stimulated by the emetic center located near the brainstem. When chemotherapy or a metabolite of chemotherapy enters the gastrointestinal tract, there is stimulation of 5-HT$_3$- receptor sites within the chromaffin cells of the duodenum. This stimulates the vagal afferent to send an impulse to stimulate the chemoreceptor trigger zone of the postrema of the forth ventricle. This site is the vomiting center that works with the nervous system in controlling muscles. This produces abdominal and diaphragm muscle contractions. This situation affects vomiting in three patterns as:
1) the acute pattern, it occurs after drug administration within seconds or minutes and may continue to 24-48 hours, 2) the chronic pattern, it occurs after drug administration within 24 hours and may continue every day, and 3) the anticipatory nausea pattern. This occurs before drug administration. This situation occurs by experiences with drug administration. Some women may vomit when she suddenly thinks about receiving the drug (Hogan & Grant, 1997: 9). This effect occurs with the total number of side effects remaining relatively constant from cycle to cycle. These women fail to adapt or “get used to” the chemotherapy. This may also be due to the development of anticipatory nausea (Love, Leventhal, Easterling & Nerenz, 1989: 611).

In the CMF regimen, 5-FU and methotrexate are chemotherapy that induce mild nausea and vomiting. It usually occurs in 6-12 hours after receiving these drugs. Cyclophosphamide (endoxan) which taken orally produces moderate nausea and vomiting. It occurs in 2-6 hours after receiving this drug and it has a half-life 4-6.5 hours. Nausea and vomiting in women on the first day can be severe. By the time that 5-FU and methotrexate is added in 2-3 days, the side effects are usually very severe. After finishing the side effects of 5-FU and methotrexate, there are the side effects of endoxan. On the eighth day, the women receive 5-FU and methotrexate by intravenous again. There are more side effects again and it can increase on the 8-9 days. The side effects usually decrease to be mild or to having no symptoms.

1.1.2 Delayed toxicity

1.1.2.1 Bone marrow suppression. Anticancers drugs are highly toxic to the bone marrow. The bone marrow is a tissue with a high proportion of proliferating cells. Myelosuppression reduces the number of circulating neutrophils, thrombocytes, and erythrocytes. The time the blood counts are their lowest is called the nadir. With cyclophosphamide, the nadir occurs between days 8 and 14, with recovery by days 18 and 25 (Wilkes,1996: 101). White blood cells are more sensitive that other blood cells (Lehne, Moore, Crosby & Hamilton,1998: 1015).

1.1.2.2 Hair loss or alopecia. This is clinically detectable when 25-40% of the scalp hairs are lost due to atrophy of the bulb or breakage of the hair shaft (Keller & Blausey,1988: 603). Hair loss will start approximately 1 week after the first dose due to depression of hair follicle cell growth. This symptom is remarkable in 1-2 months. Hair on head is most commonly affected, but hair loss may also occur on the face, arms, legs, underarms, and pubic area (Lehne, Moore, Crosby & Hamilton, 1998: 1016-1017). The scalp may become tender and hair that is still growing may become dull and dry. This effect, however, is not permanent, and healthy cells grow back normally once chemotherapy is completed (Goodman, Ladd & Purl, 1993: 760-761; Seipp, 1995: 467).

1.1.2.3 Cystitis. Cyclophosphamide is excreted from the body by the liver and kidneys. 20% of this drug is unchanged, so the active metabolite irritates the cystic musoca and causes a chemical cystitis. The symptoms are dysuria to hematuria (Luken & Middleton, 1993: 104).

1.1.2.4 Gastrointestinal tract. This is sensitive to the chemotherapy. The mucosa is destroyed and it effects the new cells. Women will suffer from the pain in the mouth due to sores in the mouth. Moreover, there are the changes in taste. Women feel anorexia due to a metallic taste (Luken & Middleton, 1993 : 101).

1.1.2.5 Estrogen levels decreased. It frequently causes women to have irregular menstruation or amenorrhea during treatment. Depending on age, this may lead to an early menopause. Pregnancy during or soon after a course of cytotoxic treatment can result in serious fetal damage with gross abnormalities (Luken & Middleton, 1993: 109).

1.1.2.6 The effect on the lungs. It can cause pleuritis, pneumonia, and pulmonary fibrosis.

1.1.2.7 Hyperpigmentation. There is hyperpigmentation of the skin such as: knees, elbows, and knuckles. Moreover, there is nail discoloration and ridging of the nails (Luken & Middleton, 1993:107).

1.1.2.8 Secondary malignancy. This is due to primary cancer. After receiving alkalating agents, women have 1.6-2.3% risk of developing acute nonlymphocytic leukemia within 10 years, peaking at 2-3 years (Camp-Sorrell, 1993: 361).

Cyclophosphamide is not used in women who are sensitive to it. It can cause severe bone marrow depression, cystitis, obstruction of the urinary tract and acute infection.

1.2 Methotrexate is a folate antagonist, antimetabolite or cell cycle specific drug in the S-phase. It blocks the reduction of folic acid to tetrahydrofolic acid by inhibiting an enzyme called folic acid reductase. This blockage impairs purine biosynthesis and inhibits the synthesis of DNA and thus cells reproduction. This drug has a terminal half-life of 8-15 hours. 92 % of this drug is excreted via the kidneys within 24 hours. This drug has side effects like other drugs (Germ, Carvalho, Wittes & Allegra, 1995: 110-111; Otto, 1994: 499-503; Lehne, Moore, Crosby & Hamilton, 1998 : 1014-1017).

1.2.1 Acute toxicity

1.2.1.1 Mild potential in nausea and vomiting

1.2.1.2 Diarrhea

1.2.2 Delayed toxicity

1.2.2.1 Bone marrow depression. The nadir occurs between days 7 and 14, then recovery in days 14 and 21 (Wilkes, 1996: 101).

1.2.2.2 Digestive tract injuries. It can cause stomatitis and bleeding in the gastrointestinal tract after receiving the drug. Therefore these women can have ulcers in the mouth. They can have anorexia, paralytic ileus, and abdominal distension.

1.2.2.3 Hair loss occurs 3 to 5 weeks after the first course (Grem, Carvalho, Wittes & Allergra, 1995: 110).

1.2.2.4 Headache, drowsiness and blurred vision.

1.2.2.5 Fatigue, chill and fever.

1.2.2.6 Skin rash, photosensitivity, skin changing.

1.2.2.7 Chronic hepatic fibrosis may result from long-term low-dose treatment (Grem, Carvalho, Wittes & Allergra, 1995: 110).

1.2.2.8 Abnormal kidney function in the case of high doses.

1.2.2.9 Renal tubular obstraction and injury may occur with high-dose therapy (Grem, Carvalho, Wittes & Allergra,1995: 110).

12.2.10 Changes in menstruation and vaginal discharge. In pregnant women, this drug may effect the fetus and induce abortion.

1.2.2.11 Thrombophebitis due to irritation.

This drug is not using in women who are sensitive to it because it can cause severe bone marrow depression.

1.3 5-Fluorouracil or 5-FU is an antimetabolite that is cell cycle specific drug in the S-phase. This drug has the structure like pyrimidine that can be changed to fluorodeoxyuridine monophosphates, which is necessary for synthesis of pyrimidine. The effect of this drug is to inhibit thymidine syntheisis and DNA synthesis. The side effects of this drug are as follows: (Germ, Carvalho, Wittes & Allegra, 1995: 111-113; Otto, 1994: 499-503; Lehne, Moore, Crosby & Hamilton, 1998: 1028-1029)

1.3.1 Acute toxicity

1.3.1.1 Mild nausea and vomiting.

1.3.1.2 Diarrhea is a frequent side effect. By injuring the lining of the intestine, anticancer drugs can impair absorption of fluids and other nutrients, thereby causing diarrhea. Diarrhea can be reduced with a diet high in fiber and by eating constipating foods (Camp-Sorrel, 1993: 341).

1.3.1.3. Phlebitis occurs due to irritation from administration of the drug. Moreover, there is venous discoloration (Luken & Middleton, 1993: 107).

1.3.2 Delayed toxicity

1.3.2.1 The nadir occurs between days 7 and 14, with recovery by day 16 to 24 (Wikes, 1996:101).

1.3.2.2 Paralytic ileus and abdominal distension

1.3.2.3 Stomatitis, gastritis, inflammatory, gastrointestinal , bleeding in the gastrointestinal tract.

1.3.2.4 Inflammatory of skin, skin rash and changing of skin, pigmentation of skin and nail change.

1.3.2.5 Alocepia.

1.3.2.6 Thrombophebitis due to chemotherapy from irritation of blood vessels mucosa.

1.3.2.7 Anorexia, less consumption, and weight loss are found especially in women who have nausea and vomiting (Anderson & Doyle-Mirzadeh, 1993: 436).

1.3.2.8 Fatigue or weakness due to psychological problems, such as the consequences from the treatment and side effects of chemotherapy. (Winningham et al., 1994: 23; Wyatt & Friedman, 1998: 767). Fatigue is the most common symptom in 80-96% of patients within 3-4 days after chemotherapy (Irvine et al, 1994: 367). This symptom may occur until receiving a new course and it affects daily life, attention, with emotional and physical changes of women.

This drug is not used in women who are sensitive to it, because it causes severe fatigue, severe bone marrow depression, and liver disturbances.

1.4 Doxorubicin hydrochloride or adriamycin or as the trade name Rubex. It belongs to the antitumor antibiotic group. It is a cell cycle non-specific drug. It will form a complex with DNA by interaction between base pairs that leads to the formation of free radicals. It also inhibits topoisomerase II. This contributes to inhibit DNA synthesis and DNA-dependent RNA synthesis. Doxorubicin is active throughout the cell cycle. It remains in plasma for 45 minutes, with a half-life of 20 hours. Side effect are as follows: (Grem, Carvalho, Wittes & Allegra, 1995: 99; Lehne, Moore, Crosby & Hamilton, 1998: 1028-1029)

1.4.1 Acute toxicity

1.4.1.1 Mild potential in nausea and vomiting (Otto,1994:512)

1.4.1.2 Diarrhea

1.4.1.3 Arrhythmia. Changes in EKG when receiving doses of 500-550 mg/m^2 due to myopathy (Luken & Middleton, 1993: 107).

1.4.1.4 There is red urine within 1-48 hours after receiving the drug but it is not abnormal.

1.4.2 Delayed toxicity

1.4.2.1 Skin rash and skin changes due to hyperpigmentation and photosensitivity (Luken & Middleton,1993:107).

1.4.2.2 Hair loss

1.4.2.3 Stomatitis and anorexia

1.4.2.4 The nadir occurs between days 10-14 with recovery by day 21-24 (Wikes, 1996:101).

1.4.2.5 Chills and fever

1.4.2.6 Conjunctivitis

1.4.2.7 Fatigue and tiredness. The study of Berger (1998: 60) indicated that doxorubicin-based protocols affects a women's activity, rest patterns and ability to maintain lifestyle roles at home, work, and in social situations more than nondoxorubicin protocols.

This drug is not used in women who have abnormal function of the heart and in women with liver disease.

2. Psychological changes

The psychological reaction to breast cancer chemotherapy varies from women to women. Beside the side effects from chemotherapy, women are distressed from the results of the treatments post surgery. This distress comes from the operation, pain, anxiety in illness, side effects of chemotherapy, changing body image, and changes in relationship with their family (Wanchai, 1996; Hordern, 2000: 231).

Moreover, women deal with changes in body image and low self esteem not only from the operation but also from experiencing chemotherapy-induced alopecia (Carpenter & Brockopp, 1994: 751). This affects the physical and mental distress of women. It causes also emotional imbalance, anger and loss. They can also feel uncertainty, fear of recurrence, negative feelings about the future, and life distress (Anderson & Doyle-Mirzadeh, 1994: 434).

3. Social changes

Most women have social changes due to the illness and changes in body image. Moreover, the treatment with chemotherapy affects women physically by causing fatigue and having fewer social gatherings with family and friends.

4. Economical changes

One consequence of cancer is the cost of treatment (Moore, 1998: 1615). Most women have financial problems due to the cost of treatment, transportation, and loss of work. Some women can not return to the their work. This affects the women's financial status within the family. Moreover, the extent of out-of-pocket expenditures may depend on treatment protocol, ease of symptom management, functional status, and nonclinical elements such as socioeconomic factors (Moore, 1998: 1615).

5. Role changes

Women with breast cancer face changes in their role and their families' role because of their chronic illness (Woods & Lewis, 1995:135). After receiving chemotherapy, women must cope from role changes from their health status (Macran, Clarke & Joshi, 1996: 1203-1216).

5.1 Work role: In the stage of treatment, women face more nausea and vomiting. This affects their work and they may lose their employment.

5.2 Family role: The changes in family life, dependency, and sexuality affect women with major emotional problems.

5.3 Wife role: Women treated with chemotherapy experience menopausal symptoms and sexual dysfunction symptoms. Women treated with chemotherapy have more negative body images and mood changes (Young-McCaughan, 1996: 315). Whereas, there are barriers within the health care professionals as they feel uncomfortable with their own sexuality. Therefore, they can not communicate effectively, openly and honestly with women about sexuality. Issues of survival overshadow these barriers (Hordern, 2000: 231).

In conclusion there are three consequences of chemotherapy. The first, side effects symptoms that must use a laboratory to measure the amount. These side effects only health care providers can know what is happening but the women do not known what is happening. These symptoms are bone marrow depression, organ toxicity such as toxicity to heart, liver, bladder and lung. The second is side effects symptoms, which women know but health care providers can not know. These are subjective symptoms such as nausea, fatigue and distress. The third side effects are both the women and health care providers can know about the symptoms because the women have physical changes, such as vomiting, alopecia, and skin changes.

Caring for women with breast cancer from a feminist perspective

The caring process by the medical perspective can help women get through their life crisis. It utilizes the women to survive and live longer. Women receiving chemotherapy for breast cancer must face distress from side effects of chemotherapy in their homes, as there is no continuing care. As a result, women may discontinue the treatment. A study about the experience of Thai women with breast cancer indicated that those who perceived the treatment with fear and rejection can have delayed treatment and these women seeked another treatment (Chenlessakul, 1997: 176). Women face physical changes and loss of energy in their daily living. As the health care service is not appropriate, the women face symptom management by themselves and without the support from the health care service.

The issues in the literature review with women with breast cancer receiving chemotherapy indicated that there is a lack of a study in the caring process of these women. The existing knowledge was only some concepts or some group of participants in the caring processes that researcher’s interested. The summary of existing knowledge composed of these following:

1. Descriptive research mostly was surveyed and they described the relationship of concepts. For example, Kaveevivitchai (1993:73-74) studied relationship among selected factors, uncertainty in illness, social support receiving chemotherapy in 130 women with breast cancer receiving chemotherapy. The result indicated that uncertainty in illness was correlated with adaptation in negative direction, social support was correlated with uncertainty in illness.

Kongchum, (1996:56) studied health related hardiness, social support, selected factors, and adaptation in 110 women with breast cancer-receiving chemotherapy. The result revealed that the patients had high hardiness characteristics, a high perceived social support, and good adaptation.

The studied of Thongtanunam (1998:91) in role adaptation of mastectomized patients with adjuvant chemotherapy. The result indicated that the 90 patients, maternal and work role adaptions yield rather good result while spouse role adaptation did not.

Pritsanapanurungsie (2000:67-68) studies patterns of fatigue, related factors, and self-care actions among 30 breast cancer patients receiving chemotherapy. The result indicated that there were four patterns of fatigue: severe and then gradually declining, moderate and sustained, moderate and then gradually declining, and mild and then gradually declining. There were positive relationships between fatigue and sleep disturbances in all courses of chemotherapy.

Soivong, Hanucharurnkul, & Ratanatharathorn, (1996:19) studied patterns of nausea and vomiting, associated factors, and self-care among 44 breast cancer patients receiving chemotherapy. The result revealed that there were four patterns of symptom experience. Self-care actions which were considered by the patients to be quite effective for maintaining adequate fluid and nutrients was drinking carbohydrate beverages, and the self- care action which was considered to be the best to most completely relief the symptoms was taking a prescribed antiemetic.

The study of Sanguanjiraphan (1997:62) was the purpose to investigate weight gain among 55 breast cancer patients receiving adjuvant chemotherapy. She found that 78.18 % of women gained weight.

2. Experimental research mostly related to interventions for releasing distress, getting quality of life, or facilitating in adaptation. Most of them used teaching and supportive strategies. For example, Aimmak (1994:102-103) studied a self-help group of post-mastectomy patients with chemotherapy. The result revealed that 20 women with breast cancer receiving chemotherapy had participated in the three sessions of the self-help group, the sample had a significantly higher quality of life scores ($p>.05$) before participating in the group. This study also revealed that the emotional distress was decreasing.

Chinsawangwatthanakul (1995:72) studied the effects of group process to adaptation of breast cancer patients receiving chemotherapy after an operation. The experimental group received teaching by the researcher, the control group received teaching from staff nurses. The result indicated that the examination group had a score adaptation higher than the control group.

3. Action research was studied by Chotanakan (1996:108-109). Her study was development in self-care model for breast cancer women receiving chemotherapy. The process of self-care development by 20 patients consists of two stages, the initial stage required the decision making process after all the information was available and the second stage will be the action taking step which will be dictated by time and experience which the latter can come from their own trail and error process as well previous experiences provided by the other patients.

4. Developed the instrument, as Brinkman, Hay & Laubinger (1994:1731) developed the chemotherapy toxicity assessment using a self–report tool.

5. Qualitative studies were studies in breast cancer, family or nurses. For example, the study of Wilson & Morse (1991:78), the title “Living With a Wife Undergoing Chemotherapy” with 14 informants. This study revealed that a three-stage model was developed, consisting of identifying the threat, engaging in the fight and becoming a veteran. This finding was called “the process of buffering”.

Odling ,G., Norbect, A. & Danielson, E. (2001:77) studied the care of women with breast cancer on a surgical ward: Nurses’ opinions of the need for support for women, relatives and themselves. The result revealed that the nurse described the need to talk and receive information as being the most important among women and theirs relatives, as well as among themselves.

Fall-Dickson & Rose (1999:904-906.) studied caring for patients who experience chemotherapy-induced side effects: the meaning for oncology nurses. The resulted indicated that there were 6 main themes composing of patient feeling down, being challenged by personal and professional imperatives to act, reconsidering the meaning of sick and well, being changed by ties of shared experience, advocacy for self and patient, and the fundamental structure of meaning for oncology nurses.

Moreover, there was a study in title "How Women Receiving Adjuvant Chemotherapy for Breast Cancer Cope With Their Treatment: A Risk Management". The result of this study indicated that the women tried to cope with the physical and mental suffering associated adjuvant chemotherapy through normalizing strategies, such as keeping a brave face, maintaining previous pattern of life, looking for humor and restructuring time. However, the rapid alterations in physical and mental state resulting from cycles of adjuvant chemotherapy resulted in a "rollercoaster" experience for women which normalization was more difficult (Cowley, Heyman, Stanton, & Milner, 2000: 314).

A critical review of the emerging research indicated that most studies used teaching methods for symptom management (Smith, Holcombe & Stullenbarger, 1994: 1205). The research report about women receiving chemotherapy for breast cancer in Thailand mainly deal with concepts and variables that the researcher was interested in, such as self care and adaptation (Kongchum, 1996; Thongtanunam, 1998; Kaveevivitchai, 1993). Some of the research is about interventions that were created by the researcher (Chinsawangwatthanakul, 1995; Soivong, Hanucharurnkul & Ratanatharathorn, 1996: 5). Another of the research is about developing self-care (Chotanakan, 1996). Most of the research in Thailand is mainly about women in the urban areas. Studies about women living in the disadvantage areas are not found. These women have access to limited personnel and care services. Therefore, the caring process that is appropriate to these women should be explored.

Based on a feminist perspective, this caring process must include the following: (Wheeler & Chinn, 1989: 1-3)

1. Praxis is a thoughtful reflection and action that occurs in synchrony. Praxis is values made visible through deliberate actions. Thus, the caring process should be the process that comes from the women, families, and health care providers.

2. Empowerment is growth of personal strength, power and ability to enact one's own will and love for self in the context of love for others. This process should initiates women and families to have strength and power in caring their suffering situation.

3. Awareness is an active, growing knowledge of self and others and the world in which we live. This process helps people who are sensitive to change. It

can predict or transform the significance of women in society. Thus, the caring process should be transformed to the process based on real women's problems.

4. Consensus is an active commitment to group solidarity and group integrity. This process should be appropriate to the mutuality of women, families, and health care providers.

5. Evolvement is a commitment to growth, where change and transformation are conscious and deliberate. This process must transform the caring process into the real situation.

The health care system for women with breast cancer receiving chemotherapy in a research setting

In order to study the caring process of Thai women with breast cancer receiving chemotherapy at a research setting, the researcher will portray the services for these women to help with the understanding of the phenomena of services for them.

The regional hospital in the lower northern part of Thailand is a research setting. The services of this hospital are for the population in Phitsanulok, Nan, Sukhothai, Tak, Petchaboon and Pichit Provinces. This hospital also provides services for health care professionals. Medical, nursing, pharmacist and medical technical students practice for their profession in this hospital.

For breast cancer service, there is a screening service in the afternoon of every Tuesday. Only one doctor and one nurse are responsible for this service. If the women do not come to the hospital on Tuesday, they will receive the services from other surgical physicians. After a breast cancer diagnosis, women must be admitted to the inpatient unit for surgery. The adjuvant chemotherapy begins about 1-2 weeks after their operation. The women who must receive radiation therapy are referred to the cancer center in Lampang, Chiangmai or Bangkok Province. The women can decide where to go for their radiation therapy.

The standard chemotherapy is CMF. The others regimens may apply in some women who have a more serious or progressive stage of cancer. In the first treatment, the doctor exames the women physically for diseases such as liver disease, renal disease, and heart disease. Every cycle, the women must have a blood test. They will not be given the treatment if their WBCs are lower than 3800 cells/cu.mm. The doctors would then give the essential medication for blood production and make a new appointment for chemotherapy.

To administer the chemotherapy, there is a service at in-patient unit. The women would meet the doctor for a physical examination in the morning, then they would go to in-patient unit for administrating medication and receiving intravenous medication in the injection room in the afternoon. There is only one nurse to give intravenous administrations and she also services other patients. After receiving chemotherapy, the women return to their home for take oral medication on day 1-14. On the eighth day, they must come back to the hospital to receive intravenous medication again.

For the addition cycles, the doctors examined their blood cell counts. If they were normal, the women will receive chemotherapy. If the white blood cells shows less than 3800 cells/cu.mm., the women would receive medication and make an other appointment for chemotherapy.

In each service, the nurses provide information for managing their symptoms and side effects. When the chemotherapy is completed, the doctor makes an appointment for 1 month for continuing treatment. The liver function tests and chest x-rays will be reviewed. The doctor will make an appointment every six or twelve months for screening for recurrence of the cancer. Summary is detailed in the diagram as follows.

