

Exploring the Influence of Female Friendships on Decisions to Discuss the
Breast Self-Exam in Young Adult Women

Sondra Davis, BScN

Submitted in partial fulfillment of the requirements for the degree of
Masters of Arts in Applied Health Sciences
(Community Health)

Co-Supervisors: Dr. Lynn Rempel and Dr. Joyce Engel

Faculty of Applied Health Sciences, Brock University
St. Catharines, Ontario

Sondra Davis © August 2013

Abstract

The breast self-exam (BSE) has been an important method for detection of breast cancer, especially in women under the age of 40. This study used grounded theory to explore the possible influence of female friendships on young women's decisions regarding BSE.

Conversations with six women in their 20s and 30s revealed that discussion of BSE is an *exceptional conversation* facilitated by the *female friendship "safe zone"* and a *germinal event*. Without being prompted by a *germinal event*, such as a health scare, it is generally considered to be an *unnecessary conversation* about *private matters* and viewed as out of the ordinary, especially for low-risk women. This conversation most easily occurs within the *female friendship "safe zone"* that develops through *the body in common*, a *sense of trust*, and *private information sharing*. Implications include peer mentoring for sharing and educating women and healthcare professionals on conditions that facilitate the *exceptional conversation*.

Keywords: breast self-exam, young women, female friendship, decision-making, grounded theory

Acknowledgements

I would first like to thank my thesis committee members and my two co-supervisors in particular. This has been a long and tiring process but despite many bumps in the road you have all stuck by me and provided your continued support, advice, and expertise. It has not gone unnoticed and has been appreciated more than I could express in words.

I would also like to thank my family and friends for your ongoing praise, support, and encouragement. You have helped me in more ways than you could ever know. Special thanks are directed to my parents, for always being proud of me and for encouraging me to pursue higher education. I would not be here today if you had not pushed me from the very beginning to always do better. Thank you to my sister for your continuous praise and excitement for my accomplishments. It has been a motivation for me throughout this process.

Lastly but definitely not least, I want to graciously thank my wonderful husband Daniel. This has been a very long journey for the both of us and you have stayed by my side through thick and thin. Your ongoing support, praise, encouragement, love, and respect have kept me motivated to keep going. I do not know how I would have completed this without you. I owe every last word of this thesis to you. You have truly been my inspiration and have lived up to your title of husband—best friend and soul mate.

~Daniel, I love you, forever and ever.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
List of Figures.....	viii
List of Appendices.....	ix
Chapter 1: Introduction.....	10
Researcher’s Interests and Background for Thesis.....	11
Context and Significance.....	11
Breast Cancer Statistics.....	13
Early Detection through Breast Self-Examination.....	14
Significance of Friendship.....	15
Summary.....	16
Review of the Literature.....	17
Context of the Breast Self-Exam.....	17
Breast Cancer in Young Women.....	17
Significance of the Breast Self-Exam to Young Women.....	19
Decision-Making.....	21
Social Norms.....	22
Cultural Norms.....	25
Social Networks and Social Support.....	26
Friendship Development.....	29
Characteristics of Friendship.....	31

Summary.....	34
Chapter 2: Methodology.....	36
Background and Definition of Grounded Theory.....	36
Research Design.....	37
Symbolic Interactionism.....	38
Research Context and Procedures.....	39
Ethics and Confidentiality.....	39
Data Collection.....	40
Data Analysis.....	44
Open Coding – Identifying Categories.....	45
Axial Coding – Relating Categories.....	47
Diagramming.....	48
Selective Coding – Integrating and Refining the Theory/Centrally Occurring Theme.....	51
Reaching Data Saturation.....	52
Memoing.....	52
Sample and Recruitment Procedure.....	54
The Participants.....	56
Melanie.....	56
Jennifer.....	57
Stacey.....	58
Melissa.....	59
Sarah.....	61

Christine.....	62
Trustworthiness of Findings.....	63
Credibility.....	63
Transferability.....	63
Reliability.....	65
Chapter 3: Findings.....	66
Substantive Theory.....	66
Categories that Discourage Discussion.....	69
Private Matters.....	69
Unnecessary Conversation.....	69
Categories that Encourage Discussion.....	70
Female Friendship “Safe Zone”.....	70
Germinal Event.....	70
Description of the Categories.....	71
Private Matters.....	71
Unnecessary Conversation.....	83
No Risk.....	84
Female Friendship “Safe Zone”.....	87
Sense of Trust.....	90
The Body in Common.....	94
Germinal Event.....	97
Exceptional Conversation.....	100
Summary.....	100

Chapter 4: Discussion.....	103
Transferability to Other Female Populations.....	105
Implications for Practice.....	106
Implications for Education.....	109
Implications for Further Theory Development and Research.....	111
Study Limitations.....	112
Concluding Reflection.....	114
References.....	119

List of Figures

Figure 2-1. Preliminary Category Diagram.....50

Figure 3-1. Category Diagram.....68

List of Appendices

Appendix A. Study Consent Form.....	125
Appendix B. Initial Conversation Question Guide.....	127
Appendix C. Follow-Up Questions.....	128
Appendix D. Study Invitation Flyer.....	129

Chapter 1: Introduction

The purpose of this grounded theory study was to explore the influence of female friendships on decisions regarding the breast self-exam. Breast cancer is a significant illness for young women because in comparison to other cancers, young women are impacted more (Kearney, 2006). When younger women are diagnosed with breast cancer they tend to develop more severe types of breast cancer than women who are diagnosed at an older age (Ma et al., 2012).

The breast self-exam is the only method that is used for early detection of breast cancer in low-risk women under the age of 40. The significance of the breast self-exam for young women was noted in studies suggesting that women under 40 years old with breast cancer detected their cancers through practice of the breast self-exam (Fancher et al., 2011). Since the breast self-exam can be a beneficial technique for knowing one's breasts, it is important to determine how and why young adult women make decisions regarding this technique.

