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Living with an Altered Body: A Qualitative Account of Body Image with Cancer Diagnosis and Its Treatment Among Women in Kolkata, West Bengal, India

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Abstract
Cancer diagnosis and its treatments influence the body image of patients in addition to bodily functioning. This qualitative study explores cancer patients’ experiences with their bodies following cancer diagnosis and its treatment. For this study, in-depth, semi-structured interviews with five female cancer patients were conducted in Kolkata, West Bengal, India. The interviews were transcribed verbatim to include the insider’s perspective and then analysed using thematic analysis. The findings are divided into three major themes and eight sub-themes: the altered body (changed appearance, failing functional capabilities), emotional conflicts (feelings and emotions, loss of identity), and coping strategies (avoidance, clothing adjustments, social support, religious beliefs). Studies such as this one can help raise awareness among healthcare professionals about the heightened vulnerability of cancer patients, particularly women, to psychological distress arising from body image issues and beliefs. Additionally, insights from such research might help in the development of a framework for engaging in conversations about body image within oncology and palliative care teams, facilitating more effective patient care and support.

Keywords
body image, cancer patients, coping, emotions, reflexivity, thematic analysis, qualitative research, women

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Cancer diagnosis and its treatments influence the body image of patients in addition to bodily functioning. This qualitative study explores cancer patients' experiences with their bodies following cancer diagnosis and its treatment. For this study, in-depth, semi-structured interviews with five female cancer patients were conducted in Kolkata, West Bengal, India. The interviews were transcribed verbatim to include the insider’s perspective and then analysed using thematic analysis. The findings are divided into three major themes and eight sub-themes: the altered body (changed appearance, failing functional capabilities), emotional conflicts (feelings and emotions, loss of identity), and coping strategies (avoidance, clothing adjustments, social support, religious beliefs). Studies such as this one can help raise awareness among healthcare professionals about the heightened vulnerability of cancer patients, particularly women, to psychological distress arising from body image issues and beliefs. Additionally, insights from such research might help in the development of a framework for engaging in conversations about body image within oncology and palliative care teams, facilitating more effective patient care and support.

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Introduction

Cancer and associated treatment often affect the patient’s physical appearance and self-perception (Fitch, 2020). Sometimes, for some individuals, the location of cancer and its visible appearance may act as a constant stressful reminder of the disease and may trigger pre-existing vulnerabilities and psychological issues. For the patients, apart from their increased problems with functional issues, changes in their appearance can be especially stressful (White, 2002).

Some forms of cancer such as head and neck cancer result in clearly observable appearance changes (Rhoten et al., 2013). However, cancer patients are adversely impacted even by changes which are less visible to others, such as the effects of lymphedema that causes swelling in their lymphatic system that can have a negative impact on appearance and can influence their clothing choice (Bowman et al., 2020; Rhoten et al., 2013). Their psychological wellbeing is also impacted by not just the physical changes, but also the speed with which those changes occur. Also, a patient’s response to the change in appearance depends on the permanent or transient nature of the said change. The patient’s coping process becomes comparatively easier in the case of a temporary change in body appearance (e.g., in the case of temporary ileostomy; Wang & Feng, 2022; White, 2002; Williams & Jeanetta, 2016).

As a result of their treatment, patients with cancer face many side effects (Collins et al., 2011; Fitch, 2020). The physical changes, such as loss of body parts, tissue damage, hair loss, weight gain, and loss of fertility can negatively influence the afflicted women’s perception
about their bodies (Fitch, 2020; Fobair et al., 2006; Helms et al., 2008). There are quite a few studies which have discussed how individuals diagnosed with cancer experience body image and body dissatisfaction (Fingeret et al., 2014; Lehmann et al., 2015; Williams & Jeanetta, 2016), and this may last for many years, even longer after the completion of the cancer treatment (Falk Dahl et al., 2010; Unukovych et al., 2012). Body image is a complex, multifaceted construct (Schilder, 1950), a subjective concept (Grogan, 2008) which entails concepts such as “body ideal,” “body reality,” and “body presentation” that also includes the patient’s perception resulting from the attitudes of others and their interactions with them (Price, 1990; Schilder, 1950).

In simple terms, body image is understood as one’s perception about and feelings towards their physical self, appearance, and functionality, resulting from one’s self-observation, social interaction, and belief (Lehmann et al., 2015). Disruption in appearance due to cancer and its treatment often leads to a negative body image and produces various psychosocial issues (Brunet et al., 2013). Negative body image can lead to a sense of body dissatisfaction, involving negative thoughts and feelings, that one may have with respect to his or her body (Grogan, 2008). Grogan (2008) argues that a major reason for dissatisfaction with one’s body comes from how the person perceives an ideal body and then evaluates his or her real body, only to find it woefully falling short of the perceived ideal body. He points out weight, shape, size of the body, etc. as some of the parameters on which the concerned individual compares the “body real” and “body ideal.”

Women diagnosed with cancer must constantly grapple with the task of managing the changes in their physical appearance and their emotional response towards it. Studies on breast cancer survivors tell us about the extent to which breast cancer and its treatment have adversely impacted the patients’ psychology, especially their negative body image, leading to a reduced quality of life (Alcorso & Sherman, 2016; Curtis et al., 2014; Fingeret et al., 2014; Przedziecki et al., 2013). Przedziecki et al. (2013) surveyed 279 women who had completed cancer treatments and found that body image disturbance and reduced self-compassion are related to increased psychological distress in these individuals. The altered body image and diminished self-esteem are frequent psychological responses by women after cancer diagnosis and treatment (Abrahams et al., 2018; Fetaini et al., 2020). Irrespective of the type of cancer, it is found that negative body images are directly related to increased risks of anxiety and depression (Bullen et al., 2012; Fobair et al., 2006) and they also result in a low quality of life (Falk Dahl et al., 2010; Taylor-Ford et al., 2013). A few qualitative studies have provided insights on the subjective experiences of cancer and the way it shapes one’s body image (Brunet et al., 2013; Fallbjörk et al., 2012; Froude et al., 2017; Williams & Jeanetta, 2016).

Williams and Jeanetta (2016) discussed the lived experience of women who had breast cancer. Through interviews of 15 women, they concluded that the participants experienced frustration and a sense of abandonment after completing treatment and felt uncertain about what survivorhood meant to them. Using interpretative phenomenological analysis, Brunet et al. (2013) explored women’s experiences with their body who had undergone breast cancer treatment. The authors emphasized the importance of recognising and addressing women’s concerns about body image and its impact on their psychosocial and emotional well-being.

White (2002) points out that despite the knowledge that physical appearances can significantly alter due to cancer, at least in some forms of cancer and its treatments, there still is a dearth of theoretically informed literature on the same. In the recent past, there has been a certain increase, but they tend to have inconsistent findings, which creates difficulty in interpreting results and definitions of body image which have often been vague (e.g., “positive,” “negative,” “secure,” “insecure”), wherein distinctions among multiple body image dimensions have not been made (White, 2002).
In the Indian context, several studies following a quantitative approach have investigated the issues of cancer patients majorly focusing on the physical and psychological impacts of cancer diagnosis and treatments (Alexander & Murthy, 2020; Arunachalam et al., 2011; Bhattacharyya et al., 2017; Chaturvedi et al., 1996). Alexander and Murthy (2020) assert that emotional well-being is compromised in individuals living with cancer, advocating for the inclusion of emotional health support across all stages of cancer care.