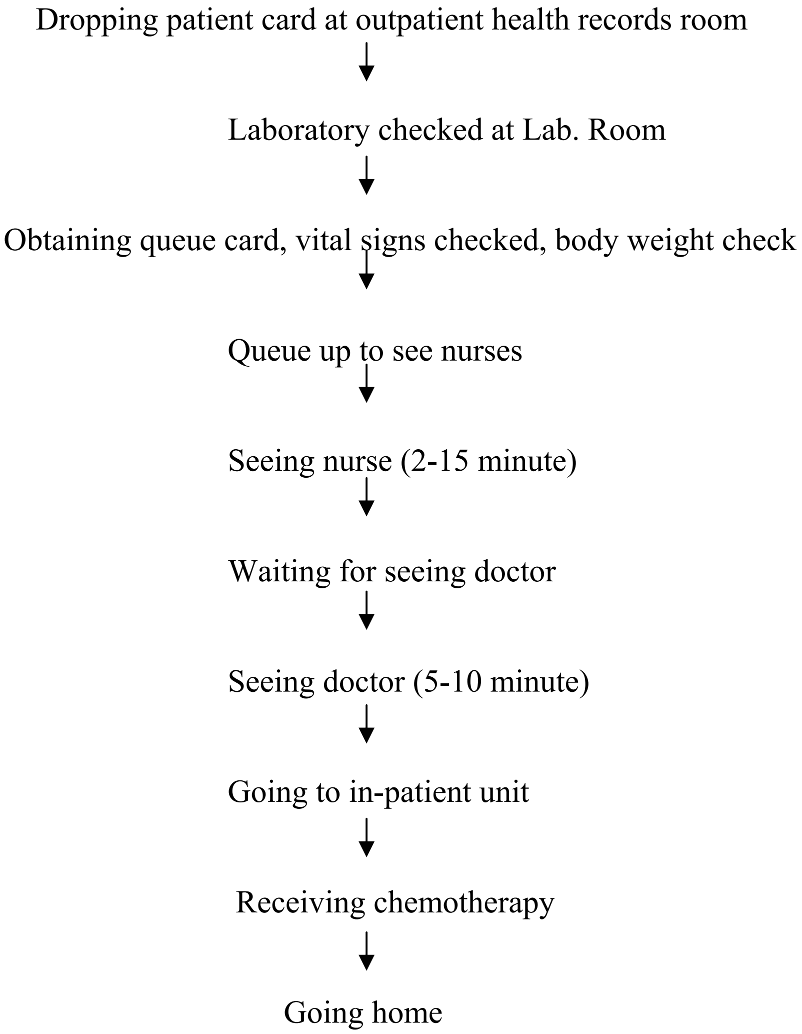

Figure 1: A diagram illustrating an the service for women with breast cancer receiving chemotherapy at a research setting

In conclusion, the caring system of setting for women with breast cancer receiving chemotherapy is problem solving, hospital setting, and no continuation of care.

Conceptual based

In this study, the researcher used a feminist perspective as the conceptual basis for theoretical sensitivity in the data collection, data analysis and synthesis of the knowledge. Moreover, the grounded theory was used as the method.

Feminism can be defined as a worldview that values women and that confronts systematic injustice based on gender. This perspective is not concernes only with women's issues. It is more than a list of problems relevant to women, and it is not inherently antimale. Moreover, feminism would encourage us to embrace our rich cultural heritage within nursing and value our predecessors, who made brave and courageous strides in developing the foundation upon which nursing is built (Chinn & Wheeler, 1985:74,76). Feminism critique of science is that it is not neutral. In the feminist view, men tried to create everything in the world causes by everyday life management belong to women's duty. This knowledge served man in order to maintain his power.

Socialist feminists assert that women's condition are over determined by structures of production (from Marxists feminism), social of children (from liberal feminism), and reproduction and sexism (from radical feminism). They believe that women's interior world must also be transformed (from psychoanalytic feminism), to be liberated from patriarchal thought that undermines his confidence. Socialist feminist perspective is suitable in this study in women because it is the perspective of women that was focused on (Wheeler & Chinn, 1989: 6-8).

1. The process

The process does not emphasize only the results of treatment or rigid program. A feminist perspective is attention to the process of the study. This study focuses on the caring process that is not directly related to the outcome but emphasis is on the process. If we know how the process in the phenomena occurs, we can manage the outcome.

2. The whole

Feminist values the whole of sharing knowledge and skills. It is attention not only to data from various sources but includes personal knowledge, professional knowledge, hospital records, literature reviews and documents. This data served as a whole in the phenomenon.

3. Collectivity

A feminist perspective values the personal power of each individual. This study collects the opinion of all people that have a relationship with the study.

4. Sharing

It emphasizes the passion along with knowledge and skills in order that all may develop individual talent.

5.Integration

The situations are viewed in context without arbitrary value-laden judgment. It is not divided between something being wrong and something being true.

The results from a socialist feminist perspective are utilized to nurture women receiving chemotherapy because the experiences of women are viewed as a resource to be cherished and respected. The results of this study are valued for the beneficial uses to which they can be used by all to share, equitable and according to need. Moreover, it considers that the study will have integration of thinking, emotion, and experience. The study must have diversity and be responsible to the process.

This study uses socialist feminism as the perspective to emphasize the understanding of women's experience. In the health care system, it is important not only understand a women's experience but also to increase the professional knowledge. Moreover, it must use both emic view and etic view. Although grounded theory is postpositivism, it is suitable for a feminist perspective. It uses the subjectivity data, sharing data, from various sources that data include the emic view, etic view, professional view and the emerging knowledge in documents and literature. This reflects the whole process. Thus, it is appropriate to use a feminism perspective and grounded theory.

Summary

The literature in this chapter can be used to stimulate theoretical sensitivity by providing ways of approaching and interpreting data. It can be used as secondary sources of data, question stimulation, direction in the selection theoretical sampling and supplementary validity. The researcher analyzed the literature in three sections composed of women's health, the health care system for women with breast cancer receiving chemotherapy in research setting and conceptual based.

CHAPTER III
METHODOLOGY

The focus of this chapter is to describe the research design and methods utilized to conduct this study. This chapter includes research design; study setting; data sources and data collection; protection of human subjects; data management, data analysis, and sampling strategies; and rigors of this study.

Research design

Grounded theory study aims to describe or develop theory explaining a basic social-psychological process or a basic social-structural process of a phenomenon. Therefore, the qualitative method of grounded theory was used to explore the caring process of Thai women with breast cancer receiving chemotherapy and explain the factors that influence this caring process.

Grounded theory as a methodology was originally developed by two sociologists: Barney Glaser and Anselm Strauss. This approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived-grounded theory about a phenomenon. It addressed “research about persons' lives, lived experiences, behaviors, emotions and felling, the same as about organizational function, social movements, cultural phenomena and interactions between nations' (Strauss & Corbin,1998:1). Grounded theory is the method for capturing the theory that comes from systematic data management and data analysis. It offers a systematic method to collect, organise, and analyse the data as well (Chenitz & Swanson, 1986:14).

As grounded theory used as a method of research process, the conceptual based in this study used socialist feminist perspective that emphasized on the power of process, letting go, the whole, collectivity, unity, sharing, integration, nurturing, distribution, intuition, consciousness, diversity, and responsibility. “PEACE” is both the intent and the process from which feminist activism arises. It represents a concept of intent/process from which actions arise:

1. Praxis is a thoughtful reflection and action that occurs in synchrony. Praxis is values made visible through deliberate actions.

2. Empowerment is growth of personal strength, power and ability to enact one's own will and love for self in the context of love for others. .

3. Awareness is an active, growing knowledge of self and others and the world in which we live. This process helps people who are sensitive to change. It can predict or transform the significance of women in society.

4. Consensus is an active commitment to group solidarity and group integrity.

5. Evolvement is a commitment to growth, where change and transformation are conscious and deliberate.

Thus, the socialist feminist alternatives are not opposites, but they do contrast sharply with the patriarchal model. Using the socialist feminist perspective as conceptual based and grounded theory as the method, it can be integrated without violating the assumption of each other (Keddy, Sims & Stern, 1996:448; Wuest, 1995:134-135). Furthermore, the integration of two approaches enhances the rigor of research methodology. The consensus between socialist feminism and grounded theory are detailed as follows:

Table 1: Comparison of socialist feminist perspective and grounded theory

Socialist feminist perspective	Grounded theory
Knowledge of relationship and contextual of women and their social setting. Women's experience is source of evidence and a starting point of inquiry.	More holistic approach than quantitative Aims to develop theory-explaining process. This theory reflects to the whole view of phenomena.
A thoughtful reflection and action that occurs in synchrony. Praxis is values made visible through deliberate actions.	Reciprocal process in sampling strategies, data management and interpretation
Awareness is an active, growing knowledge of self and others and the world in which we live. This process helps people who are sensitive to change. It can predict or transform the significance of women in society. Consensus is an active commitment to group solidarity and group integrity.	Allow to using various sources of data such as documents, personal experiences, professional experiences, participants, and field. Data obtained by interaction between researcher and participant.
Empowerment is growth of personal strength, power and ability to enact one's own will and love for self in the context of love for others. Evolvement is a commitment to growth, where change and transformation are conscious and deliberate.	Many sources of data allow researcher and participants can share information and share value.

Study setting

The settings in this study are the two areas in the lower northern part of Thailand.

1. Health service setting: A regional hospital in the lower northern part of Thailand that receives referrals from other hospitals in its network. The services of this

hospital are for the population in Phitsanulok, Petchaboon, Pichit, Kampamgpetch, Sukhothai, and Tak Provinces. This hospital provides services for women with breast cancer that covers about a 4 million population in 6 provinces. The rate of women with breast cancer hospitalization in this hospital nearly equals others in Thailand which have women with breast cancer in 1998 and 1999 as 342 and 391 respectively (Jaipat, 1999:41; Jaipat, 2000: 40).

For the breast cancer service, it has a screening service from 8.30 a.m.- 4.30 p.m. every Tuesday except for national holidays. Only one doctor and one nurse are responsible for this service. However, this hospital lacks a radiation machine. For the women who must receive radiation they are referred to upper a northern cancer center is Lampang and Lopburi Provinces, or the university hospital in Chiangmai, or Bangkok Province.

In summary, the caring system of women with breast cancer is using medication for symptom management in only the hospital. There is ineffective referral system for continuing care that side effects mainly occur at the women's home (details in chapter II).

2. The women's homes: Thirty women who receive chemotherapy at the regional hospital lived in the lower northern part of Thailand. The characteristics of the area are the rural areas except some areas are the urban areas. The characteristics of families are both extended and nuclear families. The occupations are agriculture including working in the paddy fields and farming. Most of transportation is by bus. The characteristics of the women in this area are that they are more obedient, compromising, and non-refusing than women in other parts (Fongkaew,1995). Generally they have the roles as homemakers. Some of them work both in and outside the home. They are the caretakers and caregivers in the families too (Wasikasin & Hamaprasit, 1998: 49,53).

Data sources and data collection

Data sources

Data sources are both the people and documents. Data sources includes:

1. Personal experiences are data sources of a person who experiences this phenomenon.

1.1 Women receiving chemotherapy during cycles 1-6 after surgery are the direct data sources in this study. They have experiences from the treatment. These women's data are the emic view.

1.2 Significant family members who care for these women are the women's homes context. They are utilized to broaden the process in this phenomenon.

1.3 Health cares providers are the etic view. They are employed for completeness of the process in this phenomenon.

2. Hospital records are the data adjunct to this study. They detail the treatment that health care providers manage or care for these women.

Data collection

The start of data collection is when the researcher obtained the letter for collecting data permission from the Dean of Graduate School, Mahidol University to the Director of the regional hospital. After the Director gave permission the researcher started in the data collecting process as follows:

Obtrusive data is the data sources that are prone to personal privacy. Before collecting data, all of the women were informed about the process, procedure, and benefits of the study. They were given opportunity to ask questions. The researcher built up trust with the 30 women with cancer receiving chemotherapy, 19 family members of the women, one nurse, and one doctor. To obtain this data, there are the methods as follows:

1. In-depth interview: To search for the data in the emic and etic views about the events, situations and incidents in the phenomenon of the caring process for women receiving chemotherapy for breast cancer. The researcher used broad and in-depth questions to get the real issues that affect these women. Each interview lasted at least 30 minutes and most ran for well over 1 hour. The average was 45 minutes. The variation of time was related to the personality of the participants as well as the richness and complexity of information. In the data collecting process, the researcher used praxis, empowerment, awareness, consensus and evolvement to understand the context and conditions that enhance women's power to deliberate all the time. The researcher interviewed as follows:

1.1 Women with breast cancer receiving chemotherapy: The objectives of this interview were to obtain the personal experiences after receiving chemotherapy, and how they cared for. These interviews focused on the data those women faces at their homes. Examples of questions are: Please tells me about your experience of chemotherapy side effects? When did the symptoms emerge? How did this change your life? How did you care for these symptoms? How did your family and health care providers care when you faced these symptoms? What are the factors related to hindering or facilitating care when you received your chemotherapy? How are you after receiving care?

1.2 Significant family members who care for these women: The objectives of this interview was to obtain information about the women receiving chemotherapy at their homes and the data related to the services from health care providers. These interviews focused on adding to the data from the women. Examples of questions are: Please tell me about experience of chemotherapy side effects that the woman in your family faced? When did the symptoms emerge? How did this change the woman in your family? How did you care for these symptoms? What are there the facilitating or blocking factors related to your caring? How are they related? How do you think about outcome of care after giving care? What's about your age, educational status, working status, marital status, race, religion, and relationship with woman with breast cancer?

1.3 Health cares providers: The objectives of this interview are to obtain the etic view that are related to the problems which health care providers expected women to have while receiving chemotherapy. Other objectives include looking at the success of the services provided and the treatment results. It is this significant data resource that demonstrates the whole effect of the caring process. These interviews focused on the data to add to the data from the women and significant family members who help to care for these women in this caring process. Examples of questions: Please tell me about your care for women receiving chemotherapy? Do women and family ask for help from you? How do you care them? Do you communicate with your team about caring for women? How? What are the factors related to caring when women with breast cancer received chemotherapy? How are they relating? What do you think the outcomes of care are? What's about your educational status, working status, religion, and the length of time that they worked for caring of women receiving chemotherapy?

2. Physical examination: The objective of this is to obtain the signs and symptoms of the women receiving chemotherapy by using professional knowledge of the researcher. The researcher will use the physical examination to assess the changes of the women's body after receiving chemotherapy. Moreover, the researcher asks the length of time that related to these symptoms. The physical examination includes general appearance, hair, skin, mouth mucous, nails and other assessments. (Appendix B)

3. Observation includes:

3.1 Observation at the hospital: The objective is to study the context of services in the health care setting. The observations include the caring process for women receiving chemotherapy of the physician and nurse, interactions between the women and health care providers in the outpatient and inpatient units.

3.2 Observation at the women's homes: The objective is to study the context of the women's homes. The researcher will observe the character of the home, the way of living, interactions between the women and theirs families, the practice of the women and theirs families in managing the side effects of chemotherapy, and the problems they experienced in managing. (Appendix B)

4. Hospital records: By permission from the doctor. The objective is to get the data of chemotherapy treatments and everything that health care providers provided in caring care for women.

Protection of human subjects

The researcher identified herself as a nurse researcher while conducting this research process and used the research transaction in the entire process. The researcher demonstrated and confirmed the ethical issues throughout the whole research process for the participants trust in providing the data.

The participants can make a decision to collaborate in this study without using any authority. The questions in this study will carefully be asked to imply no judgement. The participants can cancel or stop the interview at anytime (Appendix A).

In the study process, the researcher will transcribe all audiotapes. Audiotapes, transcriptions, notes, and computer files are secured in researcher's locked cabinets. Only the researcher and advisory research committee in this study can have access to the raw data. The anonymity of participants is replaced with coding and pseudonyms. In the end of the study, audiotapes, transcriptions, notes, and computer files will be immediately destroyed.

Data management, data analysis, and sampling strategies

Data management

The data analysis uses the grounded theory method. The data from in-depth interviews, observations, physical examinations, medical and nursing reports were used to manage the data. The times that the researcher collected the data were as follows:

1. Data form in-depth interview: the researcher immediately verbatim transcribed the audiotapes into text.

2. Data from observation: the researcher recorded all interactions during observations in the setting.

3. Physical examinations documented in record forms

4. Hospital records

Data analysis and sampling strategies

The researcher analyzed the data and combined it with memos and diagrams to write a tentative model. Memos and diagrams writing could be used for facilitate the researcher in considering the data. This process continued to discover the knowledge until the end.

In writing memos, a research diary was composed of personal notes, theoretical notes and methodological notes. A personal note was used to demonstrate the feelings and reflections of the researcher during this study. Theoretical notes were the theoretically sensitizing and summarizing memos. These contained the products of inductive or deductive thinking about relevant and potential relevant categories, the properties, dimensions, relationships, variations, process, and condition matrix. These memos were used to develop ideas about the emerging concepts, categories, and their relationships. Methodological notes were used to record issues about sampling and data collection, and to document important decisions. Diagrams were visual representations of relationships between concepts. In the early open coding, one had very little to diagram, for few relationships are established. In axial coding, diagrams became more complex with time. These diagrams were progressive in selective coding. They helped the researcher to classify and systematize the relationships that existed between categories and the core categories, and demonstrated the density and complexity of the theory.

Data analysis of grounded theory was composed of open coding, axial coding and selective coding (Strauss & Corbin, 1990:58). The process of data analysis was a reciprocal process with sampling strategies. In this study, the grounded theory method has various sampling strategies, which are suitable for each data analysis phase. It is demonstrated as follow**:**

1. Open coding is the initial process of the study. Its objective is concept formation by obtaining a lot of data, naming, and categorizing the data (Strauss & Corbin, 1990:61). **Selective sampling** was also called **purposeful sampling** was used in the beginning stages of data collection. Six women with breast cancer receiving chemotherapy in 1-6 cycles were this sampling in which the phenomenon of interest was most likely to occur. Moreover, the researcher used **typical case sampling**, a doctor and a nurse who work with women receiving chemotherapy and families of six women, to highlight what was the typical and normal in this caring process.

In this open coding process, the researcher used the data from the in-depth interviews from these participants, observations in health care setting, physical examinations, and medical and nursing reports for initial theoretical codes. These were the codes from the data in the initial part of the study by breaking the data down, comparing and contrasting the incidents and the facts with other similar phenomena.

To portray the process of open coding, an example is given here. The words of the participants were: *"I feel distressed because I don't know what will happen next. You know, everybody knows this disease is serious."* This statement clearly indicated naming "cancer is a serious illness". The next example is, *"Sometimes I can't help thinking: why does it have to be me? I don't want to get ill. I* *am quite afraid that it might be incurable. When I know more about it, like reading about it, I know that the disease may recur".* These statement clearly indicated naming "cancer is incurable". Another example, the words of the families were: *"I give her supplementary food like Brand. I try to feed her with nourishing diet so the body can make more blood cells. I understand this need very well and am quite interested in it. I am lavish for her recovery","I bought Brand, bought bird nest but she did not eat it. She kept saying no. I'd like her to be stronger. I told her to have a lot of boiled mushroom to nourish the body" , and "I try to get food that she can eat, like fruits or milk. I try to get her the foods that she likes such as chili dips with vegetables. Helping her to eat at a small amount. Sometimes I cooked boiled rice for her."* These statement clearly indicated naming "provision of nourishing diet".

2. Axial coding is the process of reassembling data that is broken during open coding. In axial coding, categories are related to theirs subcategories to form more precise and complete explanations about phenomena (Strauss & Corbin, 1998:124). The objective of axial coding is to develop a concept by making connections between categories. This uses a paradigm model, an analytic tool devised to help analysts integrate structure with process, to link the relationship among subcategories and categories in terms of conditions, context, intervening conditions, action/interaction strategies and consequences (Strauss & Corbin, 1990: 96; Strauss & Corbin, 1990: 123). In data gathering and analysis, the researcher wanted to sample incidents and events (from either new of previously collected data) that enable her to identify significant variations. The researcher began using **theoretical sampling**, the sampling on the basis of concepts that have proven theoretical relevance to the evolving theory, to refine the concepts.

In this process, the researcher added the other samplings from the women and significant family members to develop the concepts by making connections between categories. For example, in the outcome of caring, the researcher searched another phenomena that demonstrated variety of outcome of non-professionals in family-based care, therefore she used **criterion sampling**, the women whom had delayed treatment that reflected negative outcome of non-professionals in family-based care. **Extreme or deviant case sampling**, the women facing many side effects of chemotherapy that they could not receive the next chemotherapy regimen, used to add to the variety of outcome of non-professionals in family-based care as well. For refining the concept of adjustment of caring quality for the loved one and deviated ways of caring, **opportunistic sampling** was the selection in the fieldwork for observing the activities, care actors whom provided caring, and the time of caring. Moreover, **critical case sampling** was the advancement of knowledge and experience of both emic and etic view, the view of not only clients but also health care professionals. A retired nurse with cancer receiving chemotherapy had both emic and etic views to obtain the full data.

To portray the process of axial coding, an example is given here. In this process, the researcher developed a concept by making connections between categories. Therefore, *"bad new induced need of care", "illness induced need of caring", "sick role induced need of care", "fear of cancer induced need of care",* and *"treatment induced need of care"*, were put into the category of *"situation induced need of care".* Another example is *"constraints on caring," "promotion of care,"* and *"change in the setting of care"* were put into *"intervening conditions"*, the influencing in caring process in Thai woman with breast cancer receiving chemotherapy.

3. Selective coding is the process of theoretical development for fitting, completeness, congruence and harmonious in the phenomenon. This process selects the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development. The objective of this process is concept modification and integration.

In this step, the researcher also used all data to testing the relationship, completeness, and congruence between the theory and phenomenon. The properties of the concept were then explored through the process of constant comparative analysis, in which each data item was compared systematically with every other. Throughout this coding process, the views of other women and family were used to validate the interpretation of the data. **Maximum variation sampling** was the addition to purposeful random sampling for various data. The women and significant family members in this group provided information about their age, educational status, working status, and marital status. Moreover, the family who provided good care for the women and these who did not take care for women were added in this process too. Moreover, **confirming and disconfirming cases**, the phenomena of women receiving good and non-good caring, was the selection for elaborating and deeping on the initial analysis, seeking exceptions, and testing variation. This sampling utilized for emergent patterns that confirmed the knowledge and made advancement in the knowledge.

The objectives, sampling strategies and data analysis were concluded in the Table.

Table 2: The objectives, sampling strategies and data analysis in the study of a caring process for women receiving chemotherapy for breast cancer.

Objectives	Sampling strategies	Data analysis
To explore , name, and categorize of the data	- Purposeful sampling - Typical case sampling	Open coding
To develop concepts by making connections between categories. Use a coding paradigm that involves conditions, contexts, action/interaction strategies and consequences	- Critical sampling - Extreme or deviant case sampling - Opportunistic sampling - Criterion sampling	Axial coding
To develop the theory for fitting, completeness and congruence of the phenomenon	- Maximum variation sampling - Confirming and disconfirming	Selective coding

The number of participants were considered from the theoretical saturation that are 1) no new concepts were emerging, 2) the categories of the theory were full in all of them, and 3) all of the categories explained the process and variety. There was the connection of all the categories and it was well explained in the entire phenomenon.

Rigor in the research

Rigor in this study was the qualitative research which the researcher approved this study in all of the research process. It emerged in the content and process of the research. The criterion of the rigor of this qualitative research included credibility, fittingness, auditability and confirmability (Guba & Lincoln,1981; Beck,1993:264).

Credibility measured how vivid and faithful the description of the phenomena was. The researcher demonstrated this by:

1. Sampling strategies were different in the women group that had diversity in events, incidents and experiences. Moreover, this study considered age, educational status, working status, and the intensity of the side effects of chemotherapy.

2. The collecting of data was from many sources and methods. The data sources were personal experiences, professional experiences, chart reviews, documents and literature. The methods in data collection were in-depth interviews, observations, physical examinations, literature and documents.

3. The researcher was collected the data until 1) no new concepts emerged, 2) the categories of the theory was full in all of them, and 3) all of the categories explained the process and variety. There was the connection of all the categories and it was well explained in the entire phenomenon.

Fittingness or transferability was demonstrated in the study by congruence in the other women receiving chemotherapy for breast cancer. The researcher confirmed the results by making the documents for fittingness testing to apply to other women receiving chemotherapy for breast cancer.

Auditability. The reliability in quantitative research measured how consistently an instrument obtained similar results over repeated testing periods. With qualitative methods, the criterion of auditability, rather than reliability, was more fitting. Guba & Lincoln (1981) referred to auditability as the ability of another investigator to follow the decision or audit trail. The decision encompassed all the decisions made by the researcher at every stage of data analysis.

Confirmability meant obtained direct and often repeated affirmations of what the researcher had heard, seen, or experienced with respect to the phenomena understudy (Leininger, 1994:105). Guba and Lincoln (1981) suggested that conformability was achieved when credibility, transferability, and auditability were established.