Research evidence suggests that friendship is important for having conversations about worries, uncertainties, and private issues among women (Aries & Johnson, 1983). The importance of friendship regarding influence on health promoting behaviours has been explored in a number of studies and demonstrates the possible value of knowing whether or not female friendships are relevant to young women's knowledge about and practice of the breast self-exam.

Researcher's Interests and Background for Thesis

As a researcher, my interest in a study that explores the impact of female friendships on the influence of decisions regarding the breast self-exam initially evolved from my own notions and preconceptions about the breast self-exam and why I was not practicing it or even engaging in discussion about it among close friends upon initiation of this study. I was curious as to whether or not other young adult women were in a similar position.

My professional and student nursing experiences consistently led me into areas focusing on women's health, women's issues, and women's interests. These experiences have suggested that health promotion measures such as the breast self-exam are important in maintaining overall wellness and that a variety of relational issues can influence what many young women decide regarding their health. Thus, this study was conducted to increase our knowledge about the thoughts and values of young women regarding the breast self-exam and their comfort level to perform the technique and discuss it with friends. The process of utilizing the breast self-exam as an informative health promotion method for early detection, education, and awareness of breast cancer could encourage many young women to take more control of their own health and bodies than what women who lack awareness of the breast self-exam might do.

Context and Significance

For this study, young adult women (or young women) were identified as between the ages of 20 to 39. Literature that was reviewed upon selection of the topic for this study explored different factors about breast cancer among women of this age group, such as breast cancer statistics, the use of breast self-examination as a health promoting

behaviour and for early detection, and the significance of friendships among young women. As described in the model by Tannahill (1985), health promoting behaviours encompass all aspects of health, such as health education, health protection, and health prevention and are reflective of what the breast self-exam promotes. The literature determined that young women who do not have a family history of breast cancer have a much lower risk of developing breast cancer compared to those who do have a family history of breast cancer. The risk is also lower for younger women when compared to higher risk women and as they get older, but there is still risk at any age, no matter how low it may be. Knowing that there is still a risk, even if it is low, prompted a further look into the health promotion behaviours available to young women for breast cancer awareness. This determined that the breast self-exam is the only technique that young women who do not have a family history of breast cancer are able to use for detection, since mammogram is only used for high-risk women or those 50 years of age or older.

As a researcher who identifies with the low-risk group of young women, I began to ponder whether or not young women actually use the breast self-exam and what factor may be significant for young women in order to promote awareness, discussion, and practice of this behaviour. After determining that female friendships are significant to young women, that became the focus of this study—to explore the influence of female friendships on decisions to discuss the breast self-exam. The initial literature that prompted this topic includes breast cancer statistics, the use of breast self-examination for health promotion, and the significance of friendships among young women and is described in further detail.

Breast Cancer Statistics

Many young women believe they are not at risk for developing breast cancer, however, “compared to other types of cancer, breast cancer disproportionately affects the young” (Kearney, 2006, p. 802). When considering the risk factors for breast cancer diagnosis in young women under the age of 40, it is also significant to understand the statistics for how many young women have reported a breast cancer diagnosis at a young age, as well as the likelihood of a positive prognosis.

Research from a study that examined breast cancer mortality rates reported that 6.4% of their participants, who had been diagnosed with breast cancer, were under the age of 40 at the time of diagnosis (Gnerlich et al., 2009), demonstrating that breast cancer is not just for *older* women. Younger women tend to develop more severe types of breast cancer and women, who are diagnosed with a palpable form of breast cancer that is not easily screened through mammogram, tend to be younger, with more advanced tumours (Ma et al., 2012).

Once a young woman has been diagnosed with breast cancer, focusing on positive outcomes becomes important; nonetheless, negative outcomes were suggested in another study that examined the survival rate and prognosis of young women with breast cancer. Liukkonen, Leidenius, Saarto, and Sjostrom-Mattson (2011) reported an 80%, 5-year overall survival rate in their patient population of women who were 35 years of age or younger. While this percentage was described as an improvement for young women, it was considerably lower when compared to the survival rate of breast cancer in patients of all ages.

These research studies represent the significance of awareness and knowledge of the risk factors for breast cancer diagnosis at a young age. Since the prognosis of breast cancer was considered to be worse in young women than among breast cancer patients in all age groups, despite the lower risk, importance should be focused on how to improve prognosis and awareness through exploration of early detection methods that are significant and available to young women, such as the breast self-exam.

Early Detection through Breast Self-Examination

As a health promotion method for early detection of breast cancer, there has been recent controversy surrounding regular use of the breast self-exam (Ma et al., 2012). The “lack of a consensus regarding a standard recommendation for the breast self-exam is problematic and confusing” (Allen, Van Groningen, Barksdale, & McCarthy, 2010, p. 445), considering the breast self-exam is still regarded by many as a tool that makes it possible for women to get to know their breasts. The breast self-exam has allowed for many women to detect their own cancer by noticing something abnormal (Fancher et al., 2011).

Providing women with the ability to know what is normal for their own breasts is a positive outcome of the breast self-exam. Research studies have also noted the effectiveness of this technique. Fancher et al. (2011) noted that 822 women from one hospital had been diagnosed with breast cancer between the years 1994 and 2004, and determined that almost 8% of these women were under the age of 40 years old at the time of diagnosis. These researchers found that nearly 69% of the women who were under the age of 40 and diagnosed with breast cancer had detected their cancer through practice of the breast self-exam (Fancher et al., 2011). Furthermore, Ma et al. (2012) reported that

36% of the young women in their study who had been diagnosed with different forms of breast cancer had discovered their cancer through practice of the breast self-exam or clinical breast-exam.