A few qualitative inquiries have been taken up in this domain, mostly giving a description of the issues faced by cancer patients. For instance, Jagannathan and Juvva (2016) studied 75 patients and found that those suffering from head and neck cancer have a relatively high risk of developing emotional disturbance after diagnosis and treatment. They conclude that to develop any effective intervention programme in India, it is crucial to focus on issues such as understanding of emotions, their roots, coping strategies, and spiritual as well as cultural orientations. Likewise, Chawak et al. (2020) conducted a qualitative investigation involving 26 cancer patients to understand their needs and expectations, especially from their support network, throughout their illness trajectory.

Despite this research on cancer patients, there is a noticeable dearth of literature addressing the impact of body image on cancer patients in India. While a limited number of quantitative studies exist, such as the work by Nikita and Kumar (2022) who explored body image distress among 170 individuals with head and neck cancer using the Derriford Appearance Scale-24 and a socio-demographic and clinical profile checklist, there remains a lack of qualitative exploration into the subjective experiences of cancer and its effects on body image and overall well-being of cancer patients from India. Addressing this gap in research would contribute significantly to understanding the experiences of individuals affected by cancer in the Indian setting.

It is against this backdrop; my qualitative study aims to know how cancer and its treatments adversely influence the body image of women cancer patients and how these changes are perceived and experienced by them. Insights about their experiences in terms of their body image would help identify the issues that they usually face and subsequently enable healthcare professionals to effectively intervene in such conditions by assisting in easing their psychological burden and improving their quality of life.

Situating (My)Self

Qualitative researchers should contemplate the ways “that any one set of prescribed methodological strategies, personal knowledge, and social context creates theoretical and perceptual access influencing understanding” (Benner, 1994, p. 99). As a researcher, I attempt to be transparent about how I understand this situation. It is pertinent to note that for a researcher to be able to access and understand the participants’ honest and truthful voices, they must be acutely aware and acknowledge their own individual biases, preconceptions, and experiences, as well as the theoretical apparatus which makes their research consequential to them in ways that help them understand both themselves as well as their participants (Benner, 1994). Benner further states that a researcher “can never escape her or his own taken-for-granted background or stance that creates the possibility of an interpretive foreground” (Benner, 1994, p. 100).

Lopez and Willis (2004) also enumerate the importance of background understandings which he considers as impossible and unproductive to nullify for a researcher, especially as these understandings play a crucial role in conceptualizing and investigating any study. My personal experiences of being with a family member with cancer have led me to situate myself in the topic of existential concerns that offered me a stance in which to have a personal perspective.
During my childhood, my mother’s cancer diagnosis brought a change in her demeanour. Although I cannot recall her initial emotions, it became apparent that she was uncertain about herself. She was losing her usual rhythm with the world. She was no longer at home within herself or in the world, just drifting. Physically, she was not able to engage with the world, which brings with it an awareness of actions and tasks that are no longer unselfconsciously carried out with ease, and amidst this, her body played a significant role. She did not inhabit the body as she did before the diagnosis and became alienated from her sense of self and from her taken-for-granted body. The changes in the body led to a disruption in her social world, resulting in her withdrawal and diminished interaction with others.

Regardless of the setting, whether familial gatherings or other events, there was a shift in how people responded to her. Her appearance was a concerning factor; her altered and unpredictable body hinted at her unwell state, and this often contributed to her frustration, anxiety and, at times, sadness. I came to a realisation that prior to her diagnosis, my mother’s body was a source of reliability and comfort, instilling confidence in her. However, following the diagnosis, everything changed dramatically. Her body, bearing the manifestations of cancer and its accompanying side effects from the treatment, became a source of agony and served as a constant reminder of her altered body, leading to distress and emotional struggle. Witnessing my mother’s struggle first-hand motivated me to investigate this issue. It instigated me to explore how cancer and its treatments affect the body image of the diagnosed women and how these changes are perceived and experienced by them.

Being privy to the realities faced by cancer patients in such a situation, I formulated the inquiries that shaped this study. My intention is to shed light on the struggles that an individual goes through with respect to their body image alongside other symptoms. I hope that studies such as this will raise awareness among healthcare professionals about the heightened vulnerability of cancer patients, particularly women, to psychological distress arising from body image issues and beliefs. Understanding the subjective experiences of cancer patients regarding body image will help healthcare professionals recognise the potential risks of anxiety and depression arising from body image concerns. Moreover, this knowledge may guide care professionals in determining when to refer patients for psychosocial support. Additionally, insights from such research might help in the development of a framework for engaging in conversations about body image within oncology and palliative care teams, facilitating more effective patient care and support in India and worldwide.

Methods

Qualitative enquiry is most suited to explore the perceptions and experiences of the patients diagnosed with cancer as their deeper-most feelings can find an outlet through this method. Moreover, using a qualitative inquiry is beneficial when one intends to acknowledge individual uniqueness and understand the complex subjective worlds of individuals by disclosing the temporal, emotional, and contextual aspects of lives and relationships (Smith & Sparkes, 2008). This qualitative study takes recourse in an explorative design through individual interviews which are in-depth and extensive, the purpose of which is to dig deep into the varied experiences of the individuals about a phenomenon/event that they are closely entwined in, that is, the disease of cancer and its treatment regime along with its associated side effects (Creswell, 2006).

This study whose stated objective is to explore and investigate the varied experiences of cancer patients during their treatment regime, was necessitated since such studies in India are very few. The participants were selected based on their willingness to participate and their ability to communicate their insights through a series of four or five interviews. Participants were selected through purposive sampling from Medical College, Kolkata, West Bengal, India.
I had access to outpatients and met with them during their visitation and later at a place convenient for them.

A total of five female cancer patients undergoing cancer treatment were purposively sampled. A concerted effort was made to enlist those participants for the study from whom one could get detailed and in-depth information. To obtain detailed and in-depth understanding, the data were taken from women, irrespective of their socio-economic status, ages, or type of cancer. Additionally, purposive sampling facilitated the selection of participants who can provide detailed insights. The preliminary interviews helped me in assessing the depth of understanding, ability to articulate their experiences, and the willingness to engage in a reflective interaction. As I introduced myself and described the motive of the study, I received a few immediate expressions of interest and slowly, there were more offers of willingness to participate than I could accept. The logic and strength of purposive sampling lies in selecting information-rich cases for an in-depth study (Patton, 1990). According to Robinson (2014), purposeful sampling allows a researcher to intentionally select participants based on their ability to explain or describe specific themes, concepts, or phenomena.