Summary

The grounded theory approach was both a ways to do qualitative research and a way to create an evolving theory of caring process of Thai women with breast cancer receiving chemotherapy. Several of sampling was used in the stages of data collection within informed consent for the rights of participants' protection. Data were collected through the use of in-depth interview, observation and personal information records. Data analyzed by the strategies of Strauss and Corbin. The criterion of the rigor of this qualitative research included credibility, fittingness, auditability, and confirmability.

CHAPTER IV

OVERVIEW OF THE FINDINGS

The grounded theory portrayed here is enacted from the realization that the caring process of Thai women with breast cancer receiving chemotherapy. The study findings are presented in five sections. The first focuses on the characteristics of participants and overview of the evolving theory of caring process of Thai women with breast cancer receiving chemotherapy. The second focuses on the causal condition of caring process, which is the first phase in this caring process: "situation induced need of care," and "emergence of care agents and ways of caring." The third focuses on the intervening conditions of caring process that consists of three categories: "constraints on caring," "promotion of care," and "change in the setting of care." The forth addresses on a shift from care agents to non-professionals in family based care, the action/interaction strategies, which is the second phase in the "caring process of Thai women with breast cancer receiving chemotherapy." It consists of two categories: "adjusting quality of care for the loved one," and "deviance from the right ways of caring." The last phase focuses on outcomes of care, the consequence of caring process, which is the third phase. In this theory it consists of two categories: good outcomes and poor outcomes.

In the presentation, the constructs and the concepts emerging from the raw data in each phase are presented. Statements from interviews and observations are quoted with identification numbers and transcript page numbers.

Characteristics of participants

Data of Thai women with breast cancer receiving chemotherapy

All the Thai women with breast cancer receiving chemotherapy in this study were Buddhists. Age of Thai women varied from 33-70 years with a mean of 45.8 years and a standard deviation of 9.31. Income in family varied from 1,000-30,000 baht/month with a mean of 6783.33 baht/month and a standard deviation of 707.00.

Cost of transportation varied from 40-350 baht with a mean of 155.33 baht and a standard deviation of 71.86.

The majority of women were couple (63.3 %, n=19). Twenty-four of them has a primary education (80.0%). Twenty-two of them were resident in Phitsanulok (73.4%) and eleventh of them were employee (36.6). Thirteen of them used health card for payment of care (43.3%). The majority of women had nuclear family (76.7%).

Table 3 : Characteristics of Thai women with cancer

Characteristics		Frequency	Percentage
Marital status			
	Single	2	6.7
	Married	19	63.3
	Separate	4	13.3
	Windowed	5	16.7
Educational background			
	None	1	3.3
	Primary school	24	80.0
	Vocational school	2	6.7
	Bachelor degree	3	10.0
Residence			
	Phitsanulok Province	22	73.3
	Sukhothai Province	3	10.0
	Pichit Province	3	10.0
	Pethchaboon Province	2	6.7
Occupation			
	None	3	10.0
	Employee	11	36.6
	Agriculture	7	23.3
	Official	3	10.0
	Merchant	2	6.7
	Housewife	2	6.7
	Own business	1	3.3
	Retirement	1	3.3
Payment for care			
	Health card	13	43.3
	Gov. Official welfare	8	26.7
	Health welfare	7	23.3
	None	2	6.7
Type of family			
	Nuclear family	23	76.7
	Extended family	7	23.3

The data of Thai women with cancer as related to chemotherapy indicated that five of Thai women with breast cancer receiving chemotherapy for neo-adjuvant chemotherapy (16.7 %). Two of them were in the recurrent group (6.7 %). Eighteen of them had second stage cancer and received CMF for treatment (60.0%). Twenty-seven of them had invasive ductal carcinoma (90.0%) and 96.7% of them had continuous treatment.

Table 4 : Data of Thai women with cancer related chemotherapy

Characteristics		**Frequency**	**Percentage**
Regimens			
	CMF	18	60.0
	FAC	12	40.0
Stage of cancer			
	2	18	60.0
	3	12	40.0
Site of breast cancer			
	Left	18	60.00
	Right	12	40.00
Type of cells			
	-invasive ductal carcinoma	27	90.0
	-invasive lobular carcinoma	1	3.3
	-adenocarcinoma	1	3.3
	-medullary carcinoma	1	3.3
Continuing in treatment			
	- schedule continuity	29	96.7
	- dropped out	1	3.3

Characteristics of family

Nineteen families care actors were participants in this study. It was found that most of them were Buddhists. Age of them varied from 12-75 years with a mean of 42.11 years and a standard deviation of 12.03. Eleventh of them were male and husband of women with breast cancer (57.9%). Thirteen of them were married (68.4%) and eight of them were farmers (42.1%).

Table 5 : Characteristics of family of Thai women with cancer

Characteristics		Frequency	Percentage
Sex			
	Male	11	63.2
	Female	8	36.8
Relationship with women			
	Mother	2	10.5
	Husband	11	63.2
	Daughter	6	26.3
Marital status			
	Single	4	21.1
	Married	13	68.4
	Separated	2	10.5
Educational background			
	None	2	10.5
	Primary school	10	52.7
	High school	2	10.5
	Vocational school	3	15.8
	Bachelor degree	2	10.5
Occupational			
	None	2	10.5
	Farmers	8	42.1
	Own business	2	10.5
	Employee	2	10.5
	Official	1	5.3
	Merchant	1	5.3
	Local politician	1	5.3
	Student	2	10.5

Data of health care professionals whom responsibility for woman with breast cancer receiving chemotherapy

There was only one nurse and one physician for direct responsibility for woman with breast cancer. The nurse was a registered with a bachelor degree. She had four years experience in breast cancer caring (started from April,1999). In breast cancer care, she had only training by climate work with the head nurse and doctor. The physician received a specialist status in general surgery. He trained for oncology from abroad many times. He had six years experience in direct responsibility for woman with breast cancer (started from October, 1997). Both of them had a polite personality.

Overview of an evolving theory "caring process of Thai women with breast cancer receiving chemotherapy"

The finding of the phenomenon by using grounded theory was presented in type of relationship, categories, subcategories, properties and dimension. Type of relationship composed of causal condition, intervening conditions, action/interaction, and consequences (Strauss & Corbin,1990: 96-97). A causal condition is the events, incidents, happenings that lead to the occurrence or development of a phenomenon. Intervening conditions are the structural conditions bearing on action/ interaction strategies that pertain to a phenomenon. They facilitate or constrain the strategies taken within a specific context. Action/interaction is strategies devised to manage, handle, carry out, and respond to a phenomenon under a specific set of perceived conditions. Consequences are an outcome or results of action and interaction. Whereas, properties are the most concrete feature of something (idea, thing, person, event, activity, and relation) that can be conceptualized, which will allow the order of specificity required by analyst for purposes of her or his research (Strauss, 1990:21).

The phenomenon of this study was "caring process of Thai women with breast cancer receiving chemotherapy." This phenomenon has three phases.

The first phase, emerging of caring process, was the causal condition. Emerging of caring process is composed of "situational induced need of care" and "emergence of care agents and ways of caring".

Situational induced needs of caring were as follows: "bad news induced need of care," "illness induced need of care," "sick role induced need of care," "fear of cancer induced need of care," and "treatment induced need of care".

Emergence of care agents and ways of caring were as follows: "caring is professional responsibility," "caring is family sharing responsibility," and "women performed self-care".

The second phase, a shift from care agents tonon-professionals in family based- care, was the action/interaction strategy in this caring process. It composed of "adjusting the quality of care for the loved one," and "deviance from the right ways of caring."

The last phase, outcome of care, was the consequence of caring process. This consequence is composed of "good outcomes of care," and "poor outcomes of care".

Moreover, intervening conditions of this caring process were “constraints on caring,” “promotion of caring,” and “change in the setting of care”.

All constructs and concepts in this evolving theory “caring process of Thai women with breast cancer receiving process” are summarized in Table 6

Table 6 : Initial study findings from grounded theory analysis

Type of relationship	Categories	Subcategories	Properties	Dimension
Causal condition	Situation induced need of care	Bad news induced need of care	Situation related to receiving news. This news was negative views in illness that had impact on a woman's usual lifestyle. It is comprised of the news of having serious illness, the news of health deviation, specifically in healthy woman. Bad news also led to discouragement and care requirements.	High intensity/ Low intensity
		Illness induced need of care	Situation related to illness. This illness led to decreased role performance, inability to maintain the usual role, and inability to perform self-care. This illness also induced the need of caring in women with cancer.	High intensity/ Low intensity
		Sick role of woman induced need of care	Situation related to sick role of women with breast cancer. In general, women are usually perceived as a major caregiver of the society. The caregiver role of women is especially dominant in a family. When the women had breast cancer, it was generally perceived as ill persons and they normally took a sick role. Thus, they need someone to care for them. This situation led to need of caring	High intensity/ Low intensity

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	Categories	Subcategories	Properties	Dimension
Causal condition		Fear of cancer induced need of care	Perceiving of cancer is a serious illness. It is an incurable disease and it can recur. Moreover, people with cancer may die sooner than usual, the disease can spread to other parts of the body and its treatment is costly. Fear of cancer led to need of caring	High intensity/ Low intensity
		Treatment induced need of care	Treatment is the process in which physician used to cure cancer cells. The women developed needs of caring from the reception of information about medication side effects and long term for curing. Moreover, side effects of chemotherapy also have negative impact on women's role performance and their images.	High intensity/ Low intensity

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	**Categories**	**Subcategories**	**Properties**	**Dimension**
Causal condition	Emergence of care agents and ways of caring	Caring is professional responsibility	Health care profession responsibility to deliver care to women with cancer, who are their clients. They play their roles as educated from well-established academic institutes. Their education is based on knowledge about specific disciplines, scientific learning and references such as textbooks for the delivery of professional care. For the family, the members have responsibility in caring for an ill member.	Taking actions effectively/ Ineffectively
		Caring is family sharing responsibility	The family's delivery of care, however, should be shared with health care staff. Each family demonstrated different ways of caring, depending on their situation. The women also looked after themselves.	Taking actions effectively/ Ineffectively
		Women performed self-care	The performance of self-care either emerged from self-confidence, or resulted from the lack of caregivers in the family.	Taking actions effectively/ Ineffectively

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	Categories	Subcategories	Properties	Dimension
Intervening Conditions	Constraints on caring	Constraints on Professional care	Constraints on professional care were the blocking factors related to professional care that could interfere or delay the process of caring. These constraints were underused of nurse's proficiency, the delivery of nursing care as a supplementary role rather than a major role, and the exclusive restriction of woman care to physicians.	High intensity/ Low intensity
		Constraint on family care	Constraints on family was the blocking factors related to family that could interfere or delay the process of caring Constraint of family was lack of essential information about caring, and the sense of family burden due to the uncooperative manners of the women.	High intensity/ Low intensity

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	**Categories**	**Subcategories**	**Properties**	**Dimension**
Intervening Condition		Constraint on self-care	Constraints on self-care were the blocking factors that could interfere or delay the process of caring. Constraints of women were a cause of limitation in the reception of knowledge about self-care, restrictions on information exchange with health care professionals, financial problems and transportation.	High intensity/ Low intensity
	Promotion of care	Professional Encouragement	The facilitating factors related to health care profession that influences the women in caring process in positive ways. This factors composed of various significant sources of health care providers such as giving time for taking and mental support It helped the women by raising their spirit in managing the symptoms.	High intensity/ Low intensity
		Support from family and other people	The facilitating factors related to family and other people that influence the women in caring process in positive ways. This factor is composed of mental support, being nice to women, giving close care and helping them.	High intensity/ Low intensity

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	Categories	Subcategories	Properties	Dimension
Intervening ondition		Self-encouragement	Self-encouragement was the most significant support that woman created by herself. It composed of building hope for recovery from the disease, hope for longer life-years and hope that the disease would be cured.	High intensity/ Low intensity
	Change in the setting of care	Care-sharing between nurse and the families .	Nurses used proactive role by her knowledge that side effects emerged at woman's home. Thus, nurse suggested the family to take care of the women.	Taking actions effectively/ Ineffectively
		change of care setting from hospital to women's home	Shift of care setting from hospital to women's home because women received the treatment at a cancer unit and went back home straight after the treatment was completed. The symptoms of medication side effects, therefore, occurred, while the women were at home.	Good prepare/ Not good prepare

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	Categories	Subcategories	Properties	Dimension
Action/ Interaction strategies	A shift from care agents to non-professionals in family based-care	Adjusting the quality of care for the loved one	Action of the family that made an effort to give the best care to the person they loved within their limitation. They tried to adjust their ways of caring to be relevant with the woman's problems or sufferings. The adjustment of caring included supportive caring to help the woman overcome the crisis period of chemotherapy. The supportive caring comprised the provision of nourishing diet , financial care, and caring for the compliance with treatment.	Taking actions effectively/ Ineffectively
		Deviance from the right ways of caring	Action of the family that made an effort to provide the best care to the person they loved. However, they might confront limitations and had to alter the ways of caring in response to the woman's problems or sufferings. The deviation in the ways of caring might be developed from making a trial and being patient with the problems.	Taking actions effectively/ Ineffectively

Table 6 : Initial study findings from grounded theory analysis (cont.)

Type of relationship	Categories	Subcategories	Properties	Dimension
Consequence	Outcomes of care	Good outcomes of care	The result of caring that demonstrates in the good ways. It composed of the good psychological, physical strength, Women's willpower and family strength.	Recognized/ Unrecognized
		Poor outcomes of care	The result of caring that demonstrates in the worse ways. It composed of the being unhappy and problems in physical stamina.	Recognized/ Unrecognized

CHAPTER V

PHASE I: EMERGING OF CARING PROCESS

This chapter presents causal condition that is the first phase in the caring process in Thai woman with breast cancer receiving chemotherapy. This phase explains the emergence of the caring process, which consists of three constructs including "situation induced need of care," "emergence of care agents," and "ways of caring."

Situation induced need of care

This study has found that the caring process for Thai women with breast cancer who receive chemotherapy was mainly initiated from various situations that induced the need of care. Situation induced need of care is the situation that is related to women's illness and led them to face to seriousness in daily living life, psychological, physical, social and economic problems, and changes in their life in the future. Although this study was focused on the reception of chemotherapy, several relating situations, which are impact of cancer, were inseparable from the process of chemotherapy. These situations included 1) bad news induced need of care, 2) illness induced need of care, 3) sick role induced need of care, 4) fear of cancer induced need of care, and 5) treatment induced need of care, as discussed in details below.

1. Bad news induced need of care

Bad news commonly occurs in a person's life, depending on his or her living context and perception. For women with breast cancer, the bad news that induced need of caring was the news about her illness, which is a major component contributing to care requirement. The bad news about illness that had an impact on a woman's usual lifestyle comprised the news of having a serious illness, the news of health deviation, specifically in healthy woman. Bad news also led to discouragement and care requirements.

1.1 News of having serious illness threat into a woman's life

One day while a woman was living her normal life, she felt ill and received the news that suddenly made her life feel like it was being lurched away- the news of a serious illness. This news led the woman to confront emotional problems, as stated in the following examples:

> "I did not have much symptoms at first, just a small nodule. A neighbor said I'd better have it pierced; it would take only half a day and I'll recover very soon. Seven days after cutting it off, I went to see the doctor…to get the test result. The doctor said that lump was a malignant tumor. I couldn't say anything at all; I just went back home and cried."
> (Woman ID.26-P6)
>
> "I used to wonder why this disease happens to me. But lately the doctor said many people have it too."
> (Woman ID.28-P3)
>
> "The main turning point for me is having cancer. It's normal at first. It's like I was happily strolling on a mountain, enjoying the view, the birds and the trees; and, all of a sudden, I fell into a deep abyss. I dropped into that deep space and I have to struggle back. I have to climb back to the mouth of the abyss."
> (Woman ID.30-P3)

1.2 News of woman's health deviation

The women perceived that her health was deviated from a normal condition. This news had a strong impact on the women, specifically those who had been healthy until receiving the bad news, as stated in the following statements.

> "Nurses asked me if I was discouraged. I said I was- I felt sad and I did not know what I could do. I was never ill before."
> (Woman ID.04-P7)
>
> "She has this disease. I know she will be upset. She was never ill since she got married. When this thing was found – the cancer, she have to rest all the time. It's normal to think about it."
> (Family of woman ID.21-P5)
>
> "Normally, I am healthy. I would not easily get ill, if I did not have cancer."
> (Woman ID.25-P4)

1.3 News that induced discouragement

This news led women to the feeling of despair, discouragement and hopeless. For example,

> "I felt distressed. I have a serious illness. I cried everyday at first. For all the disease it could be, I've got this severe disease."
> (Woman ID.12-P5-6)

> "She has lost her spirit, has lost it ever since she has known she's got the disease."
> (Family of woman ID.1-P27)

2. Illness induced need of care

Apart from the bad news, illness also induced the need of care in women with cancer. The illness led to decreased role performance, inability to maintain the usual role, and inability to perform self-care.

2.1 Decreased role performance

The illness altered the woman's health condition and had an impact on her performance of various activities. The decreased in role performance also led to problems of emotional changes, as stated below.

> "It's like my health is not the same as before. I am upset sometimes, as I cannot do anything I'd like to do. I was able to do it before and, suddenly, I am unable to. Sometimes I feel annoyed and upset, you know, I want to do something but I cannot do it, as I want to, because I am ill."
> (Woman ID.09-P1)

> "I was a worker but now I cannot work anymore. So I just stay home, doing nothing. I can do only a few things because I am ill. To be a worker you need physical strength, but I have no strength now. I am getting old too; my eyes and my ears are not good anymore so I have to stop working."
> (Woman ID.24-P3)

> "I worked in the rice field before. I still want to work there but I cannot do it. If somebody hires me to do some light work, I'll take it. But for heavy work, I have to refuse. I cannot do it."
> (Woman ID.16-P4)

2.2 Inability to maintain the usual family role

The illness disabled the woman in maintaining her usual role in the family, either as a wife or a mother. Some women said,

> "I stopped working when I knew I had this disease. Only my husband has a job now. He said I shouldn't work; he's afraid my illness will worsen. I am unable to work anyway. I am always very tired and have to sleep all the time."
> (Woman ID.14-P2)
>
> "I stop doing some housework and do not have sex with my husband."
> (Woman ID.23-P3)
>
> "I cannot just stop doing something. When my child is ill, it's difficult not take care of him or to sleep further away from him. You know, we always sleep together and now I have to separate from him. My child is still very young. He doesn't understand that I am ill."
> (Woman ID.27-P3)

2.3 Inability to perform self-care

In addition to the impact on role performance, illness also had an impact on the woman's performance of self-care. Having cancer restricted the woman from conducting usual self-care activities, as exemplified below.

> "It's…aching. I have body ache. The tiredness is not too bad, not too much. It's my mind that is very tired and despairs. I used to be able to go anywhere, to do anything. I was able to do anything like other people."
> (Woman ID.06-P5)
>
> "I am tired. I want to sleep. I cannot do anything, too tired to do anything."
> (Woman ID.13=P3)
>
> "My mother stays at another place but when I am ill she comes to stay with me. She helps me with housework, cooking, taking care of the house chores."
> (Woman ID.14-P1)

3. Sick role of woman induced need of care

Women with breast cancer had to take a sick role. In general, women are usually perceived as a major caregiver in society. The caregiver role of women is especially dominant in a family, which is the smallest social unit. A woman normally cares for other members of the family; however, she has to receive care from members of the family when she becomes ill.

3.1 Having sick role

Breast cancer is perceived as a chronic severe disease that may spread to other parts of the body. Hence the women with breast cancer were generally perceived as ill people and they normally took a sick role. Some women said,

> "When I become ill, I take care of him less than before because I am unwell too."
> (Woman ID.24-P3)

> "What's frightening is the disease inside me. Also, my child is still young. It makes me feel stressed and very worried."
> (Woman ID.29-P2)

3.2 Being the family caregiver

The woman was usually the caregiver of a family, caring for the living, well being, and performing of duties among the family members. In addition, when a member of the family became ill, the woman usually took care of the ill person.

> "I have to take care of my mother too. She has heart disease and hypertension. I am more likely to be the caregiver of the family."
> (Woman ID.18-P12)

> "There are several ill people in our family. My aunt has to take care of the others. There are ill people at home and my aunt's duty is to take care of them."
> (Woman ID.24-P6)

3.3 Care provision from the family

Illness with breast cancer put the woman into the sick role and other family members provided care for her, as stated below.

> "My mother and my husband care for me. My mother lives somewhere else but she comes to stay with me when I am ill. She helps me in doing housework, cooking, taking care of the house. We do these works together. When I come here for a week treatment, I'll stay with my mother. Next Tuesday, when the treatment finishes, my husband will

> take me back home. Normally, I take care of them. When I am sick, we reverse the role."
> (Woman ID.13-P13)

> "My husband and my daughter stay with me. They take turn in caring for me and in taking care of the food, housework, and rice growing. They do the works together. "
> (Woman ID.14-P3)

4. Fear of cancer induced need of care

The fear of cancer resulted from various components, including the fact that cancer is a serious illness, it is an incurable disease and it can recur. Moreover, people with cancer may die sooner than usual, the disease can spread to other parts of the body and its treatment is costly. Thus a woman's awareness of having breast cancer induces the need of caring.

4.1 Cancer is a serious illness

Among several diseases that have impact on a person's life, cancer is well known as a severe disease. The awareness of having cancer, therefore, induces fear and resulting in the need of caring due to distressed feeling.

> "I feel distressed because I don't know what will happen next. You know, everybody knows this disease is serious."
> (Woman ID.10-P9)

4.2 Cancer is incurable

Cancer is known as an incurable disease. This fact has been publicized through various media-radio, television, and publications, for quite a long time. The occurrence of cancer, therefore, induced fear and need of caring among the women, as stated below.

> "I know that this disease may recur, so I still feel unsure about it."
> (Woman ID.01-P15)

> "Well, what can I say? I don't really know how much this disease could be cured."
> (Woman ID.10-P2)

> "Sometimes I can't help thinking: why does it have to be me? I don't want to get ill. I am quite afraid that it might be incurable. When I

> know more about it, like reading about it, I know that the disease may recur."
> (Woman ID.27-P2)

4.3 Cancer may recur

The women knew that cancer might recur. They might perceive the recurrence from the experience of other patients or from their own experience. The recurrence of the disease induced fear and need of caring. Some women said,

> "I don't know if I will recover. Some people have it again after the surgery. I am afraid of that too. Some women had one breast surgery and have the disease again in the other breast. I am afraid that after an operation on one breast I may have it back on the other breast too. I am afraid of that."
> (Woman ID.02-P9)

> "Well, I am afraid because I have it again."
> (Woman ID.07-P8)

4.4 Cancer leads to early death

Breast cancer is perceived as a severe disease partly because of the fear of early death, as the disease may shorten a person's life. The expectation of early death had strong impact on women with family burdens.

> "My daughter-in-law and my son have come back to take care of me probably because they think I am not going to live much longer as I have this disease. Well, everybody fear of cancer, right?"
> (Woman ID.04-P7)

> "I cry on my own. I am afraid my son may not graduate, afraid that he may have to live alone. I cry everyday."
> (Woman ID.24-P5)

4.5 Cancer can spread to other body organs

The women perceived that cancer could easily spread to other parts of the body. The expectation of metastasis induced fear and need of caring among women with breast cancer, as expressed in the following statements:

> "At first I was afraid that it might spread through the blood vessels. When I have symptoms, I have body ache, feeling it trough the whole body. I can feel it even in the ribs. It's really painful."
> (Woman ID.06-P4)

> "People sometimes say I'll be dead after cutting it off, it will be spread, it will come out again here and there. These sayings scare me. I don't want to listen to anybody, don't want to go anywhere. I just go to see my sister, reading prayers, reciting prayers. Sometimes I want to take a nap in the daytime, but I can't help thinking about it."
> (Woman ID.29-P2)

4.6 Cancer is costly

Cancer is perceived as a costly disease because of its severity, tendency of recurrence and metastasis. Moreover, the disease requires long-term treatment, hence affecting incremental cost. As a result, the women were afraid of the disease.