Determining what is abnormal first involves knowing one's own breasts to understand what would be considered normal for each woman. This is a reported benefit of breast self-examination as a health promoting behaviour. Since the breast self-exam has been noted as useful for young women's diagnosis of breast cancer and knowing one's own breasts, exploring ways to promote awareness of this technique might be valuable. One possible avenue could be through a relationship that is significant to young women, such as female friendships.

Significance of Friendship

There is limited research on the topics of women's breasts, breast cancer diagnosis in young women, and on the understanding of how to promote awareness and informed decision-making regarding health promotion techniques, such as the breast self-exam. As a women's health topic and a valuable technique for enabling women to get know their breasts, it is significant to explore factors that could possibly influence decisions regarding the breast self-exam, such as women's friendships.

Friendships are a type of social connection, and in regards to social connections with others, Smith and Christakis (2008) note, "People are interconnected, and so their health is interconnected" (p. 406). A point of interconnectedness that is significant among young women are friendships, because once a young adult leaves home to attend university, the relationships that are developed are commonly with their peers (friends) as opposed to their parents. Parents may not be consulted about health issues if they are no

longer present in the young adult's daily life when they leave home to attend university. They may not fully understand certain issues and concerns that a friend who is similar in age and who is present day-to-day, may have in common.

Thus, the interconnectedness and importance of friendship was considered as a significant area of focus for this study that explored the influence of female friendships on decisions regarding the breast self-exam among young women.

Summary

Overall, it seems that many young women who do not have a family history of breast cancer perceive themselves to be at low risk, or no risk, for developing breast cancer at their age, because aside from heredity, the incidence of breast cancer for young women is generally low. Despite this factor, many young women have been diagnosed under the age of 40 and more importantly, young women who are diagnosed tend to have a worse prognosis for breast cancer survival, when compared to women of all age groups who are also diagnosed with breast cancer. Considering the benefits of the breast self-exam as a health promotion technique for early detection of breast cancer among young women could improve the overall prognosis for young women and promote awareness of the benefits to knowing what is normal for their own breasts.

Thus, this study was conducted to explore factors such as the connection between female friends that could support awareness of the breast self-exam and influence more informed decision-making among young women.

Review of the Literature

The purpose of this grounded theory study was to explore the influence of female friendships on decisions regarding the breast self-exam. Two areas of inquiry, the breast self-exam and female friendships are foundational topics to the purpose of this study that explored the relationship among these two factors and their significance to young women's decision-making. The review of the literature includes 1) context of the breast self-exam, 2) concepts of decision-making, 3) social and cultural norms, 4) social networks and social support, as well as 5) aspects of friendship development.

Literature that is relevant to the focus areas of the breast self-exam and female friendships has been reviewed to provide further context and understanding. The literature would also help to determine whether there is an influential factor about friendships, such as a friendship quality or the closeness of a friendship that impacts the views, discussion, and practice of the breast self-exam. It is also important to identify other factors that might influence decisions regarding the breast self-exam among young women. Other factors include identifying young women's perceived risk for breast cancer and the value of the breast self-exam for early detection.

Context of the Breast Self-Exam

Breast Cancer in Young Women

Breast cancer is a significant illness among women in Canada and worldwide. Statistics Canada (2013) reported that the breast cancer incidence rate for females in 2007, within Canada, was 126.6 per 100,000 and demonstrated a slight decline in incidence since 2003. Worldwide, in 2008, breast cancer accounted for 23% of all cancers diagnosed among women of all ages. Furthermore, the incidence of new cases

worldwide was 1.38 million, with an estimated mortality rate of 6 to 19 per 100,000 of those diagnosed with cancer (GLOBOCAN, 2008).

The incidence of cancer diagnoses among women of all ages is important to note in order to determine the impact that breast cancer has on all women. More specifically, breast cancer diagnosis pertaining to young women was particularly important to the focus of this study. Young women were the focus of the study by Fancher et al. (2011), where the purpose was to identify different factors associated with a breast cancer diagnosis in women who were 40 years of age or younger. Their sample included women from their community's teaching hospital who had been diagnosed between 1994 and 2005. According to the results of their study, breast cancer diagnosis in young women is *exceptional*, considered as out of the ordinary or very uncommon to this age group, with an incidence of approximately 8% of all women who have breast cancer.

Other studies support the concern that breast cancer is more severe in younger women and therefore emphasize the significance for early screening. Ma et al.'s retrospective review identified that patients under 50 years of age were more likely to develop a type of palpable breast cancer than patients over 50 years of age. As well, breast cancers diagnosed at a younger age generally have more severe identifiers with their tumours than those diagnosed at an older age (Ma et al., 2012) and can result in a more negative prognosis. Furthermore, in a retrospective, population-based cohort study, breast cancer mortality factors were compared for women younger than 40 years of age and women 40 years or older (Gnerlich et al., 2009). Gnerlich et al. (2009) found that women younger than 40 years of age tend to have a *lower* risk for developing breast cancer than older women, but their breast cancer tends to be *higher* in severity and

therefore, they were more likely to die from breast cancer than older women. Thus, since young women tend to be diagnosed with a more severe onset of breast cancer than older women, the idea of early detection is more crucial for women under 40 years of age (Fancher et al., 2011).

Significance of the Breast Self-Exam to Young Women

The study by Gnerlich et al. (2009) and the review by Ma et al. (2012) report the significance of the breast self-exam as an early detection technique for young women. Ma et al. (2012) reported that 36% of those who presented with the palpable form of breast cancer had discovered their cancer through practice of the breast self-exam or clinical breast-exam despite previous use of mammography. The usage of mammography, breast self-exam, and the clinical breast-exam for early detection were also evaluated by Fancher et al. (2011). They reported that 44 (approximately 69%) of the young women who participated in their study had discovered their own breast cancers by finding a lump through breast self-examination detection. These reports demonstrate that certain types of breast cancers are often more recognizable through use of the breast self-exam or clinical breast-exam, as opposed to mammography, and that these cancers are more common in younger women than older women.