The other inclusion criteria used to select the participants were: (a) They should have been diagnosed with cancer and aware of the diagnosis for at least one year, so that the participants had sufficient time since their diagnosis to reflect upon their experience; (b) they had undergone required surgery and should be receiving treatment; (c) they had to be 18 years or older; (d) they had the ability to interact in Bangla; and (e) they would give informed consent to participate in the study. Exclusion criteria were psychiatric issues, or any other health problem not related to their cancer diagnosis that could affect body image (such as amputation, visible scar, physical disabilities). Finally, the participants were recruited based on the inclusion and exclusion criteria as well as the convenience of their availability.

**Ethical Considerations**

A qualitative researcher has a moral responsibility to acknowledge and respect the rights, autonomy, and dignity of the participants of the study. The researcher should be straightforward while discussing the aims of the study. Furthermore, this research was complicated by the volatile nature of the study that involved cancer patients. Raudonis (1992) identifies this set of people as unique in its vulnerability related to the ongoing deterioration of the patient’s condition.

While obtaining a third-party approval was not mandatory to conduct this study in the local context, I did have approval from the Institutional Ethics Committee for Human Research at the Medical College Kolkata following a presentation explaining the study. Furthermore, my personal networks and connections within the cancer community provided further support to carry out this study. The participants and their family members were provided with an account of the study, its objectives, and potential risks. The right to withdraw at any time was discussed. I briefed them about the voluntary nature of participation. They were assured that data would be kept confidential. The researcher had access to the raw data. Identifying traits such as names were substituted with a pseudonym to ensure anonymity. Following the detailed explanation of the study’s nature and purpose, as well as addressing any questions or concerns they had, the participants provided their informed consent to participate in this study.

**Participants**

Among the participants, two were diagnosed with breast cancer, and others with liver, abdominal and stomach cancer. The time since diagnosis of cancer varied from three to ten years. All the participants had surgery according to their prognosis, such as mastectomy,
lumpectomy, gastrectomy or hepatectomy. Along with the surgery, all the participants had chemotherapy; but among them, three had a combination of chemotherapy and radiation therapy. The average age of the participants was 45.8 years, with the youngest being 41 and the oldest 49. One of the participants was Muslim and the others were Hindu. Each of them was married and had children.

Data Collection and Data Analysis

An interview guide was used for conducting interviews in Bengali that were in-depth and extensive. Four to five interviews were conducted that ranged in time from forty to ninety minutes. A few participants reached out to me after the interview to share thoughts or a memory that occurred to them later. The individual interviews were conducted at a place of convenience for the participants. The semi-structured interview that guided the interview process focused on body perception, their experiences, and coping strategies. Face-to-face interviews provided a detailed account of the participant’s perception of their body image and the related experiences. Interview questions were asked to elicit responses while maintaining an empathic stance. A probe often followed broad questions to acquire a detailed understanding of the situation. The interviews were transcribed verbatim to preserve the orientations, meanings, interpretations, understandings of the participants.

All the participants were fluent in Bangla – the regional language and that enabled a free flow of communication. The interviews were then translated into English as the researcher knew the regional language well. However, it is pertinent to disclose here that as I began interviews with the patients, I saw that I was drifting from the format to follow the prompts in the conversation. I followed their lead and asked about the experiences they mentioned. As the interviews advanced, I asked further questions, searching for validation or refutation of some of my intuitions. Additionally, I maintained fieldnotes filled with my intuitions, questions, and prompts to investigate specific ideas. The final interviews presented more instances of ideas I had learnt earlier. After this occurred at least thrice, I started to consider the probability that the subject was close to saturation.

During the last interview, I was pleased that, although there were a few more narratives to be heard, there did not seem to be fresh themes emerging. Following conclusion of the interviews, I reached out to the participants on several instances who supported me during the entire process of data collection and gathered more narratives that reinforced what I had seen before. I was more confident in the validity of the themes that were emerging. Guest et al. (2006) suggest that data collection should continue until theoretical saturation is reached. Often, theoretical saturation is considered the main criterion in a qualitative inquiry, especially in the context of health sciences (Guest et al., 2006). An empirical study conducted by Guest et al. (2006), using in-depth interviews, documented the degree of thematic saturation and variability in the data during data analysis. They found that, after 12 interviews, the data was relatively “thematically saturated,” and sixty per cent of all codes were identified within the first six interviews.

Following an interpretive approach, analysis was initiated. The transcripts were then subjected to thematic analysis. Thematic analysis helps identify themes and patterns and seeks relationships and commonalities among the themes (Mills et al., 2010). The thematic analysis enabled an in-depth understanding of the expressed views of the participants. I reviewed the transcripts line-by-line and recognised codes in the margins. Open coding was done to assign units of meanings to the descriptive data within the text and to identify initial themes. Preliminary analysis of the transcripts produced a huge number of coded themes. With time, I was able to improve these, recognising repetition and reconsidering my preliminary impressions. During this phase I relied on the memos that documented thoughts and questions
about the codes created from the transcripts. Finally, the data was condensed and as the analysis process progressed, clarity improved. I made summaries of the categories. Reading them over, I recognised relations between and among categories, and further clustered them into broader overarching themes. Unnecessary data were removed, and the third and fourth drafts of the findings evolved. Direct quotes of the participants were used to support the themes and subthemes.

Methodological Rigour

Since the early 1980s, standards for maintaining quality in qualitative research have been under constant examination, discussion, and modification (Emden & Sandelowski, 1998). For this research, the model of validity by Whittemore et al. (2001) was used. According to the model, validity comprises primary criteria and secondary criteria.

Primary criteria included credibility (the relativistic nature of truth claims drawn from an interpretive approach), authenticity (the precise representation of meanings and experiences as perceived by the participants), and criticality and integrity (the researcher’s acknowledgement to varying interpretations, prior conceptions, and its influence on the research; Whittemore et al., 2001).

In this study, data collection methods such as open-ended, semi-structured interviews with patients, observations, prolonged exposure in varied circumstances, clarification of impressions with participants, and recognition of researcher influence helped in acquiring credibility and authenticity of the findings and interpretations. The multiple interviews with the patients gave me the chance to explore in larger detail the influence of cancer and its treatment on their body image and how it is experienced by them. My position as a researcher provided me with the access to a diverse set of patients. I maximised each accessible chance to converse with patients, listening to their narratives, and looking for their opinions on their experiences of cancer. These varied constructions of realities gave depth to the findings that also established the authenticity of the study. Additionally, credibility and authenticity of a study require that the researcher be conscious of her impact on the phenomenon of interest. Initially, I believed that patients were not discussing their experiences and perceptions in detail, or perhaps deliberately concealing certain aspects. Body language and the message in their eyes did not seem to show genuineness, but with empathic probing and rapport, I began to see the credibility of what they were telling me.

To obtain a critical self-reflection, I observed my influence and effectiveness during each visit of fieldwork. Attention to conflicting data, repetitive checks of interpretations and familiarity with the data contributed to maintaining integrity of findings. As discussed in the segment on data analysis, I was intricately acquainted with the findings. Interpretations were considered, reviewed, and refined during the analytic process.

Secondary criteria included explicitness (understanding the interpretive efforts of a researcher) and sensitivity (Whittemore et al., 2001). To achieve explicitness, each round of coding was saved in a separate file that allowed for an easy identification of code families1 and the codes2 with these families. Field notes contained detailed accounts of the settings and of the participants. Throughout data analysis and representation of the findings, detailed accounts were grouped with instances of interactions. Thoroughness involves linkages between themes and the full development of ideas. This was a continuous process, that included several re-readings of the data as categories emerged and themes merged.