> "My family is quite short of money. After knowing that I have this disease, we thought a lot about where we can get the money for medical expenses. We do not earn income of ten thousands anymore. The income has decreased to around a hundred something per day."
> (Woman ID.02-P8)

> "Sometimes I also think having this disease is quite a waste of time. I have to come to the hospital again and again. My children are not rich and I need to spend money for the transport too."
> (Woman ID.22-P6)

5. Treatment induced need of care

After establishing a diagnosis of breast cancer, physicians commonly perform their role by giving medical treatment. The major treatment, based on the standard of medical profession, is composed of mastectomy of the affected breast, followed by chemotherapy. In addition to its efficiency in killing cancer cells, chemotherapy has adverse effects on the patients; hence inducing need of caring. The women developed need of caring from the reception of information about medication side effects or from their experience with side effects. Moreover, side effects of chemotherapy also have a negative impact on women's role performance and their images.

5.1 Reception of information about side effects

The need of caring due to side effects of the treatment resulted from the woman's reception of information from health care professionals and the family. The information included symptoms occurring from the side effects of the medications, which induced the need of caring, as stated in the following interviews:

> "Well…at the beginning, I've already knew that I need the treatment. As I already said, the doctor told me that I needed the medications. Nurses told me that the medications are important because the lump was too big to set the operation and the medications will make the lump smaller so that we can cut it off. After the surgery I will need chemotherapy for another six months. They explained everything as written in the book they gave to me. So, it's like I've already know what is going to happen. I've knew it from the nurses and from the handbook they gave to me."
> (Woman ID.01-P16)

> "My daughter is a nurse. She told me before the surgery. She is a nurse in Lopburi. She said there would be side effects and you have to endure it. She said there are side effects and I have to take it. If I can take it I will be all right. She told me before the surgery. She came to see me, spoke to me before the surgery. 'Mom, after it is cut off you will receive medications and you will have these symptoms. You will have all the side effects,' my daughter told me."
> (Woman ID.05-P2)

5.2 Long-term treatment

The reception of information about long-term treatment induced the need of long-term caring among women with breast cancer. Some women said:

> "The doctor told me that I need the medications. Then nurses told me that I need the medications because the lump is too big for the surgery. The medications will make it smaller and then I can have the surgery. After the surgery, I will need the medications for another six months."
> (Woman ID.01-P16)

> "Well, I found the lump first. I've already had knowledge about this, right? So I went to see a doctor. The doctor gave me physical examination, you know, step by step. I had biopsy and then mammogram. After that they informed me about the result and made an appointment for the surgery. After the surgery, the doctor told me that I'll need chemotherapy for another six months."
> (Woman ID.17-P1)

5.3 Decreased physical functioning

The women perceived that after the reception of chemotherapy, their physical functioning would decrease due to the reduction in energy resulting from the effects of chemotherapy. The symptoms occurring from side effects of the medications include nausea, vomiting, lack of appetite and oral ulcers. These symptoms result from the effects of chemotherapy, which directly causes tiredness; consequently, the women have decreased ability in self-care and increased need of caring.

> "After the first course, I lost all my hair and vomited very often. The first two courses were not too bad. I would feel better after vomiting for a few days and could do some work. But the third and the fourth time were very bad. It became worse and worse the more I received chemotherapy. I was unable to do anything. I had oral ulcers and needed to see the doctor. I had to stay in the hospital to take some treatment. I was unable to do anything - very tired , very weak. I could not even wash clothes. So tired, so weak…it's like I was not fully recovered and I received the medications again and again. When I was about to recovered, I got more medications. So I felt really weak."
> (Woman ID.07-P2,5)

> "They gave me advice when I had the surgery. They said I would vomit. They told me in advance. They said the side effects will make me feel annoyed and irritated, and told be not to be frightened because they are common symptoms. Nurses said after vomiting I will feel better."
> (Woman ID.09-P2)

5.4 Negative impact on woman's image

The outcomes of treatments, both the breast surgery and chemotherapy, have an impact on the woman's image due to changes in appearance. This impact induced the need of caring, as some women stated:

> "From the beginning of the treatment, the doctor told me not to be frightened. He said during chemotherapy my nails will turn purple and my hair will turn white."
> (Woman ID.02-P9)

> "The doctor said when I come to see him later I will be bald."
> (Woman ID.09-P2)

In summary, situations initiating caring process for women with breast cancer who receive chemotherapy were not solely concerned with chemotherapy but they included the accumulative outcomes of cancer that have an impact on the women. These situations included 1) reception of bad news, 2) occurrence of illness, 3) having sick role in the family, 4) being ill with cancer, and 5) side effects of medical treatment. The situations induced a need of care contributed to the emergence of the caring process.

Emergence of care agents and ways of caring

Emergence of care agents and ways of caring, is the spontaneous response of people whom provide care responsibility and the action of care agents that were provided to Thai woman with breast cancer receiving chemotherapy. The emerged care agents comprised health care professionals, family, and women as self-caregivers. The caring responsibilities of the caregivers were different, depending on their roles and duties. Health care staffs have direct responsibility to deliver care to women with cancer, who are their clients. They play their roles as educated from well-established academic institutes. Their education is based on knowledge about specific disciplines, scientific learning and references such as textbooks for the delivery of professional care. For the family, which is the smallest social unit, the members have responsibility in caring for an ill member. The family's delivery of care, however, should be shared with the health care staff. Each family demonstrated different ways of caring, depending on their situation. For instance, some nuclear families had volunteers who did not live in the same house but were relatives or siblings of the ill person. The volunteers for provision of care would share and would relieve the family from increased burdens; as a result, the caring was effective and satisfying.

Additionally, the women also looked after themselves. The performance of self-care either emerged from self-confidence, or resulted from the lack of caregivers in the family.

The ways of caring in the first phase of illness consisted of all three groups of the caregivers, hence dividing into: ways of professional care, ways of family care, and ways of self-care. The ways of care in this phase were usually focused on encouraging the women to cope with side effects of chemotherapy and to maintain their compliance with the treatment rather than to promote the relief of symptoms. This way of caring would lead to shift in caring in the following phase. The three ways of care are discussed in detail in the next below.

1. Caring is professional responsibility

The delivery of health care is a direct responsibility of health care professionals. These professionals are physicians and nurses who have learned the knowledge of their disciplines and have been trained to take the health care responsibility. They ready to care for women because they knew what going on. In addition, the delivery of care was based on the professionals' good intention for the patients.

1.1 Professional performance from school preparation

Health care professionals conducted their caring activities as they were trained from academic institutes. The delivery of care was the standard care that they had learned in school.

> " Doctors are good at their work. They try their best. They have more study about this disease. From what I see, I think they use the medications that they've learned in school."
> (Woman ID.18-P3)
>
> "We give treatment in regimens because it is the standard treatment of breast cancer."
> (Doctor-P1)

1.2 Caring responsibility

The delivery of care from health care professionals was perceived as direct responsibility of the health care staff. It was particularly a major duty of nurses. However, patients perceived that the caring was based on good intention and the health care professionals did their best to help the patients.

> "Nurses have good intention for us. It is their job anyway. They don't want to see us die, do they?"
> (Woman ID.15-P3)

1.3 Professional performance with scientific knowledge

In addition to the delivery of care with direct responsibility, health care professionals also delivered care on the basis of scientific knowledge. The caring was usually logical and there were textbooks providing guidelines of medical care.

> "I notice that the care or the suggestions from doctors and nurses are scientific knowledge. It's logical, like what they have learned. And they will add mental support in the their advice."
> (Woman ID.30-P8)

Ways of professional care

There were five major situations that induced the need of care. However, the ways of care found in the first phase of caring process did not fully respond to all situations. Health care professionals usually concentrated on the promotion of safety and the advice to maintain compliance in addition to suggestions for the maintenance of a healthy condition. These ways of caring were mainly aimed to keep the patient's compliance with scheduled chemotherapy.

1) Promotion of safety

Health care professionals affirmed the safety of the medications with the women. They guaranteed the outcomes of treatment to encourage the women's compliance with treatment.

> "I am afraid and worried that I will not be recovered. I think about it but the doctor said I will recover and I will be all right. I believe him, believe the nurses, believe in what they said."
> (Woman ID.13-P5)

> "The doctor said he would not leave patients unless the patients leave him. He will not leave me and will always look after me like this."
> (Woman ID.01-P8)

> "I agree to take the treatment. The doctor must treat this illness, making me recover from the disease. He said I would recover so that must be it. I am not a doctor, so I believe him."
> (Woman ID.03-P6)

2) Giving advice to compliance with the treatment

Health care professionals gave advice, which mainly encouraged the women to cope with the side effects of the treatment which are usually experienced by every patient. The side effects are common; hence the women were suggested that they should not be frightened with the symptoms and should maintain their compliance with the treatment. The advice included the following:

2.1) Everybody experiences symptoms of side effects

Health care professionals told the women and their family that people receiving chemotherapy usually experience the symptoms of side effects.

> "They gave advice, like after the surgery I have to do this and that. They explained to me. I asked the doctor why I was losing my hair. He said these medications normally make the hair fall out. I asked why I have nausea and he said it's normal because I am receiving this medication. That's what the doctor always said."
> (Woman ID.053)
>
> "They (nurses) told me from the beginning about what will happen when I receive the medications. They suggested me to have a lot of fruits and vegetables and don't worry about the side effects because the symptoms result from the medications. It's the medication mechanism. They told me to relax."
> (Woman ID.10-P2)
>
> "Nurses said that the medications have side effects, which occur to everybody."
> (Woman ID.17-P3)

2.2) Patients and family should not be frightened because the symptoms from medication side effects are normal

Health care professionals perceived the symptoms from side effects of medications as a normal incidence. Thus they informed the women not to be frightened with the occurrence of such symptoms because these symptoms are normal.

> "They told me, gave me advice. They said, 'don't be frightened; whatever the problems, don't be frightened.' They both told me like that."
> (Woman ID.01-P7)

> "Nurses told me that these medications would kill the malignant cells but they will make my hair fall out and make me have nausea and vomiting. She told me not to be frightened; these symptoms will disappear later and my hair will grow again when we finish the therapy."
> (Woman ID.20-P2)

3) Giving advice to keep the stamina for the treatment

Health care professionals gave advice about appropriate self-care for the women receiving chemotherapy in order to maintain the compliance with treatment. The women were suggested to maintain their physical and mental strength for the continuity of treatment.

> "Nurses told me to eat a lot - meat, eggs, milk. Otherwise I may not be able to take the medications as scheduled because I will not be healthy enough."
> (Woman ID.16-P5)

> "Nurses gave advice about the food such as meat, eggs, milk; I have them all and I also so try to compensate for the time when I feel sick. I know I need to be healthy. If I am unhealthy, I cannot receive chemotherapy."
> (Woman ID.18-P1)

2. Caring is family sharing responsibility

The emergence of family caregivers was different from that of health care professionals. Caring responsibility in family emerged in a small social unit, as part of the responsibility deriving from intimacy and good intention. The caregivers might be volunteers for the delivery of care from non-members of the family who are connected by blood relation such as relatives or siblings. The family caring had to cooperate with health care professionals, who have direct responsibility as mentioned above; it was also different from professional caring as the caring was natural and was not developed from specific learning.

2.1 Caring as family responsibility

Family caring was direct responsibility of family members when a member got ill. Family members needed to take care of each other. The caring responsibility among family members reflects effective functioning of a family, which is the smallest social unit in a society.

> "I am afraid about this too-the family. If one of us does not live, I cannot take it. So, I try to do my duty- it's the family. When someone is ill, we have to take care of that person together, not leaving her to suffer alone unless she stops us to do so. If she refuses, we have to let her be as she likes but we always look after her."
> (Family of woman ID.10-P9,12)

> "When my mother got ill, I resigned from work to take care of her. I don't let her do hard work and do housework for her because she is very tired and exhausted. I take care of the housework for her and try to cook for her. Sometimes my Dad helps too but he has other work to do. We take turns to care for my mother."
> (Family of woman ID.07-P9)

2.2 Caring with intimacy and good intention

Family caring was based on their good wishes for the ill person's health. Family could deliver close care due to the connection as a family and blood relation, which raises the sense of a company, of being a member of the same small society and mental bonding; as a woman stated:

> 'If it is the family, I think we have good intention for each other and we give very close mental support.'
> (Woman ID.30-P8)

2.3 Emergence of volunteered caregivers

In addition to family members, other people might volunteer to care for the ill person. These people might not usually live in the same house but they volunteered to help in caring to share the burden of the family resulting from an illness of a member.

> "She needed to stay in the hospital for chemotherapy before. The time of treatment was not always consistent with my days off. It took a long time to go here and there. I had to visit her (the wife); then it was the time to pick up children from school. Fortunately, her parents did not do anything at that period so they volunteered to care for her."
> (Family of woman ID.02-P16)

> "We share the duties. When it's time for chemotherapy my husband will drop me at my parents' house. I'll prepare myself for treatment there. My parents just give me nourishing food, and do not let me do anything at all."
> (Woman ID.02-P7)

> “ Before my mother was ill, we all worked and lived by ourselves. Since mother has been ill, we take turn to stay at home with her. When I am busy I may ask my brother and sister to take care of the laundry.”
> (Family of woman ID.22-P5)

Ways of family care.

The ways of family care demonstrated in the first phase of caring process did not respond to all situations that induced need of caring. The ways of family care are discussed in detail below.

1) Provision of mental support

In Thai culture, people usually respond to illness by paying attention to the ill person. Additionally, cancer is usually perceived as serious illness. Thus women with cancer usually received a lot of attention, care and support from their family, as mentioned in the following statements:

> “I give her mental support, help her with the family responsibilities when she receives the treatment. It’s difficult for her to travel here and there. When I come to help her, she feels better, pays attention to herself and concentrates on the treatment. I think she would not receive the treatment if the family ignored her. She may despair and may give up everything. But everybody cares about her and has sympathy for her so she’s got the will power. We never have to force her to come to the hospital, she voluntarily comes.”
> (Family of woman ID.13-P8)

2) Searching information about caring

A way of family care was to seek information from various sources to apply for caring for the women with cancer. Sources of information included physicians, nurses and other patients.

> “My mother asks people who also received chemotherapy if they have the same symptoms like me. She’s afraid that my symptoms might be abnormal. We asked the doctor and he said everybody has nausea and vomiting. We will be better after the vomiting and we will be alright within a week or four to five days.”
> (Woman ID.02-P3)

> “Well, I’ll ask for advice when there are problems. For example, when she feels unwell, I’ll tell the doctor and he will give medications. Sometimes nurses may ask how she is and I’ll tell her to talk to the

> nurses. They will give advice such as having fruits, having long rest and tell the relatives to give her mental support. Nurses help as much as they can; however, we have to do something too because they cannot stay with us all the time. For example, I have to take care of her food intake and take care that she has the medications all right."
> (Family of woman ID.127)

3. Women performed self-care

Women with breast cancer also had a role in caring process. They would decide to act as a caregiver for themselves, in addition to the reception of care from health care professionals such as physicians and nurses and from their family, as well as volunteers. The performance of self-care might emerge from the desire of caring for one's self or from the lack of caregivers, as detailed below.

3.1 Lack of caregivers

There were limitations in the caring, as the women had to take care of other family members such as an ill mother or a very young child. Moreover, some families did not have a member to act as a caregiver.

> "I live by myself with my baby. He's two years and five months old now. But I live next to my mother's house. She is old though. So I take care of myself, do all the housework and look after myself."
> (Woman ID.16-P1)
>
> "I have a very young baby so I have to look after the baby too. My husband works very hard in the rice field. So I have to take care of myself. Sometimes I come here with a friend or come on my own. But my mother lives nearby. When I come here for the treatment, my mother will look after my baby. When I go back, I look after the baby myself. My mother has her own responsibilities too. So I have to take care of myself. My baby is young so I have to look after him. I do not pay attention to myself very much."
> (Woman ID.23-P5)
>
> "I have nausea quite a lot and started losing my hair now but I don't think about it very much. I have to take care of my mother too. She is ill with heart disease and hypertension. I don't pay much attention to myself because I have to look after my mother."
> (Woman ID.18-P1)

3.2 Developed confidence in self-control

A woman's desire of self-care resulted from her confidence in the ability to control the situation. Self-care was usually based on self-love and sometimes it was based on the woman's love for other people.

> "I have to help myself. Many things depend on our spirit. Like nausea – how can other people help us? They have tried their best. They have already given me medications. So it depends on my mind. If I am patient and can maintain the spirit, I can take the chemotherapy. But if I feel discouraged, I will give up. I may turn away if I don't love myself enough. But I know it is only a period of time, why can't I take it? The chemotherapy is given to treat me; anybody will have to take it. If I don't come, it will be bad for myself. Who can force me to do or not to do these things?"
> (Woman ID.15-P3)
>
> "I need to give myself mental support too. The best thing is look after myself. I don't think anybody would ignore themselves."
> (Woman ID.18-P3)
>
> "I have the will power – the kids, the sisters, the husbands. They are all my hope. I have to take good care of myself, receive the treatment as appointed for everybody who loves me and wishes me the best like this."
> (Woman ID.28-P5)
>
> "I take a hundred percent care of myself. The relatives give me mental support."
> (Woman ID.19-P1)
>
> "They ask me whether I need a lot of care. I don't think so. I think I can look after myself."
> (Woman ID.30-P8)

Ways of self-care

The ways of self-care of women with breast cancer mostly resulted from the ways of professional care, as detailed below.

1) Accept and depended on health care profession

The women followed a treatment plan and suggestions and did not refuse the treatment. When physicians informed them that they needed chemotherapy, most women did not argue or asked for other choices of treatment.

Their responses might due to the lack of knowledge hence they followed the treatment plan and suggestion, as stated in the interviews:

> "I never thought of giving up. Whatever the doctor advices, I'll follow his suggestion."
> (Woman ID.11-P4)
>
> "The doctor said I should not do anything, so I don't' do anything. I just take care of myself and do not do any work."
> (Woman ID.21-P9)
>
> "I did not prepare at first. The doctor said he would give the medications after the surgery. Before I went back home, he said I needed the medications. I just take the treatment as the doctor suggests."
> (Woman ID.22-P1)
>
> "I don't know anything about this disease, just follow the doctor's suggestion. I do whatever the doctor says."
> (Woman ID.26-P5)

2) Accepted and in depended on health care profession

In this way, the women's way of developed strength for self-care or mind-control resulted from professional advice that symptoms of side effects are normal. Nurses told the women not to worry and to relax. Thus, the women accepted and in depended on health care profession.

> "They told me in advance that I would have nausea and vomiting. There will be side effects like feeling unwell. They warned me not to be frightened because it's normal. So, I am prepared for the symptoms."
> (Woman ID.10-P12)

In summary, the emergence of care agents demonstrated three groups of care agents comprising of health care professionals, family and the women with breast cancer. Caring from health care professionals was based on the sense of direct responsibility, which included the responsibility to obtain specific knowledge of caring and to deliver care with scientific knowledge. Moreover, they not ready to provide physical care but chemotherapy and mental care. Family caring for women with breast cancer was the sharing of responsibility with health care professionals, as it is a family responsibility to take care of an ill member. Family caring was natural.

Women with cancer also performed self-care. The performance of self-care might emerge from the confidence in self-ability or from the limitation of other caregivers.

The ways of caring-either professional, family or self-care, could not relieve all the problems or answer to all situations that induced the need of caring in women with breast cancer.

Conclusion

Emerging of caring process was the first phase in the caring process in Thai woman with breast cancer receiving chemotherapy and the causal condition in this process as well. In this phase, it explained "situation induced need of care" that composed of bad news induced need of care, illness induced need of care, sick role induced need of care, fear of cancer induced need of care, and treatment induced need of care, as discussed in details below. This situation had several relating situations, which impacted the cancer and were inseparable from the process of chemotherapy. Another construct "emergence of care agents and ways of caring" was the response of people whom provided care responsibility and the action of care agents that provided to Thai woman with breast cancer receiving chemotherapy. Care agents in this study composed of health care professionals, family, and women self-care. The ways of caring-either professional, family or self-care related mainly for psychological aspect.

CHAPTER VI

INTERVEINING CONDITIONS

This chapter presented intervening conditions that were influenced in the caring process in Thai woman with breast cancer receiving chemotherapy. It consisted of "constraints on caring," "promotion of care," and "change in the setting of care."

Constraints on caring

While the caring process was in progress, there were factors that affected the advances of caring. These factors were constraints on caring, which had effects on the caring process. These constrains could be divided into constraints on professional care, constraints on family care, and constraints on the women's self-care. These constraints could interfere or delay the process of caring, as discussed below:

1.Constraints on professional care

The constraints on professional care resulted from various causes such as underused of nurse's proficiency, the delivery of nursing care as a supplementary role rather than a major role, and the exclusive restriction of woman care to physicians.

1.1 Underused of nurse's proficiency

The functioning of health care staff demonstrated that nurse's proficiency was underused. This might be due to the performance of the nurse's role, which was similar to the women's relatives sometimes as nurses needed to encourage the women to tell doctors about their problems in a same way as the women's relatives. Nursing role also included being a physician assistant in the delivery of medical care such as administrating medical treatment or making appointments in accordance with physicians' schedule. Moreover, nurses who care for women receiving chemotherapy had other works in addition to caring for women with breast cancer. These other works included secretarial duty, making patients' appointment, and monitoring the patients' follow-up. These additional duties were aimed for maintaining the patients' compliance with treatment.

1.1.1 Nurse as a messenger

In caring for women with breast cancer who received chemotherapy, nurses sometimes acted as physicians' messengers in following the women. A nurse said,

> "I hardly talk to doctors. They may say, 'why this patient doesn't come; can you check?' Then I may send a postcard or may make a phone call, checking why the patient losses the follow-up. Or it may be something like the patient is scheduled for the surgery in a week and has an appointment with this unit. Then I'll follow the patient for the doctor." (Nurse-P5)

1.1.2 Delivery of medical treatment to complete the physician's order

Another nurse role that reflected underused proficiency was to follow physicians' order solely for the completion of medical treatment. Nurses did not demonstrate their potentiality beyond physicians' order to the women with breast cancer, as some women stated:

> "Nurses just give medications as the doctor has prescribed." (Woman ID.08-P14)
>
> "They provide good care. They gave care as the doctor has ordered." (Woman ID.05-P2)

1.1.3 Limitation in nurse's autonomy and authority

The limitation in autonomy and authority of nurses as a member of health care team had strong impact on caring process. Nurses did not perform the duties that they were supposed to do within their scope of efficiency and responsibility. A woman stated:

> "Nurses said I can tell the doctor right away if I have any problems. If I have nausea or vomiting, tell the doctor; then the doctor will prescribe medications. Nurses said they couldn't give medications beyond the prescription. I told the doctor, this month I could not sleep and I have headache and the doctor prescribed paracetamol. Nurses asked me first and when I have symptoms like nausea and vomiting

> they suggest me to tell the doctor and he will prescribe the medication for me."
> (Woman ID.01-P7,8)

1.2 Nursing care as a supplementary role

Nurses delivered nursing care as if it was a supplementary role, rather than a major role. Nurses who cared for women receiving chemotherapy had to do other works in addition to caring for women with breast cancer. It was found that nurses had to do secretarial work, as well as other duties relating to caring for the patients. Hence, the nursing care became a supplementary role in nurse's functioning.

1.2.1 Nurse as a secretary

Nurses acted as a manager for women receiving chemotherapy. The management was similar to secretarial work as it was focused on arranging follow-up visits and making appointments for the scheduled chemotherapy.

> "We have the list of patients who will take chemotherapy at our ward. When the patient does not show up we may call nurses at the injection room, asking them if there is a patient with this name. Then, we record the information about the course of therapy in a separate form. We also check if the person can attend the follow-up appointment."
> (Nurse-P1)

1.2.2 Caring as a supplementary role

Although nurses had direct responsibility in the delivery of nursing care to women with breast cancer, they did not deliver sufficient care to the women. The delivery of care seemed to be supplementary task, rather than principal task, as a nurse said:

> "Mostly, when we go to work in the ward, we will not have time to take care of them."
> (Nurse-P2)

1.3 Limitation of caring responsibility from physicians' performance

This constraint directly resulted from physicians who did not provide information that is essential for continuous care; in addition the physicians did not perceive the necessity of information that the women should know.