Contrary to these reports, the breast self-exam has recently not been recommended to women as a stand-alone technique for breast cancer detection. This lack of recommendation is a result of limited research demonstrating a decline in morbidity in relation to use of the technique, and of reported increases in women's anxiety about discovering lumps and masses through practice (Fancher et al., 2011). Allen et al. (2010) reviewed the position statements of various organizations as well as recent research

regarding the breast self-exam and identified the potential harms that could come from regular practice of the technique:

1) An increased number of healthcare visits; 2) Twice the number of benign breast biopsies; 3) Increased healthcare costs; 4) Increased levels of cancer with related anxiety that may require counselling or treatment; and 5) No change in mortality from breast cancer with detection from the breast self-exam (Allen et al., 2010, p. 447).

Despite the aforementioned harms or disadvantages of performing breast self-examination, a number of advantages have been identified. For example, the performance of the breast self-exam enables women to increase their accountability and confidence regarding knowledge of their own health and to have the ability to perform an early detection technique that is non-invasive yet positive for awareness and detection of abnormalities (Elmore, Armstrong, Lehman, & Fletcher, 2005). It also enables women to detect breast cancer at a stage before screening with mammography is generally prescribed and is suggested as important for a promising prognosis. The mammogram is not recommended for women under 40 years of age and the only breast cancer detection technique that is recommended for young women is to have a clinical breast-examination performed by a physician every three years. Thus, the breast self-exam becomes significant because it can be an appropriate tool for women of all ages.

A feminist action research study by Kearney (2006) engaged 13 women between the ages of 30 to 59, in discussions exploring what the breast self-exam means to them. The description of the behaviours of the participants in Kearney's study suggested that 75% had performed the breast self-exam over their lifetime and only one participant

performed this technique on a regular, monthly basis. Even though the majority of the participants in Kearney's study did not practice the breast self-exam on a regular basis, they did find it to be significant at one point in their life.

Breast cancer is not common to young women, but it is beneficial to diagnose this disease at a younger age and potentially earlier stage before it becomes more aggressive and more difficult to treat. The significance of the breast self-exam is that it may enable young women to detect a lump at an early stage and seek treatment, rather than wait until other symptoms appear and then may be too late for successful treatment. Knowing what is normal in order to determine if something is abnormal is a benefit that this simple screening technique offers.

Decision-Making

Decision-making could commonly be referred as a process that determines whether a person intends to engage in a specific behaviour or not. Emancipated decision-making and various factors that can influence the decision-making process have been reviewed in the literature and will be discussed here. These factors include social norms, cultural norms, and social networks or social support.

Factors such as social norms, cultural norms, social networks, and social support can influence the decision-making process, depending on how significant they are to someone's views, values, and beliefs. They can also hinder young women from making an emancipated decision. A descriptive correlation study by Wittmann-Price and Bhattacharya (2008) used these concepts, among others, as factors in Wittmann-Price's Theory of Emancipated Decision-Making (EDM), a theory that had been developed in a previous study by Wittmann-Price (2004). Wittmann-Price (2004) defines an

emancipated decision as a decision made in a flexible environment that precipitates the result of a freely made choice. Emancipation of decisions allows a person to make his or her own decisions without feeling forced into a decision consistent with someone else's view of what is best. Decisions are then established and informed by a person's culture, life experiences, and values but fully reflect the choices and beliefs of the person making the decision (Wittmann-Price, 2004).

Emancipated decision-making becomes significant to the topic of the breast self-exam, because if a young woman does not feel that she has the freedom of choice, she may not make the decision that is appropriate for her, as a young woman—whether this means to practice the breast self-exam or not. As well, if social norms prevent her from obtaining information that could be pertinent to her health, then she is also not able to make an emancipated decision. This could include knowing that there is still a small risk for developing breast cancer or knowing that the breast self-exam could benefit her by being able to determine what is normal for her own breasts. The expectation of emancipated decision-making would be that despite what society portrays as normal, correct, or important to know, women should be able to make the most informed and appropriate decision for them, and societal and cultural views should only inform women's decisions but not pre-determine what their choice should be.

Social Norms

The results of Wittmann-Price and Bhattacharya's (2008) study suggested that social norms developed through expectations from healthcare professionals were a factor in helping women to feel support and guidance when making an emancipated decision. Social norms are prominent in the literature as being a determining factor for health

related decisions, particularly regarding decisions about women's health behaviours and women's health in general.

Wittmann-Price and Bhattacharya (2008) suggested that social norms influenced how women decided what type of pain control would be used during labour. They suggested that women's choice of using pharmacological or psychoprophylactic pain management *should* be supported, especially if a woman has the knowledge and ability to make an appropriate decision on her own. For Wittmann-Price and Bhattacharya's (2008) study, social norms were not supportive and were described as what healthcare professionals viewed as the best option for pain management. Even though the women attempted to seek information, support and guidance, the views regarding pain management from the healthcare professional had the tendency to influence women's decisions to go along with their view, as opposed to inform the women of what their options were.

The support that women seek from healthcare professionals is similar to the support that women seek in their friendships that involve discussion of private issues, worries, and uncertainties (Aries & Johnson, 1983). In Wittmann-Price's (2004) decision-making model, however, it is important to note that there were other sub-concepts in addition to social norms that had stronger impact on decision-making, such as empowerment, flexible environment, private knowledge, and reflection. These sub-concepts demonstrate that if women had previous knowledge and information regarding the options available to them, such as the type of pain management commonly used during labour, they may have been more likely to make an informed decision and less likely to be influenced by their healthcare professionals to make a choice that was

different from their own personal preferences (Wittmann-Price & Bhattacharya, 2008).

On the contrary, they may have still decided to make the same choice that was suggested by their healthcare professionals. The underlying principle, however, was in the ability to make the choice that was right for them, whether or not this followed the suggestion from their healthcare professional.