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1 Grouping of similar codes together into a category to make sense of the data.
2 Codes are tags or labels for assigning units of meanings to the descriptive information compiled during a study.
Sensitivity is about acknowledging and respecting the individual, their culture, and social contexts, keeping in mind, the ethical considerations and concern for the participants of the study (Whittemore et al., 2001). I was continually vigilant about ethical sensitivity. I asked for permission before recording observations. I remain cautious about my misgivings and have asked for advice from my peers whenever in doubt.

**Reflexivity**

In qualitative study, the investigator herself influences the data collection and data analysis process. Reflexivity is about being self-aware and explicit as a researcher during the entire process of the study (Finlay, 2002). I have discussed my position in the beginning of the paper. Knowing my partialities, I recognised the significance of entering the fieldwork with an open attitude. I retold myself repeatedly to search for possibilities in contrast to my own experience. I kept a reflective journal throughout the period of fieldwork. This allowed me to think about situations that had arisen and in self-awareness. The journal was an important means for outlining the source of ideas and the subjectivity of self-awareness. Entering the fieldwork as a caregiver formed both a sense of relief in the situation and some confusion. The emotional effect of exposure to suffering, death and pain was unexpected. Despite the issues, it was a unique experience that further expanded my curiosity in this domain of study.

**Results**

With the diagnosis of cancer and its subsequent treatment, the participants experienced several changes in their bodies. On analysing the data, it is evident that cancer and its treatment involving surgery has affected all the participants, instigating them to reflect on their bodies. The following themes and subthemes summarise the findings of this study:

1. The altered body
   a. Changed appearance
   b. Failing physical capabilities
2. Emotional conflicts
   a. Feelings and emotions
   b. Loss of identity
3. Coping strategies
   a. Avoidance
   b. Clothing adjustments
   c. Social support
   d. Religious beliefs

**Theme 1: The Altered Body**

This theme represents the participants’ perceptions and experiences towards their bodies since the diagnosis. Patients with cancer must face various side effects resulting from their treatments, such as loss of their breast or other body part, hair loss, loss of skin elasticity, weight gain, and loss of fertility. Disruption in appearance due to cancer and its treatment among the participants led to a negative body image and produced various psychosocial issues. All the participants referred to the changes in their appearance and the loss of functional capabilities that they faced due to their illness trajectory.
**Changed Appearance**

This subtheme refers to the participants’ perceptions of their bodies due to the cancer treatment. Most of the participants had a negative outlook about their appearance and talked about the visible physical changes. They often recognised their thoughts about feeling different or changed from within. The participants considered factors, such as hair loss, having no or an asymmetrical breast, having a scar and changes in body weight, as major attributes that modified the nature of the perceptions of their body. The following excerpts show the significant physical changes experienced due to cancer and its treatment: “Body-wise, I have changed drastically. I have no hair; my abdomen has gone inside and is with scars” (P2).

Similarly, the following excerpts from P4 further provide insights into the physical changes experienced by cancer patients:

> Look at me, I am losing my strength, health, beauty, and everything else. I am so thin, my bones are visible, I used to have long, thick, and black hair but now see what’s left… I used to wear 36 inches blouse, and now I use 26-inch blouse. I don’t know this body. It seems it’s someone else. I can’t buy readymade blouses anymore; I have to tailor it… this [cancer] changes you in every form. (P4)

This participant expressed her distress over the loss of strength, health, and beauty. She explicitly describes the visible changes in her physique, such as thinness and the visibility of bones, which were not present earlier. The changes resulted to a feeling of alienation from their own body, and this is evident when the participant says: “I don’t know this body. It seems it’s someone else.” The participant’s remark on the alteration in clothing size refers to the substantive changes in the physique due to the cancer treatment which was a concern and a cause of stress for her.

All the participants considered hair loss as a particularly difficult experience. It was difficult for them to accept their hair loss as it evoked a feeling of loss of normalcy. The following excerpt illustrates a participant’s belief that their personality or essence has been severely affected by the physical changes due to the cancer treatment: “I don’t feel normal anymore. I have lost all my hair, even my eyelashes. I am not me anymore. Losing all of your hair changes your personality completely. You look totally changed as if this is someone else” (P5).

This participant’s statement “I don’t feel normal anymore” indicates a shift in the participant’s perception of themselves, suggesting a departure from their previous sense of identity. The mention of losing hair, including eyelashes further emphasises how these changes can contribute to a sense of loss of self-image and identity. Additionally, the statement “I am not me anymore” reflects a profound existential crisis within the participant with respect to the changing identity, showcasing the participant’s perceived disconnect from their pre-cancer self.

The participants with breast cancer underwent surgery, resulting in an asymmetrical breast or with no breast. The following excerpts shows the participants’ perceptions of their bodies before and after the surgery: “One is smaller than the other. They aren’t similar anymore, and this is very apparent” (P1). “After the surgery, I just have a flat chest and yes with scars… it’s just a bare ripped chest (P3).

The excerpts show the participants’ perception of their body before and after surgery. P1 clearly express the difference between the size of her breast before and after surgery while the use of evocative terms and phrases such as “flat chest” and “bare ripped chest” by P2 highlights the serious impact of the physical changes due to cancer surgery on body image and the significance that it holds to the participants.
A few participants mentioned their experiences with changes that were often unseen by others, for instance, limbs going numb, discontinuance of menstruation, difficulty in sleeping and fatigue. These changes in their bodies created more difficulties and contributed to their perception of their body image. P2 discusses the cessation of her menstruation soon after cancer treatment. This change profoundly affected her sense of feminine self and body image. She expressed feelings of distress and a sense of being “damaged within” due to this loss of menstruation, which was previously seen as a normal aspect of woman. She said:

My menstruation has gone too. Soon after the beginning of my treatment, I had problems with my menstrual cycle. I was bleeding heavily, then it stopped. I am just forty-three years old. Earlier, when things were normal, I used to think menstruation is such an ache for us women, but now I don’t like it this way. I feel damaged within. (P2)

Failing Functional Abilities

Apart from talking about the physical changes, most of the participants discussed their losing functional abilities, which was the consequence of the cancer treatment regime. Participants mentioned their inability to perform day-to-day activities and their increasing sense of dependency on others:

Since this [cancer treatment], I am too weak to do anything. Most of the time, I am in bed. Earlier, I used to take care of the household. I did everything, but now my body has betrayed me. There are days where I can’t even manage to go to the bathroom on my own. My family was dependent on me, but now I am the one who is entirely dependent on them. (P5)

This participant expressed her struggle with diminished functional abilities since undergoing cancer treatment, contrasting with her previous ability or capacity to manage tasks and care for themselves. The participant lamented about her feelings of betrayal by her body and frustration at her inability to perform tasks independently. The statement “My family was dependent on me, but now I am the one who is entirely dependent on them” clearly indicates to the reversal of roles, emphasising the shift in the participant’s level of independence.