1.3.1 Lack of information from physicians

Physicians gave the women information about symptoms of the disease in a reassuring aspect or guaranteed efficacy of the treatment; however, they did not provide other information that the women should have also received.

> "I asked, 'Doctor, why am I losing my hair?' He said, 'it's normal because you receive these medications.' I asked, 'Why do I have nausea. He said, 'It's normal you are receiving these medications.' He keeps saying like that."
> (Woman ID.05-P2)
>
> "The doctor said my lungs are good and my blood is good. I asked him how good it is. He said, 'Come on, it's good anyway.' He did not tell me straightforwardly. I'd like to know but if I ask him it's like I am too concerned. So I just let him treat me. I am afraid he may be displeased if I ask."
> (Woman ID.06-P7,8)
>
> "He (the doctor) said the medications suppress bone marrow function. I asked him if it is related to food. He said, 'No, it's all because of the medications. It's a low number of white cells and the injected medications will stimulate white cell production. When the number of white cells increase I can continue my treatment."
> (Woman ID.10-P1)

1.3.2 Insufficient number of physicians

The number of physicians was insufficient for the delivery of medical care. There was only one physician having directly responsible for women with cancer. The physician performed every step of medical care, starting from giving physical examinations to screening for breast cancer, performing breast surgery to women diagnosed with breast cancer and giving chemotherapy. This, therefore, was a constraint on professional caring.

> "Doctor use the medications as he has learned, like anti-vomiting drugs. Mostly, he does not have much time. There are more nurses than doctors so nurses have time to talk and to give advice."
> (Woman ID.18-P3)

2. Constraints on family care

When the caring shifted from health care professionals to the family due to the situation that involved transferal and the constraints on professional care, the constraints were extended to family care. The constraints on family care resulted from lack of essential information about caring and the sense of family burden due to the uncooperative manners of the women.

2.1 Lack of essential information of how to care

The family did not have sufficient information about appropriate caring for the women. The problem might result from no answers to required information from the physician or from the family's unawareness of women's symptoms that needed caring.

2.1.1 No answer to the request information

This constraint was developed from the physician's answer to the family's inquiries about the woman's illness.

> "I feel uncomfortable when I don't get the information. Sometimes doctors are… Well, I am considerate too. I ask them and they don't know much. Sometimes they don't tell me and sometimes I cannot follow them. In Lampang, they told me. They explained how it would be like in the future. They told me step by step."
> (Family of woman ID.07-P10)

2.1.2 Unawareness of symptoms

The family did not know about the symptoms or the sufferings that the women experienced because some symptoms, such as nausea or headache, are not visible.

> "I know she is in pain but sometimes I don't know what to do. Like having nausea or headache, I wouldn't know unless she tells me. If she doesn't tell, I will not be aware of her sufferings."
> (Family of woman ID.01-P15)

2.2 Family burden

The family felt like they had a burden. This feeling resulted from the women's uncooperative manner or the women's over-endurance to symptoms that need caring, as detailed below.

2.2.1 Burden from uncooperative manner. The feeling of burden resulted from the women being uncooperative in the caring process.

> "I'd like her to have a rest. But she is stubborn and always asks to go home. She's not cooperative."
> (Family of woman ID.07-P10)

> "I am more tired because I have to do everything now. I am a cook and a housewife too because I don't want her to lift any heavy objects or do any hard work. If something happens, it could be serious as we live far from the hospital. But she sometimes…., well, if I am not there, she would do some work and I would complain. She is an active person. Her idea is different from mine. Like running, I said no running; doctors said just walking. She said to be healthy she should run. Her idea is different from mine; and at the end, her symptoms get worse."
> (Family of woman ID.21-P7)

2.2.2 Burden from over-endurance

This feeling resulted from the woman's over-endurance to symptoms that had effects on the treatment and the caring.

> "After receiving the medications and returning home, she vomited. It was very bad and the symptom remained for a while after that. During the treatment, she was very weak and there were complications. She is quite a stubborn person and does not come to see the doctors when she feels sick. It's more difficult when she waits until the sickness is very bad."
> (Family of woman ID.07-P9)

3. Constraints on self-care

These constraints resulted from several causes. The women themselves might be a cause of limitation in the reception of knowledge about self-care. Restrictions on information exchange with health care professionals were due to the women's fear of answer from the physicians. Financial problems and transportation also contributed to the constraints on self-care.

3.1 Lack of knowledge

The women's lack of knowledge resulted from various causes including the reluctance to impose on health care professionals.

3.1.1 Being reluctant to ask questions

The women felt uneasy and reluctant to raise questions with health care professionals.

> "I don't want to ask. I want to know but I won't ask. I don't want to bother the doctor. He may think I am fussy. I don't always ask for details."
> (Woman ID.04-P7)

3.1.2 Having insufficient knowledge to ask questions

The women did not want to ask questions because they did not have sufficient knowledge to ask for further information. Thus they agreed to receive medical treatment despite no information exchange.

> "I don't ask. To think about it, I won't know much anyway. So, I don't ask I just take the treatment."
> (Woman ID.06-P14)

> "I don't have any knowledge about it so I just follow the doctor's order. Whatever he says, I'll follow him."
> (Woman ID.26-P5)

3.1.3 No expectation of help

The women perceived that nobody could help. They solved the problems, which were dependent on themselves.

> "I did not tell. I don't see why I should tell them. Well, something is up to our mind, other people are not able to help even if I told them. Sometimes I am more worried about my child than about the treatment."
> (Woman ID.16-P2)

3.1.4 Loss of memory

Another constrain on self-care was decrease ability in memorizing, which had effects on the received information as the women could not apply the knowledge to practical use.

> "I don't know for sure, but there was no symptoms. I can't remember exactly. Sometimes I had watermelon, but… Actually, they told me but I don't know why I can't remember anything. It's strange. I was not like this before. But I am very forgetful these days. I don't know, well, I was fine this morning but I can't remember the prayers."
> (Woman ID.24-P1)

3.2 Limitation in sharing information

The limitation in sharing information with health care professionals resulted from the women's fear of physician's answer.

3.2.1 Fear of the answer

The women were afraid of the answers that they might receive from the physician.

> "I'd like to know but when I am about to ask, well…I think the answer might worry me so I didn't ask. I just let the doctor treat me. I am also afraid that they may not like me asking them too much."
> (Woman ID.06-P8)

3.2.2 Fear of physicians

Some women were afraid of raising questions with physicians, as they did not dare talk to the physicians.

> "I didn't dare ask him (the doctor). I don't have the courage. Well, I'd like to ask but I don't dare. He's nice but I don't have the courage. When he comes to see me I feel a bit scared, somehow."
> (Woman ID.29-P5)

3.3 Problems affecting self-care

Other problems that contributed to constraints on self-care were problems concerning financial status and transportation. These problems had direct effect on the women, as detailed below.

3.3.1 Transportation problem

This problem arose when the women had to travel to receive the treatment. Although the hospital allows the women to stay overnight at the hospital after chemotherapy, most women wanted to return home. The transportation problem also contributed to constraints on follow-up visits.

> "The problem is I need to travel a long distance and it is really bad on the way back. Yes, the hospital allows me to stay overnight but I don't want to stay. I just want to go home. It is very tiring and I always have nausea. I am getting older too."
> (Woman ID.11-P6)

> "The problem is my home is far from the hospital and I have to travel a long way. I use the health insurance card for the medications but there are other problems like the transportation fee. That's quite a problem as I don't have much money."
> (Woman ID.12-P7)

> "The doctor said that I should finish the course and then just come to the follow-up appointment. I have to come on the right day of the appointment. If I don't come on Monday, I won't see the doctor so I have to come on that particular day. But the transportation is difficult because I live very far away from the hospital."
> (Woman ID.11-P6)

> "I don't have to pay. I have the gold card so I don't have to pay anything. But I have to pay for the transport a bit more than a hundred baht each time."
> (Woman ID.18-P5)

3.3.2 Financial problem

The women had financial problem because their illness disables them from earning. Although most women held an insurance card for low-income citizen or some might have a health insurance card, they had transportation expenses and family expenses. Some women had to take out a loan and had some debts. This problem also restricted the women from nourishing their physical condition.

> "I have a card for low-income people so I do not have to pay for the treatment. If I did not have this card, I would not take the treatment. But sometimes I got bored of the treatment, and I am worried about my child too. I don't have much money. My child's father sends me 2500 baht a month. I have to spend that money for my child going to the school, the transportation, medications and many other things. Like my bother-in-law taking me to the hospital, so I have to pay for a meal there and may buy some fruits back home."
> (Woman ID.29-P5)

> "I used to work as a worker but now I cannot do labor work so I have to stay home, doing nothing. I can do something but most worker jobs are laboring. I cannot do it now because it needs strength to do such work. Moreover, I am old too. My eyes and my ears are not very sharp anymore, so I have to stop working. I have to live economically. My children have to be economical too. Two of them are still in school, one in Matthayom 5 and another one in Matthayom 3. My other two

> children have finished school already. They work and send money to me sometimes.
> (Woman ID.24-P3)

> “I don’t have anybody. The father has run away, not sending money to me. He ran away, I don’t know. He may have a new woman. I have a sister but her life is quite hard too. I’m so poor, you know. This illness makes me so poor. A child sends me 500 baht and it is not enough for the living. Another child is married but she is very poor too. I don’t have money; and have to borrow other people as I can’t do any work. I have rice but no other foods so I cannot eat it. My mother rents the rice field out so we have about 10 big sacks of rice.”
> (Woman ID.25-P5)

In summary, constraints on caring resulted from problems concerning health care professionals, the family and the women. The results of these problems had effect on caring process.

Promotion of care

Caring process for women with breast cancer could be promoted with various significant factors including mental support from people related to the women and the women’s hope. The facilitating of caring is discussed in details below.

1. Professional encouragement

The women perceived mental support from health care professionals hence raising their spirit in managing the symptoms. The women felt that other people were aware of their sufferings. Professional encouragement also induced complete care for women with breast cancer.

> “Nurses talked to me, telling me not to lose my spirit. Nurses would console me. Nurses who came in to take care of me would talk to me. Many of them give me mental support.”
> (Woman ID.14-P1)

> “There are more nurses so they have time to talk, to give advice. I feel more comfortable to talk to nurses in some issues. I’ve gained spirit after talking to them. I think it’s important. If we have the medications but no mental support, it will be incomplete.”
> (Woman ID.18-P3)

2. Support from family and other people

In addition to health care professionals, the family, as well as close friends and relatives, played a significant role in providing mental support to the women. The support might be given through various manners such as being nice to the ill women, giving close care or helping them in doing some work.

> "I got mental support from friends, people who know me, the family and myself. I have to give mental support to myself too.'
> (Woman ID.18-P3)

> "My husband is very nice. He tries to take care of the children for me and always gives me mental support. He takes care of the housework when I feel ill and takes me to receive the medication every time. So I receive very good mental support."
> (Woman ID.27-P2)

> "I can help with something like taking care of the housework, cooking and giving her mental support. I just try to make her realize that she still has her self- worth and is wanted. So she will have the will power to receive the treatment all the way."
> (Family of woman ID.12-P7)

> "During the chemotherapy, I helped taking her to the hospital until the therapeutic course was completed. That's how I helped her. I'd like her to live for a long time. The chemotherapy is more painful than the surgery but I have to ask Mother to endure it. Like when she has nausea, I and my father had to give her support."
> (Family of woman ID.15-P5)

> "I think mental support is very important. When we have mental support all difficult problems seem to be easier. I keep giving her mental support, giving her hope. I love her; she is my child. When she is ill I have to fully take care of her."
> (Family of woman ID.26-P8)

3. Self-encouragement

Self-encouragement was essential for women with breast cancer. It was the most significant support. The encouragement might be developed from hope for recovery from the disease, which is a spiritual component. The women would hope for longer life-years and hope that the disease would be cured. Their hope might come from talking with health care professionals, or they might have the hope by themselves. Women's hope is a significant factor that promote caring as it encouraged the women to comply with medical treatment, to accept medical care from physicians and nurses, and to perform appropriate self-care, as demonstrated in the following statements:

> "I have to give mental support to myself too. The best thing is to look after myself. I don't think anybody would ignore themselves."
> (Woman ID.18-P3)
>
> "I've got mental support from the family and the children; it gives me the will power to fight. Also, I got the support from doctors and nurses. So I keep hoping that I will recover form this disease one day. I want to live with my children for a long time."
> (Woman ID.20-P7)
>
> "The doctor said my disease is not very bad and I should recover after receiving the treatment. I believe him. My tumor was small so I have hope. Doctors and nurses give me hope and I'd like to be patient for my child. He is still young. I want to be with him for a long time."
> (Woman ID.23-P5)
>
> "Well, I keep my spirit up, I'll have hope to go on living. A patient without any spirit will not be able to fight with the resist. Sometimes the spirit helps me to endure chemotherapy, making me strong. It is the sufferings upon the hope that I will live longer. For me it's for the children, nieces and nephews."
> (Woman ID.17-P6)

In summary, the promotion of caring increased the women's stamina and raised their spirit in performing self-care. However, there were factors that induced shift of caring to the family and the women despite insufficient preparation.

Change in the setting of care

During the caring process, the caring was changed from a group of caregivers to another group. The caring was transferred from health care professionals to natural caregivers that included the family and the women. In other words, the caring was changed from professional-based to family-based during the caring process for Thai women with breast cancer who received chemotherapy. The change of caring occurred under various conditions comprising care sharing between nurses and the family and the alteration of care settings, as detailed below.

1. Care-sharing between nurses and the family

Nurses played a significant role in the shift of caring from health care professionals to the family.

1.1 Nurse's assignment

Nurses directly assigned the family in caring for the women.

> "The relatives have the role too. They cooperate in caring so we give them suggestions, helping them to understand as we do. When the relatives understand, they can support the patient and most of them are able to do it."
> (Nurse-P21)

1.2 Discontinuation of hospital cares

Women receiving chemotherapy came to the hospital to receive the treatment and went back home when the therapy finished; hence they did not receive continual medical care after the therapy.

> "I go back home after the treatment and will have the symptoms at home. Doctors and nurses do not come home with me so I have to take care of myself. I use the knowledge that nurses told me and use my own knowledge too. I don't ask for care from anybody. Doctors and nurses are at the hospital so I should take care of myself."
> (Woman ID.24-P6)

2. Change of care setting from hospital to woman's home

The hospital provided service for chemotherapy by making appointment for the women to receive medications as scheduled. The women were appointed to have blood examination on the first day of each therapeutic course. Then, the women received the treatment at a cancer unit and went back homes straight after the treatment was completed. The women would come back to receive the treatment again on the eighth day of the therapeutic course. The symptoms of medication side effects, therefore, occurred, while the women were at homes.

> "I take care of myself most of the time anyway. Doctors and nurses care for me only for a short period during the treatment but when I come back home I need to care for myself and care for my child too."
> (Woman ID.25-P6)

Summary

Intervening conditions are influencing in the caring process in Thai woman with breast cancer receiving chemotherapy. They consists of “constraints on caring,” “promotion of care,” and “change in the setting of care”. These factors emerged from health care professionals, women and family as well.

CHAPTER VII

PHASE II: SHIFT FROM CARE AGENTS TO NON-PROFESSIONALS IN FAMILY-BASEDCARE

This chapter portrayed the second phase of the caring process of Thai women with breast cancer receiving chemotherapy, the shift from care agents to non-professionals in family- based care, which included adjusting the quality of care for the loved one and deviance from the right ways of caring.

Adjusting the quality of care for the loved one

The family made an effort to give the best care to the person they loved within their limitation. They tried to adjust their ways of caring to be relevant with the woman's problems or sufferings. The adjustment of caring included supportive caring to help the woman overcoming the crisis period of chemotherapy. The supportive caring comprised the provision of nourishing diet, financial care, and caring for the compliance with treatment, as detailed below.

1. Provision of nourishing diet

The family sought nourishing foods to promote physical strength of the woman. They received information about nourishing diet from various advertising medias. The women also took care of having nourishing diet.

> "I give her supplementary food like Brand. I try to feed her with nourishing diet so the body can make more blood cells. I understand this need very well and am quite interested in it. I lavish for her recovery."
> (Family of woman ID.07-P10)

> "I bought Brand, bought bird nest but she did not eat it. She kept saying no. I'd like her to be stronger. I told her to have a lot of boiled mushroom to nourish the body."
> (Family of woman ID.08-P8,11)

> "I try to get food that she can eat, like fruits or milk. I try to get her the foods that she likes such as chili dips with vegetables. Helping her to eat at a small amount. Sometimes I cooked boiled rice for her."
> (Family of woman ID.21-P6)

The women also made an effort to maintain their strength and energy. They took care of their diet and rest, they kept their spirit up and sometimes took supplementary foods, aiming to enable themselves to receive chemotherapy as scheduled.

> "I try to keep myself healthy so that I can take the treatment continuously without having a pause. There are times when I have no symptoms; additionally, my mind is quite strong. I don't want to let anybody see my weakness so I will endure until finishing the therapeutic course."
> (Woman ID.19-P5)

> "Well, I know that I am going to have this treatment so I have prepared for it. I have enough sleep and keep myself healthy in order to be able to take the whole course of treatment."
> (Woman ID.22-P6)

2. Sharing woman's tasks

The family helped the woman in doing her tasks, sharing her usual burden. The women perceived the significance of family help with the housework, as stated in the following examples:

> "They help sometimes; mostly when I feel really ill. Like cooking, the smell makes me fee sick. If I vomit, it will be over. But it is not that simple; I just have nausea and cannot do anything. Then my husband or the child has to cook. They'll help until I feel better."
> (Woman ID.01-P17)

> "When mother got sick, I resigned from my job to look after her. I do not let her do hard work and do all the housework myself because Mother is weak and tired. So, I take care of the housework for her and try to cook too. Sometimes my father will do it but he has a job. We take turn to look after mother."
> (Family of woman ID.07-P9)

3. Financial support

In addition to the help in performing daily activities, the family also provided the woman with financial support.

> "The family gives me mental support and help with the housework when I cannot do it. Some people give me financial help such as my older brother. Normally, it seems like all the siblings just take care of one's self but when I am ill they all come to support me, seeing me overcome the difficulties while receiving the treatment."
> (Woman ID.01-P17)
>
> "I come to care for Mother and do less work at the farm. I just leave it and go back there once in a while. Mother may go to have a look there, just look, though. We don't have to work much in the farm. My older sister sends money to us so we can get by."
> (Family of woman ID.15-P4)

4. Support for the compliance with chemotherapy

Another family support was to accompany the woman in receiving chemotherapy, to give mental support and to encourage the compliance with scheduled treatment and follow-up visits.

> "I said I didn't want to take the medications anymore because it gives me headaches but people at home encouraged me to go to the follow-up visit. There's a person so stubborn and she is now very thin and very weak. So I go to see the doctor; enduring the pain and I will feel better soon. My brother comes to visit me quite often. Sometimes I said I didn't want the injection anymore and he would say, 'Why didn't you go? Take the medications, then you'll recover.' So I go."
> (Woman ID.01-P5,11)
>
> "She was not going to go. We had to talk to her for a long time. Nine-no; ten-no; I said, 'Mother, you should go. If you don't want to go, why did you cut it off in the first place? You've received the treatment this far so you should take it all the way'."
> (Family of woman ID.08-P3)
>
> "They said, 'Let's go, Mother. Then you can recover. There are only a few months now. When you recover you can come back home. When my children said that, I had the spirit to go. I think I must go so I will be better and will recover. I used to think that I felt very bad and did not want to go to the hospital at all; but my husband encouraged me to

> go. He said I nearly reach the destination now and should be patient a bit more. I felt discouraged sometimes, once or twice a month."
> (Woman ID.0214)
>
> "I give her mental support and share the burden when she comes for chemotherapy. It will be difficult if she comes to the hospital and goes back home and comes back again. Now, I come to stay with her so she has increased spirit, is interested about herself and is determined to get the treatment. If the family ignores her she may not take the treatment and may give up. But, the fact is everybody is concerned about her, has sympathy for her; so she has the will power to treat herself. We don't have to force her to come to the hospital, she willingly comes here.'
> (Family of woman ID.13-P8)

Deviance from the right ways of caring

The family made an effort to provide the best care to the person they love. However, they might confront limitations and had to alter the ways of caring in respond to the woman's problems or sufferings. The deviation in the ways of caring might be developed from making a trial and being patient with the problems.

1. Making a trial to decrease side effects of chemotherapy

The women and the family tried out various ways to reduce the feeling of distress from side effects of medications. The trial was based on the woman symptoms, assuming that it might solve the problems and may be repeated or changed; for example:

> "I drink warm water. Some people suggest ginger tea. Warm water is good enough when I have nausea. I don't usually drink cold water. I didn't ask anybody. I tried it and felt better so I've been drinking warm water everyday, about a glass a day."
> (Woman ID.01-P11)
>
> "For example, once I had nausea and nurses said I should try having sour food so I follow the suggestion. Sometimes I try different foods, checking whether I feel better after having this food or that food."
> (Woman ID.24-P6)

2. Making a trial for the treatment of the disease

The women tried out alternative treatment such as herbal medicines, aiming to have the cancer completely cured.

> "I would like to recover from the disease but I am afraid I cannot. If there is anyway that can help the recovery, I'd like to try it. Like Lin-jue mushroom, I have it and have increased spirit after having it."
> (Woman ID.20-P7)

> "It's a traditional belief that this thing could cure cancer. Well, in fact we don't know how much this disease can be cured. So far, they look at how long you can live with this disease rather than having it cured. I have to look for a method that can cure the disease or can help me. I'll do it. Well, if it's not bad to my health I should try it."
> (Woman ID.10-P2)

> "Like, Beijing grasses; I don't think it has any bad effects so I use it. But I will not use the herb that I don't know. I don't take only one treatment. I take quite a few, as I'm afraid I may lose a chance to recover. I am afraid that I may not recover if I only take the medications without trying something else. But if I don't take medical treatment at all, I'm afraid I may miss something, as the medicine is very advanced these days. So I combine them all. "
> (Family of Woman ID.10-P11)

> "(Where do you find alternative therapy?) From other patients. Each time I come here I try to ask them what they eat and ask them to buy it for me, like a hundred baht a pack, boiling before use. Sometimes I think, well I don't know what it is. But I see other people take it, so I take it too, at least to lift my spirit."
> (Woman ID.27-P2)

3. Endurance to the known side effects

The women had experience with side effects of the medications. In addition, they received the information that medication side effects induce the symptom to everybody receiving chemotherapy; hence they could endure the symptoms.

> "Having nausea and vomiting, I'll have the medications that doctors gave me. (Laugh) I just let it happens. I understand that it is the side effects of the medications; it may be bad in some people or not too bad in some, depending on each individual. I am busy looking for some combination treatment so I do not really be preoccupied with the symptoms of side effects. I try to be patient and it doesn't last long so I can endure it."
> (Woman ID.10-P3)

4. Endurance due to the known short-term

The women could endure side effect symptoms because they would receive the chemotherapy for six months.

> "The symptoms do not last very long, so I endure it. I try to sleep when I feel tired and keep thinking about my child; then I can endure it."
> (Woman ID.23-P5)

> "I don't have much symptoms and it is not very severe. So it can be gone and I will have a recovery period. I just prepare for the problems such as watching out my food intake and going to bed early the night before coming to get the treatment because I have to leave home early. I just do something like that, as my symptoms are not to bad so I can stand it."
> (Woman ID.24-P5)

> "My child is still very young and I have to look after him, so I don't have time to care for myself. The symptoms dose not last long so I can put up with it, like when I have morning sickness (during pregnancy). I try to get some sleep when I'm tired and try to think about my child. When I think about him I can endure it as I want to live longer to look after my child. If I don't take the treatment, I may not be able to live much longer; this thought gives me the spirit to endure the treatment. My husband is not a talkative person and just carries on doing his work. Sometimes my mother comes to help me looking after the child, but only for some times, especially a few days after the chemotherapy, not all the time. Apart from those times, I look after the child myself. Doctors and nurses are nice to me; so I feel good and do not want to turn away from the treatment."
> (Woman ID.23-P5)

Summary

The shift from care agents to non-professionals in family-based care composed as a consequence of constraints on caring encouraged the family to apply their potentiality to the delivery of the best care for the person they love- the woman receiving chemotherapy. The shift of caring led to adjusting the quality of care for the loved one and deviance from the right ways of caring.