The findings from the study by Wittmann-Price and Bhattacharya (2008) suggest that education, awareness, and discussion are important facilitators for determining the influence of social norms. Further, these findings suggest that social norms are essentially *social*, or expectations of behaviours and thoughts that are developed through interactions with others. Social norms can be determined by awareness, education, the frequency that a norm or issue is discussed among societal members or on the news, or even by the frequency that a norm is presented in the most prominent research. The goal of emancipation for individuals, however, should be to determine self-norms and what is suitable for an individual's own life. The importance is to be aware of social norms and realize that they can provide awareness of options and guide self-norms, but to also realize that social norms are not rules and what is *normal* can look completely different for everyone. Friendships also have the ability to guide and inform individuals' decisions based on what norms are discussed or are identified as most significant among them.

From the literature, social norms could be inferred as affecting some decisions and behaviours related to women's health differently than others. For example, in the study by Aries and Johnson (1983), social norms helped to guide women's awareness so that they could make an informed decision. Conversely, in the study by Wittmann-Price and Bhattacharya (2008), social norms added pressure to women to make a decision that

may not be appropriate for everyone. Thus, this may ultimately affect possible discussion regarding concerns about health promoting behaviours among friends, such as the breast self-exam.

Cultural Norms

Cultural norms were identified as a significantly influential factor in some women's perceptions and practice of the breast self-exam. Using grounded theory, Borrayo and Jenkins (2001) explored cultural norms by looking at how the beliefs, values, and norms of women of Mexican descent between the ages of 49 and 81 years old influenced how participation in breast cancer screening techniques was regarded.

The study utilized focus groups and discovered that many of the women did not see their healthcare professional for a mammogram and did not perform the breast self-exam. They determined that this was due to cultural beliefs suggesting that it is indecent and improper to touch oneself, or to have others do so, even for health reasons (Borrayo & Jenkins, 2001). The study also suggested that many of the women did not discuss these practices with other women because their cultural norms determined that private matters regarding women's breasts should not be discussed publicly. The results of the study suggested that the women who had strong supports from other female family members who understood the importance of preventive practices, did decide to go for a mammogram with a female healthcare professional and did decide to practice the breast self-exam, despite cultural norms that emphasized otherwise (Borrayo & Jenkins, 2001).

The findings of the Borrayo and Jenkins' (2001) study are particularly important to this study because Borrayo and Jenkins' suggest that cultural beliefs affect women's health related views, behaviours, and decision-making. In particular, views and

behaviours related to areas of a woman's body, such as her breasts, that could be considered private or sexual by some cultures. The effect of cultural norms emphasizes the idea that support from others, such as female family members or even friends, can be impactful to the decisions women make in regards to health promoting behaviours, even when cultural norms might suggest otherwise. It also becomes significant to note that even if the young women from my study do not directly relate their behaviours to an identified culture like the women in the study by Borrayo and Jenkins (2001), they still belong to a culture or many different cultures that ultimately affect their views, beliefs and behaviours whether it is apparent to them or not.

Social Networks and Social Support

Social networks and the connections made with friends have been linked to the utilization of "preventive health behaviours" (Hurdle, 2001, p. 74). This has similarities to the findings from the study by Borrayo and Jenkins (2001) where results reported positive effects on health behaviours through support from female family members.

Smith and Christakis (2008) differentiate between social networks and social support and suggest that a social network focuses on the characteristics of the friends within a network, whereas social support focuses on the actual existence of the connection or tie between friends and establishes the condition under which influence would occur. These networks can present in numerous forms, but are often represented by "dyadic effects" (p. 408) where one person is connected to one other person (Smith & Christakis, 2008), such as in a friendship. The effects of these networks can have an impact or influence on our behaviours, whether it is informed or misinformed and can even impact behaviours such as smoking initiation, as well as the use of alcohol and other

substances (Smith & Christakis, 2008). The “dyadic effect”, discussed by Smith and Christakis (2008), is relevant to the focus of this study in regards to how a friendship of two women can affect or influence decisions and behaviours pertaining to the breast self-exam and affect the emancipated decision-making process.

A social network may be governed by social and cultural norms that determine what each person feels comfortable confiding within this network. Each network will differ in terms of what social and cultural norms have developed and while some networks may have norms that govern openness with confiding amongst one another, other networks may not. Similarly, social networks have comparisons to the characteristics of a friendship, and in many cases a friendship can be viewed as a smaller social network, just as Smith and Christakis (2008) describe in their literature review.

An article discussing the impact of social networks and social support (Hurdle, 2001) found that there is an emphasis on the use of social support to promote a positive effect on women’s health behaviours, particularly for breast cancer screening and mammography. Examples of how social support affects the health behaviours of women included social networks as the preferred source of information particular to women’s illnesses such as breast cancer and the self-efficacy that some groups of women attributed to the support from their social networks. Several of the studies reviewed in this article suggested that use of behaviours such as the breast self-exam and mammography were more common where education was community-based, utilized peer educators, or developed a buddy system for health promotion (Hurdle, 2001). It was also suggested that women’s family members and friends were generally the *preferred* social networks and ultimate sources of support and had the greatest impact on the utilization of preventive

health behaviours (Hurdle, 2001). These are all examples of effective use of social networks and social support to promote women's health behaviours.

Social support and women's health behaviours were assessed in a review that highlighted three independently conducted qualitative studies that evaluated the effect and importance of social networks where women turn for support and advice in times of need when dealing with devastating health decisions, such as prenatal genetic screening, hormone replacement therapy, and breast cancer treatment (Brown et al., 2002). Interviews were conducted with focus groups of women who were in their mid-50s and younger, who had experienced a moment when an important health related decision had to be made for prenatal genetic screening, hormone replacement therapy, or use of alternative medicine for treating breast cancer. The information derived from the interviews suggested that the main support person was the mother in particular, but that women's social support networks also included partners, friends, and other family members (Brown et al., 2002). These support networks were influential in helping the women to make significant decisions about their health and also suggest that decision-making among women is a relational process.