Theme 2: Emotional Conflicts

This theme discusses the participants’ emotional experiences with their altered bodies.

Feelings and Emotions

Most of them shared intense feelings of dissatisfaction and displeasure towards their bodies. This experience of body dissatisfaction was often associated with their perception that their present body is a deviation from their past or ideal body: “I was slim earlier… I used to have long, thick, and black hair, and now I have a bald scalp. I have changed completely. Before this, I was beautiful, but it’s completely different” (P3).

This excerpt shows this participant’s dissatisfaction with her current body compared to their experience. Physical changes such as weight loss and hair loss are perceived as a major alteration from their previous appearance. The participant’s statement, “I was beautiful, but it’s completely different” shows the disconnect between her present and past selves, contributing to feelings of dissatisfaction:
I don’t know this body; if I show you my old pictures, it would be easier for you to understand what I mean and how drastically I have changed. After seeing them [pictures], it would be difficult for anyone to relate this [body] with me then. (P2)

This participant articulates her dissatisfaction by expressing her unfamiliarity and disconnection with her current body. The participant says that viewing old pictures would illustrate the stark changes she has gone through, emphasising the incongruity between her past and present selves. This incongruity contributes to her dissatisfaction and discomfort with her current body as it doesn’t align with her previous identity and self-perception.

A few of the participants expressed a sense of dissatisfaction towards a specific body part which was perceived as imperfect. This was associated with their missing or asymmetrical breast, weight gain and hair loss:

I loved wearing a saree; everyone complimented me whenever I used to dress up in a saree. But now, after this surgery, I can’t wear a saree. I don’t like that at all. I tried wearing one, but there is no way that I could hide my missing side. (P3)

This participant expresses her dissatisfaction with her missing breast, which is associated with her inability to wear a saree (traditional Indian outfit) comfortably. This participant’s fondness for wearing a saree is evident as it elicits compliments from others. However, following the surgery, her inability to conceal the absence of her breast while wearing a saree resulted in discomfort and dissatisfaction. Similarly in the following excerpt, participant P5 expresses distress over her bald head. She talks about her inability to hide her baldness, making it unavoidably noticeable to others, “For me this bald head is upsetting. I can still manage other things that happened in my body, but how to hide your head? You can’t go without noticing this bare head” (P5).

These excerpts show participants’ dissatisfaction with a specific body part and this dissatisfaction contributes to feelings of discomfort, upset, and vulnerability, highlighting the impact of cancer body image on the individual with cancer.

The participants also talked about a range of negative feelings that they felt while going through their treatment regime, and often, such feelings stayed with them even after the completion of their treatment phase. All the participants felt dissatisfied with their bodies after their surgery and treatment, leading to negative thoughts and emotions. They mentioned about “not feeling happy,” “ugly,” “horrible,” “damaged,” “sad,” “inadequate,” “estranged,” and “angry”:

I am no longer beautiful. I was uglier a few months ago, and now I am a tolerable sight. Now it is a decaying body with bruises, scars, and a bald head! What to else say about it? (P3)

I am not happy with this. I can’t believe that I have turned this horrendous. At times, I felt very angry, but now I am sad about this. (P4)

This excerpt illustrates a range of emotions associated with body image. The participant acknowledges experiencing unhappiness by her appearance, leading to feelings of anger and sadness. I would like to disclose that hearing the participant’s narratives and witnessing the manifestations of their experiences was sometimes distressing. When participants revealed or bared their scars from their surgery, it left a lasting impression. I often found the participants
being tearful while disclosing their feelings and emotions related to their body image. One of my field notes recorded the following:

Today’s narrative was powerful. The participant was very much affected by her changes in her body. I saw tears in her eyes as she was describing her body and her hands trembled when she removed her clothes from her torso to show the marks left by the surgeries. It was carved into her. They were deep and prominent. It began from her abdomen and probably ended near her chest. The visual was distressing. She reached out for my hand, perhaps for support, and I held hers. Though I couldn’t do much, I listened, letting her express her emotions freely. During this, I felt tears welling up within me, I maintained my composure. Today’s interaction strongly reinforced the realisation that a cancer patient endures profound emotional challenges due to the changes in their body. (FD-16:122-125)

**Loss of Identity**

Body image is an essential aspect of self-identity. Changes in the body image due to diagnosis and cancer treatment regime, especially of breast, challenged the participants’ personal identity and sense of self. All the participants referred to a diminished sense of self in terms of their body image, role, competence. As mothers, this was a concern, and it affected them the most. Participants faced a crisis within themselves as their illness challenged their motherhood and the role as a caregiver of their kids. Participants mentioned that it was difficult for them to balance the care of their children and family with their own limitations. It often made them rethink their roles as active members of the family, a competent mother, and they experienced negative emotions such as guilt, helplessness, and sadness:

Because of my treatment, I can’t do anything, can’t play with my child, can’t carry him in my lap, even I am not able to cook delicious food for him; because of me, my husband is suffering a lot too, right from the beginning he has to play both the role of a father and of a mother to our child. (P2)

This participant talks about how the physical limitations due to her cancer treatment prevented her from engaging in the traditional maternal activities in an Indian society. This inability to fulfil the traditional maternal roles leads to feelings of guilt and inadequacy, as evidenced by her husband having to take on both parental roles. The following excerpts highlight the emotional distress experienced by the participant as she reflects on moments where she is unable to fulfil maternal responsibilities, leading to profound sadness and helplessness:

I haven’t been a mother to him [son]. I haven’t been there for him as a mother should have. I can’t even take care of him. I am just merely there. I am just a mother on paper [weeping]. I am incapable of taking any responsibilities of a mother. I wish I could be there for him, but I am never there- when he first said “ma” I was lying on the bed, I wanted to pull him close to me, I couldn’t, I didn’t have the strength. I was not holding his hand when he took his first step; I wasn’t there to pick him up when he first fell and injured himself, nor I was there at the gates of his school when he went there for the first time. Look at my condition; despite being’ there, I am actually not there. I feel so helpless. (P3)
Another participant (P4) talked about the shift in her perceived role within the family. Earlier, she used to manage various responsibilities for her family, however due to her illness, she is now unable to maintain the same level of involvement: “Earlier, I used to manage everything. My kids, my husband, even on some occasions, my in-laws too. Everyone relied on me. But now, things are different (P4).”

Though most of the participants willingly opted for surgery and the subsequent disfigurement for their survival, that had an effect in their body consciousness as well. Many of them considered the scar as a marker of their difference from those who are normal, and thereby separating them from others. Some of them described that their scars and physical changes in their body constantly remind them that they are “sick,” and they have cancer: “Whenever I look at myself, my body reminds me that I am sick, someone who needs medical attention to survive (P2).”

This excerpt illustrates how the participant’s perception of their body changed following cancer diagnosis and its treatment. The statement indicates towards a heightened awareness of their body’s condition and its association with sickness: “My scars, my body, my hair loss tells me that I am different. Different from you, and from others like you. My life is different now (P5).”