CHAPTER VIII

PHASE III: OUTCOMES OF CARE

This chapter presented the third phase. It is the last phase in this study. Caring outcomes were the last component in the caring process for Thai women with breast cancer receiving chemotherapy. The outcomes were the overall result from every step of the caring process, starting from the emergence of caring, the shift from care agents to non- professionals in family-based care. Caring outcomes, therefore, are consequences of the provision of care to women receiving chemotherapy, as presented as follows:

Good outcomes of care

The good outcomes of care were the consequences of family and women competency, which they received from professional care. They composed of psychological outcomes, physical outcomes, women will power, and family strength.

1. Perceiving psychological consolation

The women expressed the feeling concerning psychological outcomes resulting from the caring. They developed the sense of comfort after receiving care. They perceived mental consolation and a great comfort from professional care. The women felt that they received both physical and mental care from other people.

> "Nurses are quite close to patients; they give advice, being a consultant for me. There are more nurses than doctors so they have time to talk and give advice and I feel more comfortable to talk to nurses in some matters. I've gained will power after talking to them. I think it's important. If we have the medications but no mental support, it will be incomplete. The suggestions from nurses and doctors enable me to take better care of myself."
> (Woman ID.18-P3)
>
> "I feel happier. Some days I could sing and my husband would ask whether the doctor gave me wrong medications (laugh). I am in good moods, unlike before this. My husband thinks doctors gave me wrong medications. I turn the music on, listening to the music. Before this, during the chemotherapy I did not want to listen to anything. I just want

> to live quietly, don't want to hear even the child's voice. Now I like loud noises."
> (Woman ID.02-P18)

> "I feel happier as I have completed the therapeutic course. I don't have to take medications that make me feel sick. I feel relieved and feel better, happier. I am still worried, though; I am afraid that the disease may have spread."
> (Woman ID.06-P14)

> "No problem now. I feel much happier but still not fully relieved. Sometimes I am afraid that it will recur. I have to take care of myself as nurses suggested. Doctors told me I should have another breast examined too."
> (Woman ID.05-P13)

2. Good physical outcomes

The caring outcomes on physical conditions of women receiving chemotherapy were presented in various ways.

2.1 Regained physical strength

The women regained physical strength as a result of caring. Although they became weak due to the effects of chemotherapy, the women could sustain their basic strength because of good preparation prior to the treatment.

> "No problems. I can take the treatment every time because the doctor had my blood tested and it's all right. Some people may not be able to take the medications so they have to stop and have a new schedule. I feel tired during the first week and regain my strength later. After receiving another course, my body becomes weak again. But I am still strong enough to fight with it.
> (Woman ID.01-P4)

> "I prepare myself before taking the medications. Let's say I am having another course tomorrow, I'd prepare my mind, telling myself that I must take the therapy. Nurses said if I can't take it, we will have to restart everything. So I tell myself I have to put up with it so that I don't have to restart, which means I will have all the sufferings again."
> (Woman ID.13-P2)

2.2 Maintenance of improved symptoms

This outcome resulted from good caring in combination with efficient caregivers and good mental support. It was found that the women were present with increasingly improved symptoms.

> "He (the husband) said I don't have to work. He has to even make a bed for me because it is heavy. He said I don't have to do anything. People around me are nice so it lifts my spirit up. I have a healthy mind and my body feels better. I am losing my hair but I have a wig. I am not going anywhere, anyway. I don't go to the market because I am afraid of the infection. The surgery cut still feels a bit strained but I have exercised as said in the book that nurses gave to me. I am tired but not exhausted. The first two months I was very tired but I feel better this month."
> (Woman ID.28-P5)

2.3 Occurrence of non-serious heath problems

Some women had non-serious health problems, depending on the treatment. However, these problems did not have strong impact on the women's well being and this was an outcome of effective care.

> " I feel tired during the first week after receiving the medications. After a week I will feel better, almost like I am recovered to normal condition. I can work like I was never ill. I can do anything all day such as washing clothes, cooking, cleaning the house. I am not tired and can work all day. But during the therapy I cannot do anything, I feel very tired."
> (Woman ID.20-P8)

> "I feel tired during the first week but will be strong later. Then I become weak again after the chemotherapy but my body seems to be strong enough and can endure the treatment."
> (Woman ID.01-P5)

> "Well, I am not seriously ill. Sometimes I don't feel like I am ill. Like after finishing the second injection, I had a fine moment. I recovered for almost 100 percent. So, there are some rest periods for me to recover from the symptoms."
> (Woman ID.18-P5)

3. Women's will power

The woman's will power was the feeling of high spirit and energy, which was an outcome of caring from various sources including health care professionals, family, neighbors and the woman herself.

3.1 Growing from advice

Some of women's will power came from professional's advisory. From this advisory, the women adjusted themselves to their caring. It helps women to have will power.

> "I can eat some foods, not feeling so bad as cannot eat anything at all. But I am more careful with my food. All the forbidden food that doctors and Miss… (a nurse) suggested, I would not have. I also follow the suggestions in the handbook. But I am not too serious about it. I admitted that I was too serious at first and I feared everything. I have gradually adjusted lately. I think my body has gradually adjusted. If I am so strict that I will not take MSG at all wherever I go, it is unavoidable in real life. I was very worried before. Lately I have adjusted, trying to tell the vendor to not add MSG in my food. However, if I forget to tell and the vendor put it in, I just take it. I avoid as good as I can. The doctor suggests me to have all five groups of nutrients so I still have meat but less than before. I also try to avoid oily food. If you ask me whether I am afraid of cancer now, I'll say not 100 percent. It's not that I am bald or have the courage but I need to reorganize my life, especially with the food. I think in my case it must come from food because there's no family history. So I am careful about the food most, the second thing is stress.
> (Woman ID.30-P26)

3.2 Able to leave difference

After the women became ill, they tried to adjust their behavior, decrease stressors, and improve their lives.

> "I try to adjust with some work, try not to be stressed. I know that stress is a cause of the disease and cancer may recur in the other breast. Doctors and nurses suggest that I should have the other one checked up. I try to adjust my work but it is quite difficult because my job concerns finance. I try, anyway. These days my behavior is better, like I am more careful with my eating, try to reduce stress and try to calm down, not getting upset too much. So I try to improve my lifestyle after I got ill."
> (Woman ID.27-P4)

3.3 Knowing from experience

Another way of getting will power, the women know from experience. They learn from managing theirs suffering.

> "After the first course of treatment, I came home, took a shower and changed clothes. I poured water on my head, as it was very warm. If it was getting really hot, I would put soaked cloth on my head. It was very hot during that time so I went to my parents' house, bought some ice and put a cold towel on my head. I felt better when it was cool but it is not good to use the fan too much so I use ice instead."
> (Woman ID.02-P2)

3.4 Will power

The other way showing the women's will power was that they can manage their problems. This way originated by women themselves.

> "When I feel upset, I'll go chatting and playing with them, having fun for a while. I'll come back when the stress has gone. I'd rather relieve the stress than just sit here, thinking about it, and make my brain dim. I'll go back to work when the stress has gone. Whatever I am doing, I'll leave it when I feel stressed. I will not pack it up yet but leave it for a while. When the stress is relieved, I'll get back to it again. I have to manage these things myself, cannot wait for anybody to tell me everything. What can make me happy, I'll have to do it. I have to manage what happens in my life such as stress. I have to deal with stress or when having nausea I have to find the way that helps me to eat more."
> (Woman ID.09-P56)

4. Family strength

Family strength emerged from the process that the family transfers power and strength to women. This family strength was the group strength that build up from the care for women. When a woman got ill and received care from the family, the family relationship was better than before as the woman received more care than her expectation.

4.1 Goodness takes care for the women

When women received chemotherapy and were faced with side effects, their family supported them in a good way. These ways build the good relationship among them.

> "I have not done any work yet, even now. My husband does all the housework. He washes the clothes too, hand-washing. He does everything when there is nobody to help. Yesterday I forgot and lifted milk cartons, about a kilo. I had the surgery on the left side and I forgot that but I try to use the right arm more often. I don't do anything, just wander around and sleep, as they say eating then sleeping – that's it. And I always have some friends visiting."
> (Woman ID.28-P2)

4.2 Happy for women to get better

It shows that their families feel good to help women. This reflects the warm environment in this family.

> "I am tired but it's normal. I come home and have to cook but it's not a burden. Well, I love my sister so I am happy to see that it's not too hard for her.
> (Family of woman ID.28-P5)

> "I think mental support is very important. With mental support, something serious can be easier. I keep giving her mental support and raise her hope because I love her. She's my daughter so when she is sick I have to take the best care of her."
> (Family of woman ID.26-P8)

4.3 Ill women are still valuable

Family tries to give caring for women. They provide the women with a sense of value. Moreover, the collaboration in the family was demonstrated as well.

> "I help her by doing household affairs, cooking, and giving encouragement. I try to do the best things. I give her a sense of value and I need her. For her… to has encouragement in treatment.
> (Family of woman ID.12-P7)

> "In the treatment period, she needs support for completeness in treatment. I help her. I need my mother's survival. Chemotherapy makes her suffer more than the operation but she must endure. I don't know some symptoms such as nausea. My father and I must give her encouragement."
> (Family of woman ID.15-P5)

Poor outcomes of care

The poor outcomes of care were the consequences of family and women competency, which received limited care from professionals. They composed of distressed feelings, serious problems and inability to perform activities.

1. Distressed feeling

This feeling was also an outcome of caring. The women expressed unhappiness due to the despair, stress and endurance.

1.1 Feeling despair

The women despaired of symptoms from medication side effects in combination with the lack of caregivers.

> "I am bored, not wanting to take care of myself. I am discouraged because the medications are very strong. My older sister goes to the rice field everyday and I go to read at her house. I am not a talkative person. Sometimes I hardly talk with my husband; it's like we live by ourselves."
> (Woman ID.29-P6)

1.2 Perceived stress

The women felt stressed because of the disease; however, they make an effort to cope with stress.

> "It's dull, not lively at all. My mind has given up. I become more stressed having a conversation with people, no mental support at all. Sometimes, I feel nobody is nice to me. I just read books. I am very stressed and try to control my mind. I pray, control my mind, put things down. I have no spirit in doing anything. I have already put things down, telling myself, 'it will not be long.' I recite that… I feel discouraged these days and do not want to see anybody. I lose my spirit every time I meet people. I want to do nothing, meet nobody, just pray and read religious books like I do now. I keep telling myself, 'It will not be much longer. Be patient.' I tell myself like that."
> (Woman ID.2967)

1.3 Living with endurance

The women felt they had to endure the symptoms, as there was no particular care to systematically relieve the symptoms.

> "Mostly I take care of myself. I just try to do it as best as I can. Just being patient; it's not very long so I can endure it."
> (Woman ID.24-P6)

2. Had a serious problems

A low number of white blood cells, a serious problem, reflected ineffective caring. It indicated the women's lack of knowledge about self-care, which led to reduction in number of white blood cells, and, finally, delay of chemotherapy.

> "Well, I always have that. The number of white cells is always low. But it is very low this time."
> (Woman ID.07-P2)

> "I feel badly sick, and vomit a lot. I also lose my hair, feel tired and have very low number of white blood cells, like some time ago."
> (Family of woman ID.10-P9)

3. Inability to perform activities

Some women were unable to do any activities. This condition was an outcome of inappropriate caring.

> "I cannot do anything as I have no strength left. I feel very tired, cannot even wash my clothes. I am exhausted and feel very weak. It's like my body is not recovered yet and then it receives the medications again. When I just start to recover, it's time for the medications again; so I don't have much strength left."
> (Woman ID.075)

Summary

Caring process resulted in various outcomes that were consequences of caring efficiency of the women and their families. Various ways of caring had effects on women in both psychological and physical aspects. Caring also had impact on women's will power and family strength.

CHAPTER IX

DISCUSSION

This chapter focuses on discussion of the study findings in Chapter IV-VIII. The strengths and limitations of the study is also presented.

Discussion of the findings

An evolving theory in this study was the caring process of Thai women with breast cancer receiving chemotherapy. It is the theory in the condition of the limitation of health care professionals. This evolving theory was studied from the perspective of women, families and health care providers that lack the study in this situation, thus there are the lack of studied related to the caring process of Thai women with cancer receiving chemotherapy. The topics of discussion are 1) present the concepts and categories and portray why they were emerged 2) describe why it was relevant or different from the others studies and 3) the evolving theory was new or not, if it was new why it was new. The topics for discussion are as follow: Emerging of caring process, emergence of care agents and ways of caring, shifting from care agents to non-professionals in family based-care, and the outcome of care. The discussion presented in details as follow:

Emerging of caring process

Emerging of the caring process of Thai women with breast cancer receiving chemotherapy is composed of situations that induced need of care, emergence of care agents and ways of caring.

Situations induced need of care is the result of bad news, illness, fear of cancer, sick role and treatment of chemotherapy.

Bad news referred to news which the listener feel high anxiety. It may effect to one’s life. This news may be the news of daily living, job status, education, and health status. The illness was perceived as bad news especially in the never-ill person. News of a cancer diagnosis, a traumatic event shattered the women whom received this news

(Tayor,2000: 782). Like this study, the studies of people with cancer revealed in the same ways that received news of getting cancer. People felt it was a struggle-life (Wagnild & Young,1990:253; Wondelowsky and Davis,1990:113; Crooks, 2001:104). Being diagnosed with cancer, women have a severe emotional distress. They had high anxiety and depression too (Cordova, Andrykowski, Kenady, McGrath, Sloan & Redd,1995: 981). Another study in process of emotional distress of women with breast cancer, indicated that some of them had emotional distress persisted for periods of months or years following initial diagnosis and treatment (Epping-Jordan et al., 1999:315).

The word 'illness' was a large meaning than the word "disease", because it was discoursed the themes of person, culture, interaction of person, and interpret of illness such as an interaction of illness, a change of state of being and a shifting of social role (Eisenberg, 1977:9). When women became ill, they could not perform the normal daily-living activity. The family offered women love and encouragement. Moreover, they cooked meals, looked after children, handled the shopping, paid the bills, or took on any of the myriad responsibilities of daily life that a ill person cannot fulfill (Ellers, 1993: 78).

Women are expected that they have the caregivers roles in the family. They must care for the ill-person, children, and the aged (Sindhu & Puttapitukpol,1999:18). When women changed role from caregivers to care receiver, they could not maintain caregivers roles. Moreover, they could not take the mother role, wife role and other role in their families. This situation led the family members to change roles for maintaining family normal function. Sick role was one of situation induced need of caring, thus the illness threw family into a crisis that is more serious than the disease itself (Ellers,1993: 182).

The word "cancer" has a negative meaning. It receives a specific feature of disease. This disease is a rapid growth of abnormal cells and they are uncontrolled. Cancer also disseminates from the origin to other parts of the body. It may continue to grow and infiltrate to the skin, lymph nodes, and blood vessels of the breast as well (Burnet, 2000:319). It was received by uncured and recurrence. The treatment of cancer has many methods such as surgery, radiotherapy, and chemotherapy etc.(Beare & Myers, 1994: 317-318). The study of the experience of women living with cancer revealed that women felt hopeless and feared the cancer because they have a life threatening illness (Colyer,1996: 298). Women face struggles in living with cancer (Carpenter & Brockopp,1994: 751). Moreover, cancer affected women by decreasing their life energy and changing their body. It was a situation led both women and family to stress. It is characterized by fear and need of caring as well (Lewis, 1990: 753).

Situation induced need of care is the result of adjuvant chemotherapy that takes a long time (Carpenter & Brockopp,1994: 751). It is a systemic treatment that enables drugs to reach the site of the tumors as well as distant sites (Miaskoski & Viele, 1999:83). It kills cancer cells that disseminated from the origin and also destroys normal cells of the body such as bone marrow cells, hair follicle cells, gastrointestinal tract cells, and others cells (Anderson & Doyle-Mirzadeh, 1994: 429).Therefore, it lead women to mental weakness (Tayor, 2000: 782; Crooks, 2001:104). Evidence supports is that women have data of temporary mental weakness as this statement:

> "Sometime I had discouragement…I think and I fear everything."
> (Woman ID29-P2)

Moreover, chemotherapy affects to temporary body function. This shows by the decreasing of duty related to side effects of chemotherapy such as nausea, vomiting, bored with food, stomatitis, and fatigue (Campbell, 1999:444). Ordinarily, people need to maintain well being that they need care agents to substitute in their function and mental support. This situation needs of temporary care agents for six months. Women with breast cancer receiving chemotherapy faced the inability in taking their role and struggled from physical distress and emotional distress. These five situations affected the women need of caring form other people in two tracts as follows:

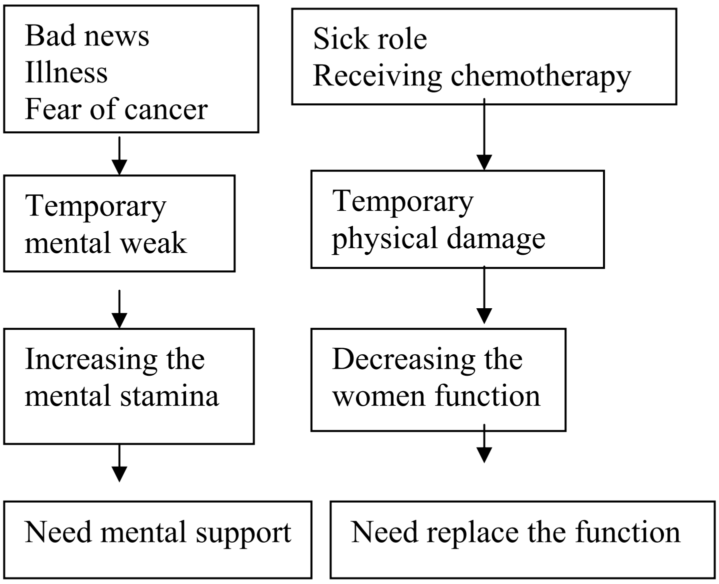

Figure 2: A diagram illustrating the situation-induced need of care

Emergence of care agents

Emergence of care agents resulted from situation induced need of care. Women need care agents thus there are both care agents and ways of caring. There are two characteristics of caring: professional care and family care. The professional caring is directly responsible and paid for service. Caring from health care professionals is in the hospital setting. They emerged from the complexity of health care system and advancement of technology in health service. Therefore, these situations need more specific knowledge until the natural caring system. The family system does not have the competency for this care (Pepin,1992: 128; Geary & Hawkins,1991:7; Helman, 1994: 65). Another caring is the caring from the other people. This care emerged from family and volunteers. It is an unpaid service (Schofield, 1998: 12-13).

In this study, there are three groups of care agents: health care professionals, family and women self-care. The professional care agents emerged by duty, family care agents emerged by loving and sharing with professional care, and women performed self-care. Moreover, there are care agents that emerged from the news of women illness. They are colleagues, neighbors, and friends that provide mental support for the women.

In chemotherapy treatment service, health care professionals act as a proactive role because the women with breast cancer already are in the health care system. Women requested the family and performed self-care. The other people were the volunteers to care. The brief of emergence of care agents presents as follows:

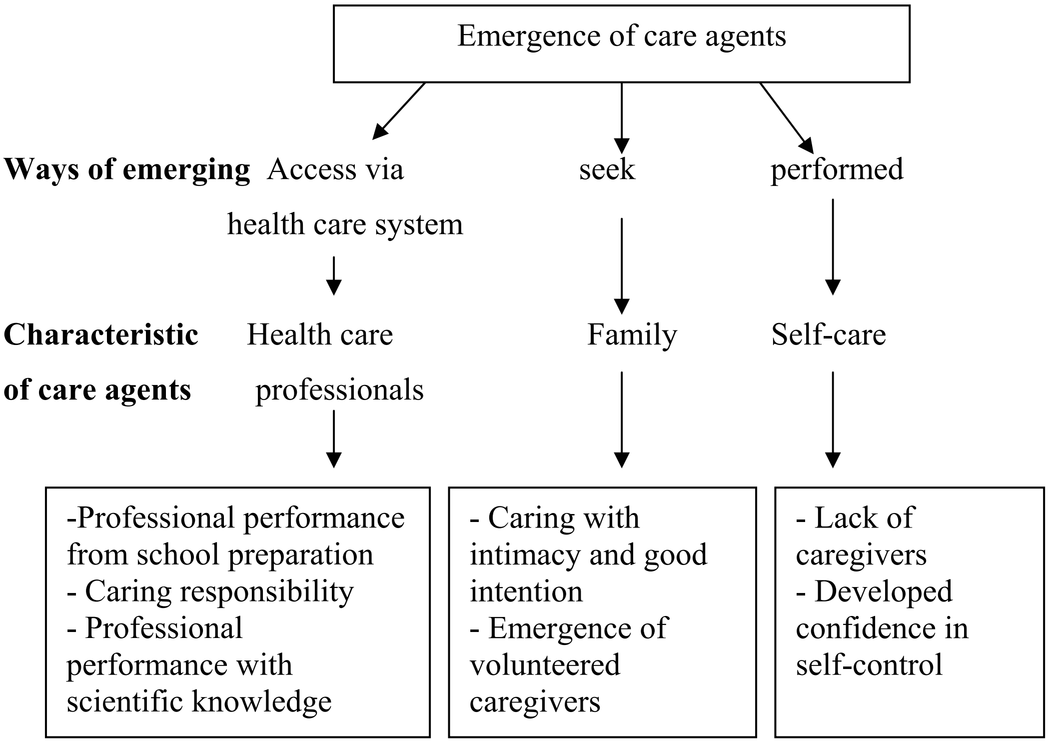

Figure 3: A diagram illustrating the emergence of care agents

Ways of caring

Ways of caring activity emerged by care agents. Professional care agents were also based on duty. Theirs responsibility were using knowledge for curing disease and caring for healing. The objective of professional care was effectiveness disease curing (Geary & Hawkins, 1991:7). Ways of caring in chemotherapy treatment was proactive of the professional's role. Physicians and nurses knew that women receiving chemotherapy had side effects from biomedicine knowledge. Thus, they tried to protect women from suffering. Physicians gave women antiemetic drugs thirty minutes before giving women chemotherapy (Johnson, Moroney & Gay,1997:51). Nurses educated women and their family with knowledge that can use for caring. They give direct caring by using scientific knowledge and humanistic as well (Metcalfe, 1990:146). They also adjusted the information to appropriate it for the clients and guide them as partnership. The ability of a knowledgeable nurse to demystify the chemotherapy experience for the novice patient was viewed as a critical nursing intervention (Cohen & Sarter, 1992:1481; Fall-Dickson & Rose,1999: 906). Moreover, in western cultures, they have the continuing care systems for women with breast cancer. Another is non-government service that has many organizations, which provided information for women and family too. Therefore, in western culture, the women with breast cancer receiving chemotherapy and their families had many sources for consultation.

In this study, ways of professionals care were promotion of safety, giving advice to compliance with the treatment, and advice to keep the stamina for treatment. These ways may be appropriate within the hospital because health care professionals create all of the caring activity for these women. In this study, the ways of caring may not appropriate for this situation because the caring situation was in the women's homes. Therefore, the family had a limitation of information for caring at women's homes.

Family ways of caring were the provision of mental support. There was a limitation care for women's function because they had a limitation of information for care. Thus, they searched some information about caring.