Brown et al. (2002) articulate that someone who is familiar, such as a mother, can help to inform women in a way that enables them to make the most appropriate health decisions. This influence factor is also found in other relationships where women turn for support. It seems possible that many women find a strong attachment within their female friendships that could be considered just as strong as the attachment that they have with their mothers because both friendships and mother-to-daughter relationships are trusting female-to-female relationships that women utilize for support. Just as Hurdle (2001)

describes, relationships are significant to women of all ages and at all developmental stages and are a “primary motivation that determines cognition, affect, and behaviour” (p. 74). Therefore, just as some women share private information and receive advice from their mothers that influence their decision-making (Brown et al., 2002), it is also possible that women could obtain this type of influence from a close female friend.

It can be inferred that the review by Brown et al. (2002) and the discussion article by Hurdle (2001) suggest aspects of both social networks and social support that are significant to the focus of this study. The concept of social network could be viewed as the classification of the relationship among friends (or mother and daughter), whereas the idea of social support could be viewed as what these young women receive after this social network, or friendship has been developed.

Friendship Development

The developmental progress and age group of a woman may be relevant to how decisions are influenced and by whom. It can affect who is sought for advice and with whom the most significant relationships are developed. Thus, it is relevant to this study to discuss the significance of developmental theories among different life stages.

In their discussion of Erik Erikson’s stages of development, Papalia and Olds (1992) suggest that the young adult, between 20 to 40 years of age, “needs and wants intimacy” (p. 398). The young adult in Erikson’s theory is described as wanting to find satisfying relationships that tend to be closer in nature than the adolescent’s relationships, where the most significant relationships are often established with marital partners (or relationship partners) and close friends (Papalia & Olds, 1992). This notion of significance and seeking advice for self-development is common among this age group

and is fundamental to understanding the basis for why a relationship or friendship may or may not have an impact on decision-making.

Erikson's theory of development, as discussed by Papalia and Olds (1992) for late adulthood, over 40 years of age, suggested that at this stage, the primary focus is not to establish close friendships because there is already confidence in oneself and the status of the pre-existing friendships and relationships. There is also a lack of desire to seek advice through friendships because of the developed confidence in one's own knowledge and decision-making. This could be a difference between young women and older women regarding influence among friends, since young adults particularly value friendships, especially during a time when they are becoming or have developed their own personhood.

The young adult finds importance in attempting to establish social ties and bonds that are more characteristic to this age group than to the older adult (Papalia & Olds, 1992) and it is possible that these bonds can be associated with more healthy habits. These bonds that develop within friendships can contribute to engagement in more healthy behaviours, as discussed by Papalia and Olds (1992), such as "sleeping and eating sensibly, getting enough exercise, avoiding substance abuse, and getting medical care" (p. 423). This may be a form of positive influence that female friendships could have on young women's decision-making.

A study by Aries and Johnson (1983) suggests that friendship is an important vehicle for the discussion of worries, uncertainties, and private issues among women. Through use of a questionnaire, they examined the types of same-sex friendships noted among adults and identified issues and topics that were more likely to be discussed in

conversation among male and female same-sex friends. Female same-sex friends more frequently discuss issues of a personal nature than do male same-sex friends and approximately 94% of the women who participated in their study had previously discussed their worries, uncertainties, and private issues with a same-sex friend (Aries & Johnson, 1983).

Each age group has different developmental milestones that affect friendships and relationships differently. The effects of friendship pertaining to influence on decision-making and health behaviours will likely differ between the young adult age group and other age groups. For example, the potentially strong influence factor of friendships during the age group of focus for this study is different from the less significant focus on friendships within an older age group. There is limited research related to the effects of friendship on the decisions that young adult women make about health behaviours, such as whether or not to practice the breast self-exam. Thus, it is valuable to study the influence of close female friendships on the decisions regarding health behaviours among young women.

Characteristics of Friendship

Friendships share a common commitment to good. They influence us as human beings to want to do what our friends are doing and to be where our friends are, whether it is to find the support and information to promote a positive behaviour such as physical activity (Bidonde et al., 2009; Coleman, Cox, & Roker, 2008; Finnerty, Reeves, Dabinett, Jeanes & Vogele, 2010) or to be influenced by our peer groups to 'fit in' by adopting substance use behaviours (Ali & Dwyer, 2010; Bot et al., 2005; Fagan, Eisenberg,

Stoddard, Frazier, & Sorensen, 2001; Gaughan, 2006; Urberg, Luo, Pilgrim & Degirmencioglu, (2003)).

As we grow through childhood and adolescence, we search for certain qualities in our friends that we desire, through “social selection” (Mercken et al., 2007) and these qualities cause our friendships to grow stronger and develop into trusting relationships where we feel safe or where we adopt the behaviours of that friend and make them our own (Mercken et al., 2007). The idea of feeling safe within our friendships can relate to a model developed by Bartholomew and Horowitz (1991) that describes adult attachment in relationships based on a positive or negative image of the self and of others. The four dimensions of this model include: “1) Secure – Comfortable with intimacy and autonomy; 2) Preoccupied – Preoccupied with relationships; 3) Dismissing – Dismissing of intimacy, counter-dependent; and 4) Fearful – Fearful of intimacy, socially avoidant” (p. 227). It is possible that the dimension of “secure” could be seen as a desired personal quality that may be sought in a friendship where a young woman feels secure about herself and about her friend. This may enable her to feel willing and comfortable to share and discuss personal information that would otherwise be kept private.