This participant talks about how the physical changes due to cancer treatment have affected her sense of identity and belonging. The presence of scar and physical changes like hair loss, serves as a visible marker of her difference and as a constant reminder that her life has been altered by the illness, leading to the feelings of difference and a shift in self-perception. Another participant (P1) talked about her struggle with her changed self-image following surgery. She said:

It is really difficult. When I think about this, it feels like I am not me anymore; I am not normal. In whatever way I try to look at myself, I can’t see myself. My old, familiarised self isn’t there anymore, and my reflection in the mirror points out this truth quite vividly. (P1)

This participant’s reflection on her changed appearance and the difficulty to recognise her familiar self-highlights the disruption to her sense of identity and normalcy due to cancer treatment and the associated difficulty in accepting and adapting to a new self-image.

The subsequent disfigurement due to the surgery and the treatment regime of the participants diagnosed with breast cancer affected their feminine identity and self-confidence. Both participants mentioned that they felt incomplete, “not a woman,” and experienced negative emotions such as sadness and disgust as they are not complete people:

It is really difficult to accept yourself like this. Every time I cleaned myself, tears would roll down from my eyes. The physical pain after the surgery was excruciating, but the pain of losing womanhood is even more and is unbearable. With time, the wound healed, and only a scar is there, but I lost my womanhood forever. I am not a woman anymore. I have learnt to live with this, but it’s painful, you know. (P1)

In this quote, the participant describes the difficulty of accepting herself after the surgery and the overwhelming emotional pain of losing her sense of womanhood, and the scar serves as a constant reminder for her loss. This indicates that for a woman her body, especially the breast stands for femininity, womanhood and beauty, and its loss or disfigurement often led to the loss of their feminine identity. Similarly, another participant (P2) expresses a similar sentiment of not feeling like a complete woman. She laments the loss of her natural beauty and
the realisation that she will never be the same. This also shows the emotional toll of post-surgery disfigurement on the participant’s self-confidence and feminine identity: “I don’t feel like a woman anymore, or at least a whole woman. I don’t like this feeling; I have lost the natural beauty that every woman possesses. I will never be the same (P2).”

A few participants talked about their changes and feelings about their sexuality. Participants mentioned the emotional stress they felt after their surgery. Participants were anxious about their husbands’ reaction towards their changed body and its effect on their sexual relationships. In general, the participants mentioned a declining sexual intimacy due to deteriorating health, “unattractiveness,” low mood and lack of interest. In the following excerpt, one can sense the participant’s immense concern about her husband’s reaction to her disfigurement post-surgery. She said: “After my surgery, when I realised what has happened to me, my first thought was about my husband. How will my husband feel about my disfigurement (P3).”

This also suggest that the participant is acutely aware of the impact of her altered appearance may have on her husband and his perception of her body. Likewise, P1 talked about feeling humiliated and expressed a sense of disconnection from her previous self, stating that she is no longer the woman her husband knew. She said:

I couldn’t go in front of him like that, with my removed side. It is so humiliating and painful. It’s not because I don’t trust him or that he is a man, how will I explain it to you? After they operated on me, I was not the woman he knew. My body has changed; I am an unattractive woman and with so many lacunas. (P1)

These excerpts also highlight the emotional vulnerability and sense of loss associated with the changes in the physical appearance post-surgery. Furthermore, participants revealed that this sense of loss of feminine identity was aggravated because of the gaze of others. All the participants mentioned that the physical changes that occurred made them noticeable by others, a situation they found undesirable. This made them feel exposed and vulnerable: “Nowadays, whenever I step out of my home, people stare at me. Earlier they used to look at my beauty, but now they stare and mock my ugliness (P3).”

This illustrates how the shift from being admired before the diagnosis to feeling exposed, and even mocked afterwards. It also reflects a change in the perception of the participant in the way she is being perceived by others, from visually pleasing to negatively judged based on their appearance.

Participant 2 described feeling uncomfortable when not covering her head and compares it to feeling “naked,” suggesting a sense of vulnerability and exposure when others look at them. She said: “Without covering my head, I feel uncomfortable, or perhaps you can say something similar to being naked, and everyone is looking at that naked me (P2).”

Similarly, another participant (P5) expressed her discomfort with going out in public due to the fear of receiving hurtful comments about her appearance, particularly her hair loss. This highlights the negative impact of others’ scrutiny and judgment on the individual’s sense of self-worth and confidence. She said: “If I go out simply, then people will pass comments about me; it’s hurtful. Sometimes they even ask me about my hair (P5).”

**Theme 3: Coping Strategies**

Changes due to body appearances affected the participants immensely by disrupting their lives and creating emotional turmoil. However, the participants tried to bring some semblance of normalcy into their lives. In my study, I found that family support and religious beliefs helped the participants cope. A few participants talked about strategies that helped them
cope and maintain the cohesion of their social interaction. I found two strategies, such as avoiding social situations and clothing adjustments, that they used to deal with their altered body and its impact and to protect them from awkward and distressing situations, avoiding further damage to themselves.

**Avoidance**

Most of the participants mentioned avoiding social situations to protect themselves from awkward and often hurtful questions about their cancer and body. A few of them described how their condition and perceived image had affected others unnecessarily:

I don’t meet people. I avoid going to social gatherings. I have been to a few, but now I have stopped going there. Everyone will look at me, and they will ask me questions about my hair and surgery. A few have even shown pity to me, my condition. (P2)

This participant describes avoiding social gatherings due to feeling uncomfortable about their changed appearance following cancer. The participant’s reluctance to attend social gatherings and interact with people arise from a desire to avoid unwanted attention and intrusive questions about their appearance and medical condition. The participant’s experience of feeling pitied by others reflects the negative attention they receive, which intensifies their feelings of vulnerability and discomfort in social situations. This excerpt clearly highlights the impact of their changed body on the participant’s social life, demonstrating how the illness experience can lead to withdrawal from social activities and interactions.

**Clothing Adjustments**

All the participants talked about their attempt to minimise and hide their physical changes with clothing adjustment. They tried to hide the most noticeable change in their body, such as hair loss, by covering their head with a scarf or bandana and asymmetrical breast by wearing loose-fitting clothes or using fillers. A few participants also used clothing adjustment to regain normalcy with their body and hide the reality from themselves; otherwise, most of the participants utilised it when they were with those with whom they didn’t wish to share their body image and tried to protect themselves from other’s gaze.