Women performed self-care and they also had a limitation of information. Thus, women used the ways of compliance with treatment and mind-control. However, the summary of ways of caring activity must be:

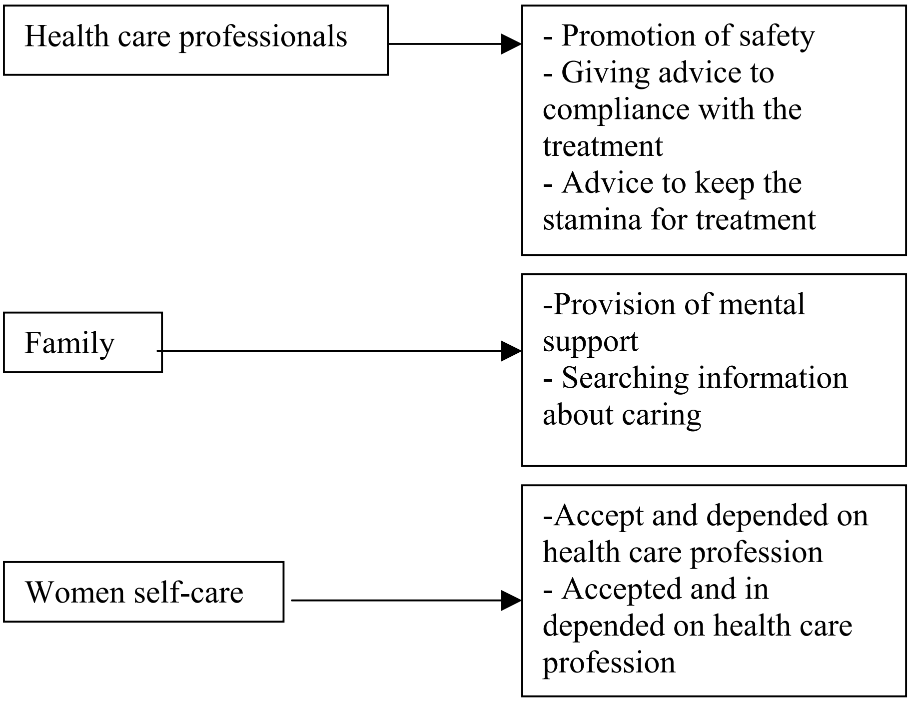

Figure 4: A diagram illustrating the ways of caring

The consequences of this situation were some problems in this phase that led to partial caring. There is only the mental support but the function was not complete care because of the lack of information. Women did not know what information that they should be receiving from health care providers too. Moreover, women were satisfied in personnel manner of health care providers as well. This data is indicated as follows:

> “A nurse wish me well. It is her duty. She didn’t want me to die. She provides full help. She encourages and suggests me to enduring”.
> (Woman ID.15-P3)
>
> "Nurses provide good care, advice, and consultation. There are many nurses, thus they have time to give conversation and advice. If I have some problems, I need to talk to a nurse. Conversation helps me to have encouragement. I think it is important, it help holistic parts that can not take from medication".
> (Woman ID.18-P3)

Change in the setting of care

Health policy for chemotherapy treatment changes from in hospital service to a daytime service. The reason for this change is to decrease the length of stay, decrease prone to infection of patients, and solve the problems in lack of health care professionals. Therefore, side effects of chemotherapy emerged at women's homes and family must care within the lack of knowledge for care.

In general, change in the setting of care from hospital to women's homes, health care professionals provide care only one day from every twenty-eight days of the chemotherapy cycle. Family provides care twenty-seven days from every twenty-eight days of chemotherapy cycle. Because of lack of continuing care and home care, the family does not have any consultant for care. However, the family must be well prepared for caring. In western cultures, there is a system of family's preparation for caring and continuing care. Moreover, family and women also have many sources of organization for helping them. In Thailand, the lack of these systems lead the family to premature of family cares activities. Women and family provide care by limitation of knowledge. Therefore, the most common care activity is mental support. The lack of significance caring in physical dimension lead women to face to many side effects of chemotherapy because women have not competency in self-care, risk to decreasing physical strength, and prone to other complications.

In this study, there are constraints on caring that composed of constraints on professional care, constraints on family care, and constraints on women self-care. The constraints on professional care originated by underused of nurse's proficiency, nursing care as a supplementary role, limitation of caring responsibility from physicians' performance. It related to constraints on family care that composed of lack of essential information about caring and family burden. The constraints on self-care composed of lack of knowledge and limitation in sharing information.

Constraint of caring was the result from the health care system and social system. Thai health care system is the hierarchy and ordering in top-down system (Pichitpornchai, 2000:39). The authority of health care providers were dominated. Health care providers used modern western scientific medicine or biomedicine in their care. The physicians were perceived as the most significant in this system. Whereas nurses whom had self-knowledge were less autonomy and power than physicians. The hierarchical relationships in Thailand push people to find strategies to encounter theirs inner feelings and obligations. As an outcome, avoidance or non-involvement in conflicting issues, compromise, and compliance have become common behavioral practices among Thai people and seen as a way for them to cope with any dispute or direct confrontation (Komin,1990). Moreover, the stereotypical image of northern Thai women is characteristics by gentleness, weakness, dependence, emotionality, and the responsibility for taking of the house and children (Fongkaew,1995).

Thai hospital organizational structure had further sustained the hierarchical relations between nurses and physicians (Pichitpornchai, 2000:42). Physician's constraints in this study originated from physician limited information due to hierarchy system. This system indicated that physician had knowledge power more than the other teams. Knowledge of physician was special for physician, thus physician should not give the client detail of this knowledge such as the data of laboratory and the data of disease. The physician must present the information in a form of translation such as normal blood examination. Moreover, in this setting, there is only one physician in response to the breast cancer unit. He had duty on the whole breast cancer unit. This job composed of screening, operating, and ordering chemotherapy treatment. His hard work affected the time that he spent with the women with breast cancer receiving chemotherapy, thus he must limit information. Like the study in of Sainio, Eriksson & Lauri (2001: 176) it revealed that hindering factors of physical in participation with the clients was lack of time.

Constraint on nurse based on underused of nurse's proficiency. Caring was a complementary role of nurses. In nurses' role, Sindhu & Puttapituxpol (1999: 17) present that nurses were preparing by systematic in education. They are educated in science, humanity, and technology in nursing. School prepared her with special knowledge and clinical competency for caring for the clients in normal life and illness. They must care in complicated illness situations as well.

In this study, nurse acts as messenger such as by making appointments. The goal of nursing care was serving physician's work. Appropriate with the document which revealed that nurse works to try to help medical treatment in the period of curing (Dorsett,1991:177). In this setting, there was only one nurse who had responsibility for the breast cancer unit. She worked like case management. She had others duty such as giving information for breast self-examination, preparing in mastectomy, caring for women receiving chemotherapy as well. The data from the nurse indicated that 50% of duty is collecting statistics, breast cancer reports, and caring for the others patients; 30 % giving information for breast self- examination, 20% educating about chemotherapy and caring for women receiving chemotherapy. This data indicated that nurse used little time to take care for women with breast cancer receiving chemotherapy.

The significant data indicated that the nurses had limited autonomy and authority for giving information. Sometimes the problems of women were not communicated for solving. This situation based on the relationship of nurse and physician was distance, formality, brief conversation and often used professional jargon (Helman,1994: 82). In this relationship, the nurse can not use the competency to bargain for efficiency care. Using low competency found in nursing information in taking food. This data present nurse's information for woman with breast cancer.

> "In this period, you should eat good food. Don't avoid meat and fish. You should eat everything such as vegetable and fruit. If you can not eat, you must try eating again".
> (Field note P9)
>
> "At 9.00 A.M. Women sit on chair near a nurse. Nurse saw chart then ask woman "How are your symptoms?" woman answer " I am disheartened and will have a headache after receiving medication." Nurse suggests "control your mind, don't consider it, tell the doctor about your headache…you look good, your hair has a little loss'. Women nod in assent. Nurse tells the women to sit outside this room and wait for doctor.
> (Field note P1)

This data indicated that nurse gave the broad information and may not be appropriate for the women symptoms, therefore women and family can not use it for caring. Appropriate with the study related to constraint of nursing care, there are 127 documents of nurse-patient communication in the cancer care that indicated the blocking of behavior of nurse. It can be summarized as follows: neglect and poor symptom management because of poor knowledge, no response to patient's emotional, spiritual, and informational needs , and lack of respect for family (Kruijver, Kerkstra, Bensing & van de Wiel, 2000: 28). Moreover, the other document revealed that the nurses' distancing themselves from patients could also be related to their lack of knowledge of how to talk with serious ill patients, and the uncertainty about which information the women received from other professionals. This could hinder when talking with and informing patients and relatives (Odling , Norberg & Danielson,2001:840).

Another dimension of caring is promotion of care that originated from professional encouragement , support from family and other people and self-encouragement. They are facilitating factors in caring and support mental caring (Morrison, 1991:5). Receiving encouragement helped women in decision-making for care because it promotes women to comply with the caring process (Sainio, Eriksson & Lauri, 2001:175). Some studies also indicated that nurses perceived psychological caring as the most importance in caring (Morrison, 1991:5). Therefore, the facilitating for decreasing premature of family cares activities can summarized as follows:

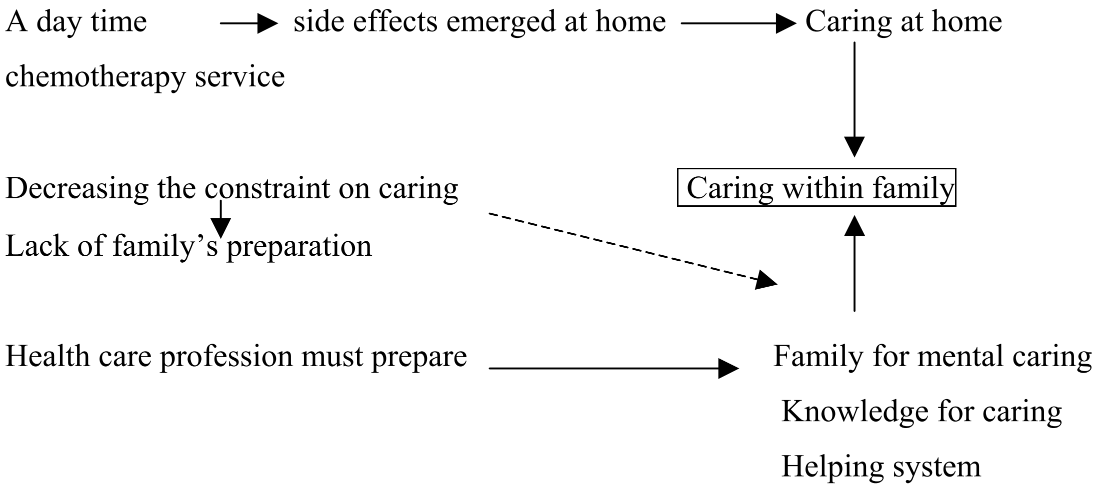

Figure 5: A diagram illustrating the facilitating for decreasing premature of Family cares activities

Shift from care agents to non-professionals in family based-care

Emerging the concept of "shifting from care agents to non-professionals in family-based care" was based on premature of family to take caring activities. However, the family tried to adjust the ways of caring by pulling the whole competency and searching ways of caring. Knowledge searching for care is both indirect professional care access from other sources and direct professional care access from people. In another ways, the family used trial and error for care. This concept was not found in the others studies. It was the result of caring in the initial phase. The family had limited knowledge of caring, they tried to care for women by theirs own ways. The influence factors were the constraint of caring and shifting setting of caring.

Shift from care agents to non-professionals in family based-care composed of adjusting the quality of care for the loved one and deviance from the right ways of caring. The adjusting the quality of care for the loved one was the method that the family cared for the quality of care. The objective was to provide care that was appropriate with problems and distress of women. Moreover, they managed to help women breakthrough the distress of chemotherapy's crisis. Some families created many methods for getting back to normal, some changed activity within the family for easily getting back to normal (Hilton, 1996:612). The ways of caring in this concept composed of nurturing, supplementary role for women, taking part in economic status and regulation chemotherapy. Whereas, deviance from the right ways of caring emerged by limited information for family's caring. This ways composed of using trial and error and enduring. The document indicated that up to eighty percent of cancer patients reported using complementary/alternative medicine. In breast cancer, family and friends generally support the decision to use CAM (Boon, Brown, Gavin, Kennard, & Stewart, 1999: 639-640). These ways risked delaying treatment. The summary of shift of caring to non professional in family based-care portray as follows:

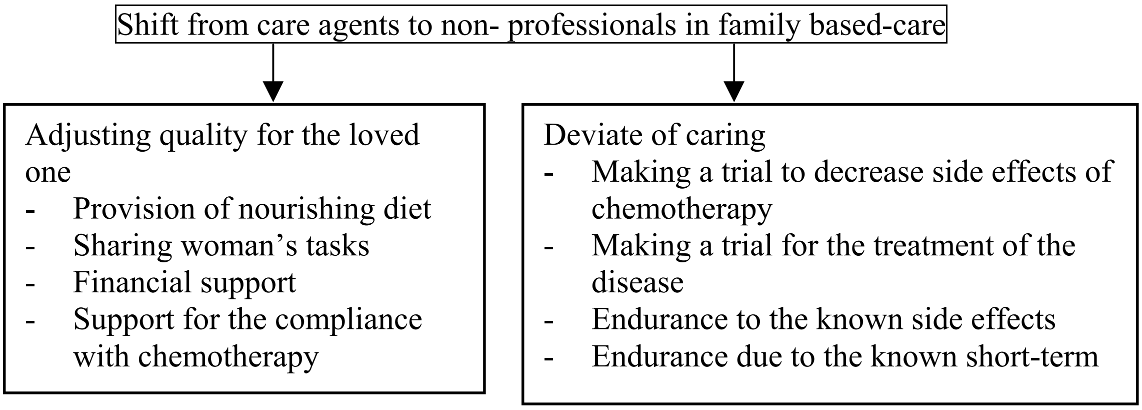

Figure 6: A diagram illustrating the shift from care agents to non- professionals in family based-care

The outcomes of care

The consequences of a shift from care agents to non-professional in family based-care are various. Outcome of care in this study composed of good outcomes of care and poor outcomes of care. Outcome of care was the result direct from shifting role of care agents to non-professionals in family-based care.

Good outcomes of care were the result of adjusting the quality of care for the loved one. Psychological outcome that emerged in this study had varied from getting a good psychological comfort to living with endurance. Caring from family members, friends, or significant person influenced to the illness experience, well being and wellness in the long term. It is more significant than received from health care providers (Ellers,1993:178). Physical outcome was the consequence of family based-care. It showed in varied forms. The physical strength was an outcome of the best family based-care. Some women had little physical problems, some of them had gradually gained their physical strength. These were the outcome of family-based care that tried to do the best ways. Moreover, women's willpower was a concept that not found in the formerly study of caring of women with breast cancer. Woman's willpower was the concept that presented women to feel encouragement and growth. These concepts were a consequence of caring within the family because the small social group of family gave support, nurture, safety, and love (Kavanagh, 1994:4). Family strength was concept that was not founded in the study of caring of women with breast cancer. Family strength was the consequence of ending caring process. It emerged when the family took the care actors' role. The strengths were the outcome of cooperating between women and family. It was very significant for the health care personnel that family strength was the key meaning of caring (Kavanagh,1994:423). Mayeroff (1971 cited in Stockdale & Warelow, 2000:1260) suggested that function of caring helped the development of people because this caring is the process and ways of interaction between the people.

Poor outcomes of care were the result of deviate ways of caring. The women had distressed feelings. They expressed the unhappiness due to feeling despair, perceived stress, and living with endurance. Moreover, some women had physical problems and low while cells. Low white cells must decrease in five to twelve days after receiving chemotherapy (Loney & Chernecky:2000: 954). When the white blood cells were below 3,800 cells/cu.mm., the women delayed treatment. If they delayed treatment, they must receive neupogen to facilitate white blood cells. The cost of neupogen at research setting is 4,220 baht. thus there is the increasing the cost of care. Moreover, some women faced the problems until they could not maintain daily activity. These problems were the result from inappropriate caring and using endurance. Using endurance, women ignored to search the ways for solving problems. Thus, physical comfort could reflect to family caring.

In summary, outcome of caring should composed be of various types related to characteristics of process. The result is consistent with Hooyman & Gonyea (1995:334) presented that a feminist model would instead define health more broadly, in terms of the type of life its makes possible for adults with disabilities and their family caregivers. Mcchanic (cited in Hooyman & Gonyea ,995:334) stated the following:

> "The quality of a health care system is truly measured not by what it spends or the number of sophisticated procedures that it performs, but how it enhances the potential of the population to fulfill its personal and social choices and the extent to which it limits suffering".

In brief of the consequences of shift of caring to non-professional in family based-care portray as follows:

Model 1 :

Families that have many support from various sources

↓

Family has many competencies

↓

They used much of adjusting quality for the loved one

They used few deviate ways of caring

↓

The best consequence

Model 2 :

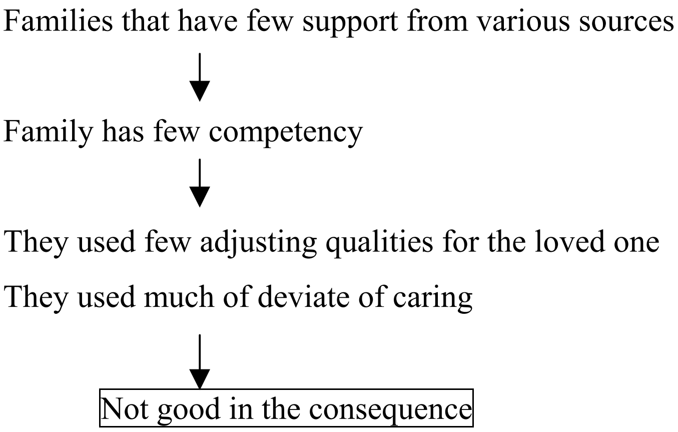

Figure 7: A diagram illustrating the consequences of shift from care agents to non-professionals in family based-care

Therefore, the best caring process needs good preparation and must be concerned with there are simplifying new cells formation, decreasing cancer cells formation and diminishing side effect of chemotherapy.

The caring process of Thai women with breast cancer receiving chemotherapy is summarized in the diagram as follow:

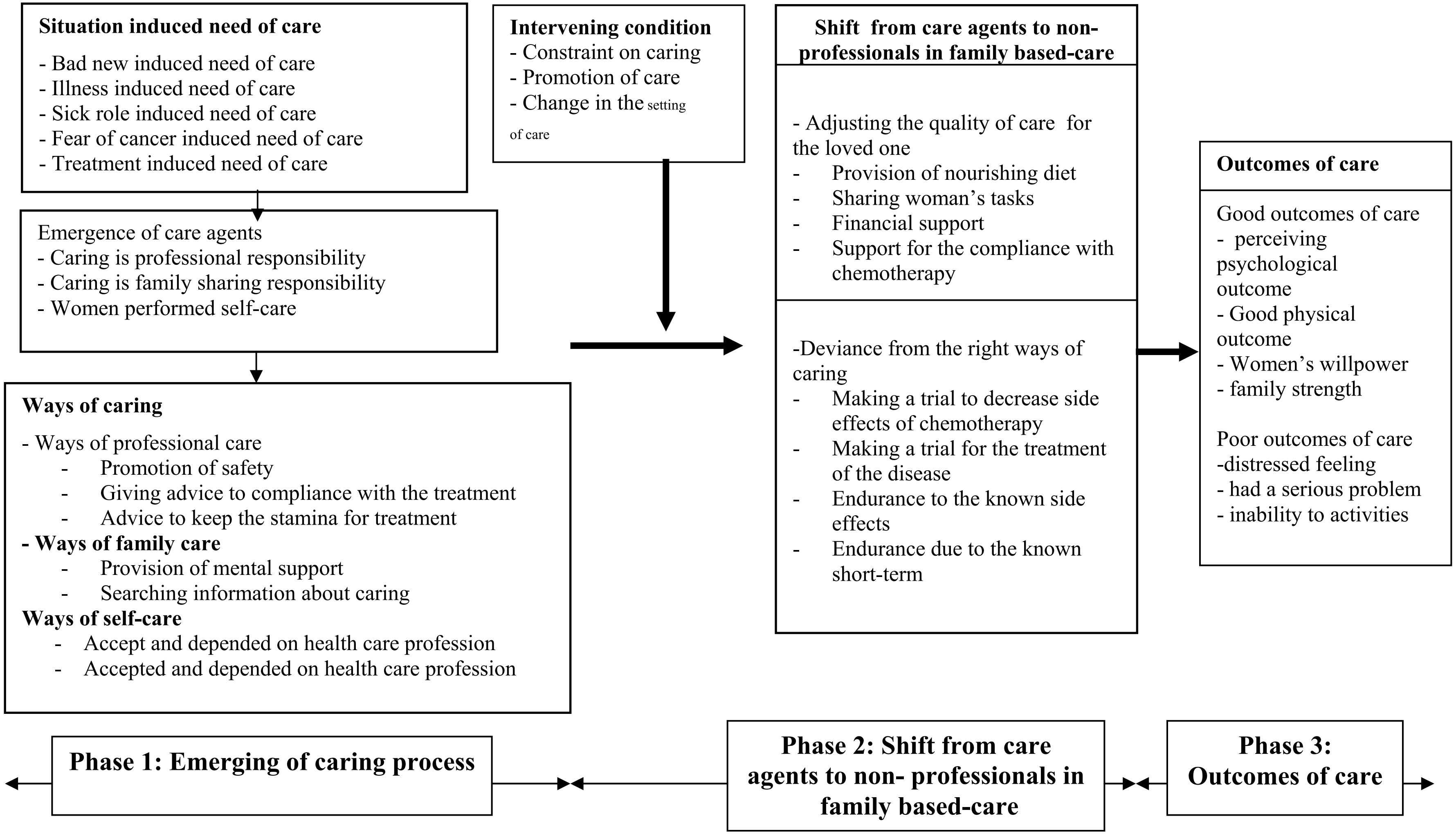

Figure 8: A diagram illustrating an evolving theory of caring process of Thai women with breast cancer receiving chemotherapy

Moreover, the best caring process are gradual sharing of professional care to family care. It begins from professional care to share care to the family. This system tries to decreased professional care and increase family care. However, health care professionals must have continuing consultant role for family and educating knowledge for family. Moreover, family and women may search the other information for care. Therefore they have direct and indirect professional information. This situation portray the best caring process of Thai women with cancer receiving chemotherapy and it consequences are good. This process destroys constraints on caring and supports family based-care.

The strengths and limitations of the study

An evolving of the caring process of Thai women with breast cancer receiving chemotherapy provides additional knowledge for nursing phenomena. It portrays the reality of caring process from hospital in the northern part of Thailand that has the limitations of health care professionals. This study also portrays voices of three groups from health care professionals, women and families. Etic and emic views in this study are other strengths of this study. Moreover, the results of this study have reduced the gap between academic theory and practice reality.

The limitations of this study are the small group of participants especially in health care providers group. Only one nurse and one doctor who were the participants in this study is the limitation information in providing professional care. Theoretical sampling in order to obtain data to adding in an evolving was a limitation as well, because the limitation in the group of women receiving chemotherapy and family.

Conclusion

This study provides an evolving theory entitled “the caring process of Thai women with breast cancer receiving chemotherapy” which explained a clear interactive process of caring process that shifted form care agents to non-professionals to family based-care within the conditions of limitation of health care professionals. This process started by situation-induced need of care and emergence of care agents and ways of caring, the causal conditions. The second phase was the shift from care agents to non-professional in family based-care, action/interaction strategies that composed of adjusting the quality of care for the loved one and deviance from the right ways of caring. The last phase, the outcomes of care are the consequence. They are composed of good outcomes of care and poor outcomes of care. Moreover, these process influences factors those were constraint of caring, promotion of caring, and change in the setting of care.

CHAPTER X
CONCLUSSION

This final chapter begins with summary of the study findings, implications and recommendations. The contribution to nursing theory/knowledge development is also presented.