In regards to this study, it was speculated that if friends enjoy one another’s company and feel comfortable around one another, they would be more likely to disclose their health concerns. Being able to disclose information to seek advice and support would provide a ‘use’ for that friendship and their common commitment to good would relate to the concern for their friend’s health and the desire to assist with important decision-making.

The importance of friendship and social support networks regarding influence on health behaviours has been explored in a number of studies. Bidonde, Goodwin, and Drinkwater (2009) and Bot, Engels, Knibbe, and Meeus (2005) discuss the importance of friendship and social networks and how they influence health behaviours. They consider the significance of a friendship on the decision to participate or not in preventive health behaviours.

The study by Bidonde et al. (2009) explored the importance of social networks for older women and the influence on physical activity. The results of their study suggested that the friendships made in a fitness group between older women who had been widowed or divorced, improved their well-being and influenced them to keep returning to the group to improve their physical fitness and to sustain their social connections (Bidonde et al., 2009). Bot et al. (2005) explored the influence of friendships on adolescents' drinking behaviour. The results of their study suggested that if an adolescent's best friend drank alcohol excessively, the adolescent would be more likely to engage in this type of drinking as well. Conversely, if a best friend did not drink, then an adolescent was less likely to engage in excessive drinking (Bot et al., 2005). Although they did not focus on young adult women, these studies demonstrate the potential for the importance of friendship and possibility for influence on health behaviours in general.

Studies that investigate women's friendships in the adolescent and older adult years (Bidonde et al., 2009; Coleman et al., 2008) are educative and informative, since there are similarities between how young adults, adolescents, and older adults view friendship. It is important to note that developmental differences in these three age groups account for possible differences in values, interests, and attributes among relationships.

This could determine a different view on friendships and their impact towards influence on decisions.

All of these articles have a diverse focus on the promotion of different health behaviours, but the underlying concept still remains the same throughout, in that women are influenced when they seek support for decision-making about behaviours that affect their own personal health.

Summary

The topic of the breast self-exam and the influence from young women's friendships is a significant and important area to research, because there is limited evidence regarding how the breast self-exam is viewed or practiced among young women. Statistics Canada, the Canadian Institute of Health Research (CIHR), the Public Health Agency of Canada (PHAC), and the Canadian Cancer Society, for example, do not have any statistics on the number of women who perform the breast self-exam and the frequency that the technique is performed. It is therefore, currently unknown as to how many young women participate in early breast cancer detection practices. While statistics regarding the utilization of the breast self-exam and the factors that are increasing the morbidity rates of breast cancer are not known, targeting and increasing awareness of a health promoting behaviour that detects the presence of the disease at an early stage is a fundamental starting point to potentially enable young women to become cognisant of resources available to them. Even if a young woman decides that she does not want to practice the breast self-exam, awareness of this tool as well as its benefits and possible harms promotes an informed decision.

The breast self-exam, like physical activity, substance use avoidance, and smoking cessation, is a beneficial health practice that will assist to achieve overall good health. Review of the literature on friendship and health promoting behaviours suggest that the relationship between friendships among young women and the breast self-exam has limited research. If other health behaviours can be influenced by friendships and social support groups then it seems plausible to presume that the performance of the breast self-exam would be as well.

Chapter 2: Methodology

Background and Definition of Grounded Theory

While grounded theory, originally developed by Glaser and Strauss, served as the methodological foundation for this study, there are differing perspectives on its function. Glaser claimed that a grounded theory study can have a product that is “an empirically grounded hypothesis” that becomes “tested and verified with further data” (Hallberg, 2006, p.143). Strauss believed “that an empirically grounded theory is both generated and verified in the data” (Hallberg, 2006, p. 143). Following this discrepancy, Glaser and Strauss later separated. Glaser’s idea was considered to be “the classic grounded theory” (p. 144) where everything is considered to be data (Hallberg, 2006). Strauss’ theory on the methodology was later combined with Corbin and together they created “the reformulated grounded theory” (p. 145) where they suggested “that reality cannot always be fully known, but can always be interpreted” (Strauss & Corbin, 1990, as cited in Hallberg, 2006, p. 145) and through analysis, reality can be constructed (Hallberg, 2006).

Corbin and Strauss emphasize the importance of listening to the voices of participants, an approach that Hallberg (2006) considers “more open and reflexive” (p. 147) than that of Glaser’s. This view of the grounded theory methodology falls within the interpretive paradigm/ontology that Guba and Lincoln (2004) describe as “critical realism” (p. 25), where “reality is assumed to exist but to be only imperfectly apprehendable because of basically flawed human intellectual mechanisms and the fundamentally intractable nature of phenomena” (p. 25). This again relates to how Strauss defined grounded theory, in that the formulated theory is both “generated and verified in the data” (Hallberg, 2006, p. 143). The construction of reality is reflected in the idea that

the theory is generated and verified in the data by knowing that the reality and theory already exists but is not fully known. It is up to the researcher to discover it and interpret it to make sense within the research and specific to the study being conducted. For the purposes of this study, the reality of decision-making and the influence of female friendships are assumed to reside within the experiences of young women and so the reformulated grounded theory approach of Strauss and Corbin guided this study.

Research Design

The goal of grounded theory is “to develop a well-integrated set of concepts that provide a thorough theoretical explanation of social phenomena under study” (Corbin & Strauss, 1990, p. 5). The overall goal of this study was to develop a substantive theory, defined by Charmaz (2006) as a “theoretical interpretation or explanation of a delimited problem in a particular area” (p. 189). A grounded theory should be “a reasonably accurate statement of the matters studied” (p. 224) and the emerging theory should be a representative example of what the researcher knows about their own data (Glaser & Strauss, 1967).