The following excerpt highlights a participant’s discomfort with their altered physical appearance due to hair loss, resulting from cancer treatment. This discomfort is evident in their behaviour of always covering their head, even when alone, indicating a profound sense of dissatisfaction with their body image. She said:

I cover my head all the time, even when I am alone. I don’t like myself as a bald person. I feel embarrassed, so I cover it up all the time. I don’t want anyone to see me like that. Moreover, I can’t see myself like this. (P2)

This participant’s aversion to their bald appearance reflects the psychological impact of cancer treatment on body image. By covering their head and expressing embarrassment, the participant demonstrates a reluctance to accept their changed physical appearance, indicating a significant emotional struggle with body image issues.
Social Support

Participants regarded family support as necessary while coping with their situation. A few mentioned how understanding relationships among the family members have helped manage their feelings and motivated them while dealing with their crisis. A participant (P3) talked about the supportive role of siblings in coping with cancer. The expresses how her brothers went to great lengths to show solidarity and support. She said:

My brothers didn’t leave me alone; my brothers would motivate me and cheer me up, but they realised that I was not feeling myself, so you know what they did!... one morning, they came in front of me with their shaved head, both of my brothers shaved their head... and said- “like you sister” and then I started crying, seeing them, seeing me they said- “silly sister of ours, it’s just hair, look! You will grow them again just like the doctor said, and we will grow them back as well. Now be fine. We are like you now. Don’t be sad anymore.” That incident made me realise that they will do anything for me… (P3)

The participant’s reaction of crying upon seeing her brothers’ gesture displays the impact of their support on her emotional well-being. This excerpt highlights the importance of familial support in navigating the challenges and shows the significance of empathy and solidarity in alleviating the patient’s distress.

Similarly, the following excerpt showcase the supportive role of a young child, the son of the participant (P5), in coping with illness. From the participant’s excerpt the young boy demonstrates empathy, maturity, and consideration by independently managing his tasks and showing sensitivity towards his mother’s need for rest. His actions show a deep emotional connection and concern for his mother’s wellbeing, reinforcing the significance of familial support in alleviating the participant’s distress and fostering a sense of comfort.

He [son] is so small but still he understands the severity of my condition, when I am sick, he doesn’t disturb anyone. He will eat on his own; would dress up and will go to school, after coming back he would come sit near me, he won’t even talk and when I insist, he says, “Ma you take rest and get well soon and then we will talk, talk a lot.” (P5)

Religious Beliefs

Religious beliefs played a vital role in helping the participants to cope with the suffering they were going through. A few participants relied heavily on destiny and fate to get along with their situation. Considering their condition as destiny and God’s wish helped some participants reconcile with their present condition. It was a significant part of the coping mechanism for these patients. P4 expresses a belief in a higher power controlling their fate, indicating an external locus of control. This highlights the participant’s reliance on religious factors to cope with their situation. The excerpt also reflects a passive acceptance of fate, and they attribute their ability to endure hardship to this belief, suggesting a sense of resignation and acceptance of their circumstance: “People often say to me that, God is the ultimate controller, he decides our fate... I am enduring everything; I will endure in future as well (P4).”

On the other hand, another participant (P1) accepted this punishment from God, but not the slow and painful manner of this punishment. She said:
If God wants to kill me, then why He isn’t doing it all at once! Why is he making me, making them suffer! Why this slow death! He can just take away my life with a snap of a finger, then why this suffering!

The participant expresses confusion and frustration over why suffering is prolonged rather than death occurring swiftly. It highlights the existential and spiritual struggle of the participant. It also suggests that the patients’ experience goes beyond medical aspects and are intertwined with existential and spiritual struggles, highlighting the multidimensional aspect of the cancer experience.

Two participants considered it because of their sins from this or a previous life. This line of thinking helped them reconcile themselves with their current situation.

If I had done something wrong, then it’s okay that he is punishing me for my sins of this or previous life through this disease. (P3)

God is testing us and our family members. I don’t remember my previous life, but all I can say is that I haven’t done anything in this life that God should punish me. I don’t know what is in his mind. (P2)

P3 perceived their illness as form of punishment for past wrongdoings of this or a previous life. This perspective suggests a belief in the concept of karma or divine retribution, where the illness is viewed because of moral transgression. This also highlights a deterministic worldview where events such as illness are perceived as a predetermined consequence of one’s action. In contrast, the second excerpt from P2 shows a different perspective. P2 expresses uncertainty behind their illness, indicating that it may be a test from God rather than a punishment for specific actions. Unlike P3, who attributes their illness to past sins, P2 emphasises on their innocence and lack of understanding regarding God’s plan.

The above examples underline the importance of spirituality for the cancer patients to help them reconcile with their altered realities of life. A sense of fatalism helps them feel both resigned to fate and gives them some sense of being at peace with themselves, instead of constantly being soaked in self-pity. The variability showcases the complexity of belief systems and the role they play in shaping individuals’ interpretations of illness experience.

Discussion

This article illustrates the ways in which women perceive their changed body after their cancer diagnosis and the subsequent treatment. The focus of the study has been on the ways women cancer patients deal with the issue of their changed body in their everyday life, in terms of how they perceive it and handle the same. Apart from the physical sign of the disease, the altered body also signifies the social presence of cancer. Each participant went through the experience of changes in their body due to the disease and its treatment regime. Additionally, all of the participants indicated towards experiencing emotional distress related to the physical manifestation of the symptoms of cancer and its treatment. A likely reason for this is that the cancer patients become visible or noticeable only when they show discernible signs of the condition. The findings of Martin et al. (2019) which brought to the fore the fears and the emotional reactions of newly diagnosed individuals with cancer, also support this finding.

For the participants, the impact of this experience was a hugely disruptive one. The relative sense of security in their sense of self and normative interactions with the world around them were brought into question by this diagnostic experience, causing them to question previous understandings about themselves and the world around them. The personal narratives
of the participants which referred to their pre-cancer self as “beautiful,” “strong,” “normal,” etc. gave way to new narratives about their own self after the diagnosis of cancer.

The new altered self for them was the one with cancer. For those with chronic illness, Asbring (2001) described a fragmented self, in which the concerned individuals did not identify themselves with the person they were pre-diagnosis and did not even fully acknowledge their illness state that their diagnosis had suggested. Like the findings of Asbring’s (2001), this study also reveals that a cancer patient neither considers himself / herself the person he/she was before the diagnosis nor do they fully identify with their new self, the one afflicted by cancer, and thus, Asbring’s (2001) notion of fragmented self seems quite apt in the case of cancer patients as well.

The diagnosis of cancer and the subsequent treatment regime threatened the taken-for-granted assumptions of the participants where continuity no longer remains predictable. Every single aspect of life which was seen as normative and was taken for granted is now questionable. The effect of diagnosis and the subsequent treatment forces one’s attention on the body. The lived experience of many participants was characterised by a state of suffering wherein a key feature was the experience of their bodily symptoms.

Several studies have discussed the relationship between the self and one’s embodied experience (Finlay, 2006; Williams, 2000). Finlay (2006) highlighted the relations between body-self-world of individuals diagnosed with chronic illness. She suggested that the embodied experience of the illness was intrinsically entwined with one’s sense of self and being in the world, something that my research findings are in concurrence with. Reliance and confidence on the body are challenged due to the threats of death and dysfunction which are constant reminders of debility, vulnerability, and mortality. The relationship between the body and the individual self are strongly intertwined in ways which are difficult to understand, and that is how the normality of the relationship leads to a familiar and comforting co-existence of the two. However, when illness and the threat of mortality enter the picture, this normality is disrupted as the boundaries between the two are destabilised, leading to unknown, unfamiliar and discomforting possibilities.