Summary of study findings

The purpose of this study was to explore the caring process of Thai women with breast cancer receiving chemotherapy for breast cancer and to explain the factors that influence this process. This study findings were obtained from data not only from observation and woman's physical examination but also in-depth interviews of thirty women with breast cancer receiving chemotherapy, nineteen family care actors, one nurse and one doctor whom provided care for these women. Research setting were the regional hospital in the lower northern of Thailand and women's homes. The grounded theory as the method and socialist feminist theory as the conceptual framework was used to capture the realistic phenomenon. This study generated the evolving theory of caring process of Thai women with breast cancer receiving chemotherapy. It was composed of three phases.

The first phase was called "emerging of caring process," which was composed of "situation induced need of care" and "emergence of care agents and ways of caring."

The second phase was called "shift from care agents to non-professionals in family-based " that was the action phase. It was composed of "adjusting the quality of care for the loved one" and "deviance from the right ways of caring."

The last phase was called "outcomes of care" reflected to a consequence of shifting care in the second phase. It composed of good outcomes of care and poor outcomes of care.

Moreover, the influencing factors that affect this caring process were constraints on caring, promotion of care, and change in the setting of care.

The theoretical findings are summarized in Table 7

Table 7: Summary of the definitions of the constructs and concepts

Constructs	Concepts	Definitions
Emerging of caring process		The causal condition that induced caring process. It was composed of situational induced need of care, and emergence of care agents and ways of caring
	Situational induced need of care	Situations that related to women's illness. These situations led a person to face to the seriousness in daily living life, psychological, physical, social and economic problems, and changed their life in the future. These situations induced women need care from the other.
	Emergence of care agents and ways of caring	The emergence of a person or group of people who were care agents for women. Health care professionals were ready to responsible deliver care to women with cancer, who are their clients. They play their roles as educated from well-established academic institutes. Their education is based on knowledge about specific disciplines, scientific learning and references such as textbooks for the delivery of professional care. For the

Table 7: Summary of the definitions of the constructs and concepts (cont.)

Constructs	Concepts	Definitions
		family, the members have responsibility in caring for an ill member.The family's delivery of care, however, should be shared with health care staffs. Each family demonstrated different ways of caring, depending on their situation. The women also looked after themselves. The performance of self-care either emerged from self-confidence, or resulted from the lack of caregivers in the family.
Intervening factors		The blocking or facilitating factors that influence the caring process in positive or negative ways.
	Constraint on caring	The blocking factors that could interfere or delay the process of caring. They were divided into constraints on professional care, constraints on family care, and constraints on the women's self-care. These constraints on professional care were underused of nurse's proficiency, the delivery of nursing care as a supplementary role rather than a major role, and the exclusive restriction of woman care to

Table 7: Summary of the definitions of the constructs and concepts (cont.)

Constructs	Concepts	Definitions
		physicians. Constraints of family were lack of essential information about caring, and the sense of family burden due to the uncooperative manners of the women. Constraints of women were a cause of limitation in the reception of knowledge about self-care, restrictions on information exchange with health care professionals, financial problems and transportation.
	Promotion of care	The facilitating factors that influence the women in the caring process were positive. These factors composed of various significant sources health care providers, family and women as well. This factors including mental support from people. It related to the women by raising their spirit in managing the symptoms. The women felt that other people were aware of their sufferings. Professional encouragement also induced complete care for women with breast cancer.
	Change in the setting of care	The promotion factors that facilitate the change of care setting from other place to another place. The change of

Table 7: Summary of the definitions of the constructs and concepts (cont.)

Constructs	Concepts	Definitions
		setting of caring occurred under various conditions comprising care-sharing between nurses and the family and the alteration of care settings.
Shift from care agents to non-professionals in family based-care		The process of shift role of care actors from professional care agents to family care agents. The family had limited information to care. Thus, they used non-professional concepts for care.
	Adjusting the quality of care for the loved one	Action of the family that made an effort to give the best care to the person they love within their limitation. They tried to adjust their ways of caring to be relevant with the woman's problems or sufferings. The adjustment of caring included supportive caring to help the woman overcoming the crisis period of chemotherapy. The supportive caring comprised the provision of nourishing diet , financial care, and caring for the compliance with treatment.

Table 7: Summary of the definitions of the constructs and concepts (cont.)

Constructs	Concepts	Definitions
	Deviance from the right ways of caring	Action of the family that made an effort to provide the best care to the person they love. However, they might confront limitations and had to alter the ways of caring to respond to the woman's problems or sufferings. The deviation in the ways of caring might be developed from making a trial and being patient with the problems.
Outcomes of care		The consequences of the provision of caring in family based care that provided care for women receiving chemotherapy.
	The good outcomes of care	The outcomes of care that women felt receiving psychological consolation, good physical, women's will power and family strength.
	The poor outcomes of care	The outcomes of care that women felt distressed feeling, had a serious and inability to perform activities.

Implications and recommendations

The finding from this study was an evolving theory of the caring process of Thai women with breast cancer receiving chemotherapy. This theory can be used for implications and recommendations as follows:

Implication and application of research findings

In this study, there is a shifting of caring from professional to non-professional in family based-care. This shifting shows the immaturity of family in caring. Therefore, the implication and application of research findings in this study was policy and system of caring as follows:

1. Health care policy for caring of Thai women with breast cancer receiving chemotherapy must be considered to change the caring system. Nowadays, there is no continuing care for them. This caring is moving from professional to family at home. Health care policy must change for this situation. As the government needs the caring to the community, they should have the policy in manpower in the community too. Moreover, health care professionals in the community must have competency for care and experience. Professional nurses are suitable for this job. They are well prepared for problem sensitivity, knowledgeable, proactive, have experience in hospital service, and commited to seeking knowledge for caring.

2. Because of lack of health care providers, nurses and physician can not provide appropriate caring for women with breast cancer. To achieve this, manpower management should be suitable for workload of nurses and physicians.

3. System must be changed to continuing care. In present, the continuing care system, caring at primary care unit, and family-based care must be developed. Moreover, nurses not only provide direct care for these women but also take role of facilitator, educator, counselor, advocator for women and families. Moreover, nurses must be coordinators of the healthcare team, and researchers to search directions for developing nursing care.

4. Development family's competency for caring

Families care actors of women with breast cancer receiving chemotherapy should be encouraged to develop competency in managing chemotherapy side effect at home. A package of management for chemotherapy side effect should be developed for families. Using this package, the family can provide the best care for women with breast cancer receiving chemotherapy.

Recommendations for further research

Recommendations for further research based on this study finding are several directions. The suggestions are discussed in details as follows:

1. The measurement of various concepts should be developed for testing theory with positivist philosophy such as “constraints on professional care”, “constraints on family care”, “constraints on women self-care”, “women’s willpower”, and “family strengths’. Theirs properties and dimensions of these concepts presented in this study could be used to guide this process.

2. An evolving theory of “caring process of Thai women with breast cancer receiving chemotherapy” should be refined through theory testing procedures. The relationships among concepts and constraints need to be additionally identified and tested.

3. In order to increase explanation power of the findings, the additional research is also needed to explore more fully the variations in health care providers. For example, the competencies of nurses in clinical practice needs further investigation.

Contribution to nursing theory/knowledge development

This study provides an evolving theory entitled “Caring process of Thai women with breast cancer receiving chemotherapy” which explain an interactive process from shifting caring from health care providers to family based-care. This evolving theory is the knowledge in nursing phenomenon that has the condition of limitation in health care providers. It indicates direction in order to prepare the family for ready to give care for women in the families and also give direction of further research in change the constraint of care. This evolving theory also present the relationships between health care providers, families and women, and the influencing factors of the caring process of Thai women with breast cancer receiving chemotherapy. After testing the theory, the findings of this study are added to the essential knowledge in nursing science.

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APPENDIX A
CONSENT FORM FOR THE PARTICIPANTS

CONSENT FORM FOR PARTICIPANTS IN THE STUDY

My name is Chommanard Wannapornsiri , a doctoral nursing candidate, from the Nursing Faculty, Mahidol University. Now, I am conducting a study of the caring process for Thai women receiving chemotherapy for breast cancer. The objectives of this study are to explore the caring process for Thai women receiving chemotherapy for breast cancer and to explain the factors that influence the caring process for Thai women receiving chemotherapy for breast cancer.

This study will provide health care providers to perceive and understand the caring process for Thai women receiving chemotherapy for breast cancer. It can be used as a guide to improve the caring process for other women receiving chemotherapy.

I think you are the person that is able to participate in this study. I will require an interview with you and I will make an appointment for the interview. Each interview takes time about 60-90 minutes. During the interview, I will use a tape recorder. I will also require a visit to your home during your treatment.

With interviewing, if you feel uneasy or unhappy with some questions, you have the freedom to refuse to answer those questions. You can decline or withdraw from the study whenever you want to and it will not effect to health care service you receive from this hospital.

After you finish the interview, the researcher will transcribe the audiotape to paper and type it and save it in a computer file. Your name or related events will be represented in a pseudonym. The tape, paper and diskette will keep in a locked cabinet by the researcher.

In the data analysis, only the researcher and my advisory committee look at the data. All of the documents will be destroyed when I finish the study. The data will be presented in the whole process and it will not effect you.

Moreover, if you have problems or doubts I will prompt by help or answer your questions. Throughout the process if you have some doubts, you can contact me at Buddhachinaraj Nursing College, Phitsanulok province. My telephone numbers are 0-5521-9041, 0-5524-8334 or 0-9895-3205 (mobile phone).

If you are willing to participate in this study, please confirm it with me.

THAI TRANSLATION FORM
CONSENT FORM FOR PARTICIPANTS IN THE STUDY

คำชี้แจงสำหรับผู้ให้ข้อมูล และการคุ้มครองสิทธิของผู้ให้ข้อมูล

ดิฉันชื่อ ชมนาด วรรณพรศิริ นักศึกษาระดับปริญญาเอก สาขาการพยาบาล มหาวิทยาลัยมหิดล กำลังทำการวิจัยเรื่อง กระบวนการดูแลผู้หญิงไทยที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด โดยมีวัตถุประสงค์เพื่อ ค้นหากระบวนการดูแลกระบวนการดูแลผู้หญิงที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด และปัจจัยที่มีอิทธิพลต่อกระบวนการดูแลผู้หญิงที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

การศึกษาครั้งนี้ จะช่วยให้บุคลากรทีมสุขภาพรับรู้และเข้าใจถึงกระบวนการดูแลผู้หญิงไทยที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด และใช้เป็นแนวทางในการปรับปรุงการดูแลผู้หญิงที่ป่วยเป็นมะเร็งเต้านมรายอื่น ๆ ที่ได้รับเคมีบำบัด

ดิฉันคิดว่าท่านมีความเหมาะสมในการเป็นผู้ให้ข้อมูลในครั้งนี้ จึงสนใจที่จะสัมภาษณ์ท่าน และขอนัดเพื่อสัมภาษณ์ โดยคาดว่าจะใช้เวลาประมาณ 60-90 นาที สำหรับการสัมภาษณ์ในแต่ละครั้ง และขออนุญาตบันทึกการสัมภาษณ์ด้วยเทปบันทึกเสียงในระหว่างการสัมภาษณ์ และติดตามเยี่ยมท่านที่บ้านในระหว่างการรักษา

ในขณะสัมภาษณ์ ถ้ามีคำถามที่อาจทำให้ท่านอึดอัดหรือรู้สึกไม่สบายใจ ท่านมีอิสระเต็มที่ในการปฏิเสธการตอบคำถาม รวมทั้งยุติการสัมภาษณ์หรือขอออกจากการศึกษาเมื่อใดก็ได้ตามที่ท่านต้องการ โดยจะไม่มีผลกระทบรับผลกระทบอื่นใดต่อการได้รับบริการรักษาพยาบาลของคุณจากโรงพยาบาลแห่งนี้

หลังจากการสัมภาษณ์ผู้วิจัยจะเป็นผู้ถอดเนื้อจากการบันทึกเทปลงในกระดาษ และพิมพ์ข้อมูลเพื่อเก็บบันทึกไว้คอมพิวเตอร์ โดยชื่อของท่านจะใช้แทนด้วยชื่อสมมุติ เทปบันทึกเสียง กระดาษบันทึก และแผ่นบันทึกข้อมูลคอมพิวเตอร์ทั้งหมดจะเก็บรักษาเป็นความลับในตู้ของผู้วิจัยที่มีกุญแจปิด

ในการวิเคราะห์ข้อมูลจะมีเพียงผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้นที่จะร่วมกันใช้ข้อมูล และข้อมูลทั้งหมดจะถูกทำลายเมื่อสิ้นสุดการศึกษา โดยการนำเสนอข้อมูลจะเสนอในภาพรวมที่ไม่กระทบต่อท่าน

นอกจากนี้ถ้าท่านมีปัญหาหรือข้อสงสัยอื่นใดก็ตาม ๆ ผู้ศึกษาก็พร้อมจะให้ความช่วยเหลือหรือตอบปัญหาให้ท่าน และตลอดระยะเวลาของการเข้าร่วมการศึกษาครั้งนี้ หากท่านมีข้อสงสัยใดๆ สามารถสอบถามได้จากดิฉันที่ วิทยาลัยพยาบาลบรมราชชนนี พุทธชินราช จังหวัดพิษณุโลก โทรศัพท์ 0-5521-9041 หรือ 0-5524-8334 หรือ 0-9895-3205 (มือถือ)

ถ้าท่านยินดีและสมัครใจที่จะเป็นผู้ให้ข้อมูลในการศึกษาครั้งนี้ กรุณาให้คำยืนยันกับผู้วิจัยเพื่อเข้าร่วมในการศึกษาครั้งนี้ด้วย

APPENDIX B

DATA COLLECTING GUIDE

WOMEN INTERVIEWING GUIDELINE

Objectives	Questions
To obtain the personal experiences after receiving chemotherapy	1. Please tells me about your experience of chemotherapy side effects? 2. When did the symptoms emerge? 3. How did this change your life?
To explore how they care their problems.	4. How did you care for these symptoms?
To explore how their family and health care providers care when they faced these symptoms.	5. How did your family and health care providers care when you faced these symptoms?
To explore the factors influencing caring process when they received their chemotherapy.	6. What are the factors related to hindering or facilitating care when you received your chemotherapy?
To explore outcome of care.	7. How are you after receiving care?

THAI TRANSLATION FORM
WOMEN INTERVIEWING GUIDELINE

แนวคำถามในการสัมภาษณ์ผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

วัตถุประสงค์	**คำถาม**
เพื่อให้ได้ข้อมูลประสบการณ์เกี่ยวกับการได้รับเคมีบำบัดของผู้หญิง	1. กรุณาเล่าเกี่ยวกับประสบการณ์ในการเกิดฤทธิ์ข้างเคียงของเคมีบำบัดที่ท่านประสบ 2. อาการดังกล่าวเกิดขึ้นเมื่อไร 3. อาการนั้นมีผลทำให้ชีวิตท่านเปลี่ยนแปลงอย่างไร
เพื่อค้นหาว่าผู้หญิงดูแลอย่างไรกับปัญหาดังกล่าว	4. ท่านดูแลอาการเหล่านั้นอย่างไร
เพื่อค้นหาว่า ครอบครัวและผู้ให้บริการสุขภาพดูแลผู้หญิงอย่างไร เมื่อต้องเผชิญกับอาการดังกล่าว	5. ครอบครัวและบุคลากรทางการแพทย์ดูแลท่านอย่างไร เมื่อท่านพบกับอาการดังกล่าว
เพื่อค้นหาปัจจัยที่มีอิทธิพลต่อกระบวนการดูแลเมื่อผู้หญิงได้รับเคมีบำบัด	6. ท่านคิดว่าปัจจัยอะไรที่ขัดขวางหรือส่งเสริมการดูแล เมื่อท่านได้รับเคมีบำบัด
เพื่อค้นหาผลลัพท์ของการดูแลที่เกิดขึ้น	7. ท่านเป็นอย่างไรหลังจากได้รับการดูแล

SIGNIFICANT FAMILY MEMBERS INTERVIEWING GUIDELINE

Objectives	**Questions**
To obtain addition information about the women receiving chemotherapy at their homes	1. Please tell me about experience of chemotherapy side effects that the woman in your family faced? 2. When did the symptoms emerge? 3. How did this change the woman in your family?
To explore family care when women faced these symptoms.	4. How did you care for these symptoms?
To explore the factors related to caring when the women receiving chemotherapy.	5. What are there the facilitating or blocking factors related to your caring? How are they related?
To explore outcome of care.	6. How do you think about outcome of care after giving care?
To obtain the personal information of significant family members.	7. What's about your age, educational status, working status, marital status, race, religion, and relationship with woman with breast cancer

THAI TRANSLATION FORM
SIGNIFICANT FAMILY MEMBERS
INTERVIEWING GUIDELINE

แนวคำถามในการสัมภาษณ์บุคคลสำคัญในครอบครัวของผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

วัตถุประสงค์	คำถาม
เพื่อให้ได้ข้อมูลเพิ่มเติมเกี่ยวกับการได้รับเคมีบำบัดของผู้หญิง ขณะอยู่ที่บ้าน	1. กรุณาเล่าเกี่ยวกับการเกิดฤทธิ์ข้างเคียงของเคมีบำบัดที่ญาติของท่านประสบ 2. อาการดังกล่าวเกิดขึ้นเมื่อไร 3. ท่านคิดว่าอาการนั้นมีผลทำให้ชีวิตของญาติท่านเปลี่ยนแปลงอย่างไร
เพื่อค้นหาการดูแลของครอบครัว เมื่อผู้หญิงเมื่อต้องเผชิญกับอาการดังกล่าว	4. ท่านดูแลญาติของท่านอย่างไร เมื่อต้องเผชิญปัญหาดังกล่าว
เพื่อค้นหาปัจจัยที่เกี่ยวข้องกับการดูแลของครอบครัว เมื่อผู้หญิงได้รับเคมีบำบัดเอื้อ	6. ท่านคิดว่าอะไรที่ส่งเสริมหรือขัดขวางในการดูแลญาติของท่านได้รับเคมีบำบัด
เพื่อค้นหาผลลัพธ์ของการดูแล	7. ท่านคิดว่าผลที่เกิดขึ้นเป็นอย่างไร หลังจากให้การดูแล
เพื่อให้ได้ข้อมูลส่วนตัวของบุคคลสำคัญในครอบครัวของผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด	8. ข้อมูลส่วนตัวของท่านในเรื่องอายุ การศึกษา อาชีพ สถานภาพสมรส เชื้อชาติ ศาสนา และความสัมพันธ์กับผู้หญิงที่ป่วยเป็นมะเร็งเต้านม

HEALTH CARE PROVIDERS INTERVIEWING GUIDELINE

Objectives	Questions
To obtain caring from health care providers when women received chemotherapy.	1. Please tell me about your care for women receiving chemotherapy? 2. Do women and family ask for help from you? How do you care them? 3. Do you communicate with your team about caring for women? How?
To explore the factors related to the caring when the women with breast cancer received chemotherapy.	4. What are the factors related to caring when women with breast cancer received chemotherapy? 5. How are they relating?
To explore outcome of care.	6. What do you think the outcomes of care are?
To obtain the personal information of health care providers.	7. What's about your educational status, working status, religion, and the length of time that they worked for caring of women receiving chemotherapy

THAI TRANSLATION FORM
HEALTH CARE PROVIDERS INTERVIEWING GUIDELINE

แนวคำถามในการผู้ให้บริการแก่ผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

วัตถุประสงค์	คำถาม
เพื่อได้รับข้อมูลของการดูแลที่ผู้ให้บริการให้เมื่อผู้หญิงเป็นมะเร็งเต้านมได้รับเคมีบำบัด	1. กรุณาเล่าเกี่ยวกับการดูแลของท่านสำหรับผู้หญิงที่ได้รับเคมีบำบัด 2. ผู้หญิงและครอบครัวขอความช่วยเหลือจากท่านหรือไม่ และท่านให้การช่วยเหลืออย่างไร 3. ท่านสื่อสารกับทีมในดูแลผู้หญิงหรือไม่อย่างไร
เพื่อค้นหาปัจจัยที่เกี่ยวข้องกับการดูแลเมื่อผู้หญิงที่เป็นมะเร็งเต้านมได้รับเคมีบำบัด	4. ท่านคิดว่ามีปัจจัยอะไรที่เกี่ยวข้องกับการดูแลเมื่อผู้หญิงได้รับเคมีบำบัด 5. ปัจจัยนั้นเกี่ยวข้องอย่างไร
เพื่อค้นหาผลลัพธ์ของการดูแล	6. หลังจากให้การดูแลแล้วท่านคิดว่าผลลัพธ์ที่ได้เป็นอย่างไร
เพื่อให้ได้ข้อมูลส่วนตัวของผู้ให้บริการแก่ผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด	7. ข้อมูลส่วนตัวของท่านในเรื่องการศึกษา ตำแหน่ง และระยะเวลาที่ทำหน้าที่ดูแลผู้หญิงที่ป่วยเป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

PHYSICAL EXAMINATION GUIDELINE

The objective:

to obtain the signs and symptoms of the women receiving chemotherapy

ID………………

DATE…………

The changing in the women's body	The length of time
1. general appearance …………………………… ………………………..……………………………………. .	
2. Hair ………………….…………………… ………………………………………………..	
3. Skin…………..…………………… General ……………………………………………….. At administration routh …………..……………………………	
4. Mouth mucous………………..…………………… ………………………………………..	
5. Nails……………..………………… ……………………………………………………………...	
6. Other ……….……………………………………………………… ………………………………………………………..	

THAI TRANSLATION FORM
PHYSICAL EXAMINATION GUIDELINE

แบบบันทึกข้อมูลการตรวจร่างกายสำหรับผู้หญิงที่เป็นมะเร็งเต้านมที่ได้รับเคมีบำบัด

วัตถุประสงค์ เพื่อค้นหาอาการและอาการแสดงหลังจากผู้หญิงได้รับเคมีบำบัด

รหัสผู้ให้ข้อมูล..........................
วันที่.....................................

การเปลี่ยนแปลงของร่างกาย	**ระยะเวลาที่พบ**
1.ลักษณะร่างกายโดยทั่วไป	
2.ลักษณะของผม	
3. ลักษณะของผิวหนัง.. ทั่วไป... บริเวณที่ให้เคมีบำบัด..	
4. ลักษณะของเยื่อบุในปาก..	
5. ลักษณะของเล็บ...	
6. อื่น ๆ	

OBSERVATION GUIDELINE

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1. Observation at the hospital

Objectives	Observations
To study the context of services in the health care setting.	1. the caring process for women receiving chemotherapy of physician and nurse 2. interactions between the women and health care providers in the outpatient and inpatient units.

2. Observation at the women's homes

Objectives	Observations
To study the context of the women's homes.	1. Observe the character of the home. 2. The way of living. 3. Interactions between the women and theirs families. 4. The practice of the women and theirs families in managing the side effect of chemotherapy. 5. The problems they experienced in managing

THAI TRANSLATION FORM
OBSERVATION GUIDELINE

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1. การสังเกตในสถานบริการ

วัตถุประสงค์	การสังเกต
เพื่อศึกษาบริบทของการให้บริการในสถานบริการสุขภาพ	1. กระบวนการดูแลสำหรับผู้หญิงที่ได้รับเคมีบำบัดจากแพทย์และพยาบาล 2. ปฏิสัมพันธ์ระหว่างผู้หญิงที่ได้รับเคมีบำบัดกับผู้ให้บริการสุขภาพทั้งตึกผู้ป่วยใน และตึกผู้ป่วยนอก

2. การสังเกตที่บ้านของผู้หญิงที่ได้รับเคมีบำบัด

วัตถุประสงค์	การสังเกต
เพื่อศึกษาบริบทที่บ้านของผู้หญิง	1. ลักษณะและสภาพบ้าน 2. วิถีการดำเนินชีวิต 3. ปฏิสัมพันธ์ระหว่างผู้หญิงกับครอบครัว 4. การปฏิบัติของผู้หญิงและครอบครัวในการจัดการกับฤทธิ์ข้างเคียงของเคมีบำบัด 5. ปัญหาของเคมีบำบัดที่ผู้หญิงและครอบครัวมีประสบการณ์ในการจัดการ

BIOGRAPHY

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