The participants had not given much thought regarding their body in terms of what their body meant to them until the time of their diagnosis. But after the diagnosis, they were forced to reflect on their body, and they became aware of it in new ways. The symptoms disrupt the bodily experience, upsetting the balance of self. This disruption in turn affects the biographical equilibrium and the relationship between the body and self. The ever-present existence of cancer in the body and its treatment led to a sense of alienation with this new altered body, and this sense of otherness and alienation disrupted the process of embodiment, bit by bit, with time. When it came to the body-person relationship, the participants felt a sense of otherness about the body, as if it is no longer a known and familiar entity, a feeling that was also accompanied by a feeling of betrayal and invasion. Moreover, with cancer afflicting the body, the body makes its presence felt by moving from a silently reliable presence to an almost malevolent one impinging upon the consciousness and the self.

The physical appearance of a body is usually a significant part of it taken-for-grantedness, and with cancer and its treatment significantly altering the body, the focus shifts even more to the body, and it is viewed as an object. The other taken-for-granted aspect of the body is its functionality, in terms of its mobility and intentionality. These too now become uncertain and unreliable. One becomes apprehensive about the rate at which the body changes for the worse, in terms of its instrumentality, as the change becomes radical at times, in terms of its deterioration. The aspects of body through which it usually becomes an instrument of relationship such as a speech act, touch, looks, or expressions no longer function in the desired manner leading to disruptions in relationships and with it, a foreboding sense of being a burden on others, as he/she finds it extremely difficult to fulfil the commitments.
Like previous research (Fouladi et al., 2018; Olasehinde et al., 2019), the findings of this study also indicates that it becomes difficult for the changing body to be able to sustain the normal and existing relationships. The lack of confidence in one’s own body translates into a lack of confidence in the ability to continue the relationships. The normative roles such as mother and wife, that are usually sustained in embodied forms, slowly but surely get challenged due to the altering and increasingly unreliable body whose functionality gets seriously compromised because of cancer and its treatment. These changes indicate that the body has become unreliable. It has become the other, an unknown and unfamiliar object.

This ensues in the individual as a sense of betrayal that the body has suddenly abandoned the relative harmony in which the body and the self-co-existed, as found in prior studies (Brunet et al., 2013; Przezdziecki et al., 2013). The body suddenly seems like it has begun a process of separation, and almost having an agency of its own. But this body needs to be regularly attended to with due urgency so that the day-to-day functionality is not fully compromised. Chemotherapy leads to tiredness and nausea which ensures that it is no longer the person, but the body to which the power has shifted, and the person is helpless in front of it. The individual’s sense of helplessness in his own body is all too perceptible and this helplessness leads to a sense of being a burden on others, a major concern for most participants in this study.

Similar to previous research in this area (Fingeret et al., 2014; Finlay, 2006; Grogan, 2008) the findings of this study shows that the body ravaged by the disease and its treatment in the form of chemotherapy, surgery, radiotherapy, etc. leaves the confidence of the individual shaken as these cause undesirable changes to the body, and all these changes require some form of adjustment from the person. Some participants talked about the way their altered body no longer fit into their earlier clothes, or in some cases, how they would make them more vulnerable to perceived public scrutiny detrimental to their sense of self by accentuating the “flaws” or disfigurements in their body, such as the absence of breasts removed through surgery. They would dress accordingly. While some decided to use camouflage, others decided to not worry about showcasing their new body, and both contrasting attitudes were coping mechanisms for the patients as well. The same is true of the disease-induced hair loss. While some decided to wear a bandana, others decided to start being comfortable with their baldness.

It was evident from my study that the cancer diagnosis and its symptoms affected the lives of all the participants, which required them to adopt certain coping strategies. This experience was mostly stressful, and the participants had to build coping strategies to lessen their distress in such an uncertain situation. For a few, this meant avoidance or the use of adjustments as tactics to cope with the unpredictable trajectory of cancer. The deep-rooted religious belief among most of the participants and strong familial bonds are seen to be enhancing their ability to adjust and cope with their altered body. Social support from family and significant others have been linked to decreased mental health problems such as depression, anxiety and suicidal behaviours and improved quality of life among women living with breast cancer (Lim et al., 2008; Matthews & Cook, 2009).

Available literature on coping with a chronic illness such as cancer support this finding and show how along with the other coping mechanisms, taking recourse in spirituality has played a major role in managing the psychological wellbeing of the family caregivers and cancer patients (Kershaw et al., 2004; Pearce et al., 2006; Shim & Ng, 2019). For caregivers, practicing Hinduism in Western India has been identified as an important resource (Thombre et al., 2010). In their study, Thombre et al. (2010) discuss how taking recourse in a religious belief system such as the emphasis on one supreme deity, often Shiva or Vishnu, while also recognising numerous other gods as manifestations of this ultimate deity, the belief in karma and dharma, and practicing rituals such as making offerings at shrines and chanting mantras helped the caregivers to look at illness with positive connotations and even assisted them in
their spiritual seeking. In my study, one finds how the Hindu philosophy of acceptance of one’s karma and fate helped in coping with the stress of caregiving among the participants. Like this study’s findings, another study conducted by Mehrotra and Sukumar on Indian caregivers stated that individuals used their reliance on faith to manage the demands of cancer (Mehrotra & Sukumar, 2007).

Like most studies, this study too has its set of limitations. My study was performed with Bengali participants, confined to a certain geographic region. Thus, some of the expressed opinions and experiences may not be applicable to cancer patients from a different region, especially since the nature and quality of health care across different parts of India are not uniform. The small number of participants used in this study could be seen as another possible limitation of this study, even though it is precisely this smaller sample size which enabled an extensive interaction with them and resulted in qualitatively in-depth data.

Moreover, since the inclusion criteria for this study did not specify the period from the time of diagnosis, the patients would be at different stages of their survivorship. Consequently, their responses sometimes would not be comparable, and the way they recollect their experiences sometimes may be coloured by the other events that may have happened since then, making the process of accurately recalling the events and their experiences a tricky proposition resulting in possible retrospective recall error (Patton, 1990). Such recall errors could influence research findings to some extent. However, I made a lot of effort through constant, but empathetic prodding in case of the seemingly contradictory or contentious opinions or narratives voiced by the participants. Moreover, it needs to be noted that the purpose of this study is to focus on the patients’ subjective experiences during their illness trajectory, especially about their changing perceptions of body image, and hence the presence of some recall error would not be detrimental in adequately exploring the ways in which they make sense of their own experiences of their body.

A study like this that explores certain aspects of experiences of the female patients diagnosed with cancer can be replicated with other such difficult diseases to cope with, and ones that play havoc with one’s sense of self through adverse impacts on one’s physical self. Further research could expand on these findings by including a larger number of participants from diverse ethnic backgrounds in India. Additionally, focusing on adolescents diagnosed with cancer, who are undergoing significant biological changes, particularly girls, could provide deeper insights into the experiences of cancer and its impact on body image.

The findings of my study can be helpful for health care professionals in moving beyond just attending to the physical aspects but also to empathically handle the psychological issues arising out of their altered body and resultant body image. My findings encourage a patient-centred approach to cancer-care and advocates a multi-disciplinary approach for the overall wellbeing of the women patients diagnosed with cancer and struggling to cope with adjusting to their altered body and the resultant negative body image.

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