Grounded theory, or the “reformulated grounded theory”, is an appropriate methodology for this research because of its emphasis on openness, reflexivity, and the importance of listening to the voices of the participants within the research. Openness and listening to the voices of participants is important in this study, because the study attempts to understand why or why not young women are practicing or discussing the breast self-exam. While many other qualitative research methods also focus on openness and listening to the voices of the participants, what sets grounded theory apart from other methods and makes it appropriate for this study is the “systematic, yet flexible guidelines

for collecting and analyzing qualitative data to construct theories ‘grounded’ in the data themselves” (Charmaz, 2006, p. 2). This structure assisted in determining for this study, if there was a common factor grounded in the data, such as young women’s friendships, that influenced whether or not they would discuss or practice the breast self-exam. This was particularly significant, because of the limited understanding and research regarding this topic.

Symbolic Interactionism

Grounded theory has its origins in the interpretive tradition of symbolic interactionism (Guba & Lincoln, 2004). Symbolic interactionism is both a theory about the behaviour of humans and also inquires about the way humans conduct themselves through interactions and relationships (Charmaz, 2006). Symbolic interactionism rests on three fundamental principles:

(1) Human beings act toward things on the basis of the meanings that the things have for them; (2) The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows; and (3) Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meaning as social products, as creations that are formed in and through the defining activities of people as they interact (Blumer, 1969, pp.1-5).

This study is also situated within the processes of human behaviour in the social context of female friendships and within the discussion, usage, and knowledge of the breast self-exam, such as its benefits and harms. Using inquiry from the interpretive perspective, from my view, was particularly relevant for a study exploring how female friendships may or may not influence how women make decisions to practice the breast

self-exam. This perspective allows for meaning and interpretations of these women's thoughts, experiences, preconceptions, values, and notions about their health, their bodies, and their opinions surrounding aspects of breast cancer and the harms and benefits regarding practice of this early detection technique.

Research Context and Procedures

Ethics and Confidentiality

For this study, six women in their 20s and 30s were engaged through conversational interviews where their views and thoughts regarding the breast self-exam were recorded and transcribed. Through the informed consent, participants learned about the purpose, procedures, and potential risks of this research and participants were not pressured to solicit participation. Participants were informed that they could change their minds regarding participation in the study at any time, without consequences to themselves and were also advised as to whom they could contact by phone or by email if they had any questions or concerns about the study. All of the participants received a copy of their signed consent.

Confidentiality was ensured by not labelling the transcripts or other pieces of information with the participants' real names or other possible personal identifiers. A number was used to identify participants in correlation with their transcripts. Numbers were also used during the analysis that represented the conversation number on the audiotapes in correlation to the hardcopy versions of the transcribed data. Anonymity was maintained by giving each participant a pseudonym (fictitious name) that was used when quoting participants in the Findings chapter of this thesis. The pseudonyms were picked at random and do not represent the backgrounds, ethnicities, cultures, or similarities to

the real names or participants, in order to identify the participants without revealing personally identifying information. No identifying information will be used in any publications of the study findings.

Consent forms (see Appendix A) and audio-recordings were secured in a locked filing cabinet at my home during the analysis stages and will continue to be kept in this filing cabinet, where no one has access to it besides me. Emails from the follow-up conversations were printed without any identifiers and the electronic version was deleted. Transcripts and other data collected over the study period were kept in a password-protected computer at my home, during completion of this thesis. This information will be kept in the locked filing cabinet and password-protected computer at my home upon successful completion of the master's program and will be destroyed after five years.

The study protocol was submitted to the Research Ethics Board (REB) at Brock University and approved prior to commencement of this study.

Data Collection

Data were collected through individual face-to-face conversations (and one online conversation), beginning with a semi-structured conversation question guide (see Appendix B). A question guide was prepared to start off the conversations and to provide a range of possible topics (for my own reference) that could arise during each conversation. Questions such as “Do you find your close female friendships to be influential on the decisions you make?” and “Do you speak to your friend about the breast self-exam?” were intended to open up the dialogue regarding the topic of this study. Thorough review of the conversational questions concluded that none appeared to be anxiety provoking for the participants since the conversations were meant to facilitate

discussion and participants could refuse to answer any question that made them uncomfortable.

Other questions evolved and changed as each conversation had been completed and analyzed, in order to follow-up on a concept, topic area, or hunch that had developed or was initiated from a previous conversation. These questions involved topics of privacy, societal norms, sexuality, relationships, reciprocity of information, and female-to-female sharing. Some examples of the questions that evolved included “How do you determine whether information is private or personal?” and “Do you feel that societal norms determine what information is shared and who it’s shared with?”

Five face-to-face conversations, which ranged from 50 minutes to 70 minutes in length and lasted an average of 60 minutes with each of the participants, were conducted between November 2010 and February 2011 (with the sixth conversation taking place in April 2011). Follow-up to the conversations occurred through email because the participants who indicated that they would be available for subsequent contact communicated that the time required for face-to-face conversations was limited. Follow-up questions were conducted through email in March 2011 with three participants.

Data collection proceeded on the basis of theoretical sampling. Theoretical sampling is sampling based on the evolving concepts from the data where the aim is to develop and saturate theoretically relevant categories in terms of their characteristics and variations, and identify relationships, interactions, and consistency between concepts (Corbin & Strauss, 1990). Theoretical sampling involved reviewing existing transcript data following every conversation, going to previous literature and looking into new literature, collecting new data on concepts and theories with subsequent conversations,

and analysing results, hunches, and emerging concepts, such as private matters and negative judgment. This occurred through the follow-up questions with three of the participants and the last conversation in order to strengthen the overall results, conclusions, and grounded theory. Follow-up questions were sent electronically to the participants, and they responded by sending an email back to me with their thoughts and insights. These questions were the same for all three participants (see Appendix C) and were meant to explore emerging and evolving ideas from the initial conversations. These questions fit within the grounded theory methodology because they were asked as a result of previous findings within the initial conversational interviews. These follow-up questions evolved based on what I heard from my participants within the initial conversations.

Some of the follow-up questions included terms such as “judgment” or reference to the “common cold”. These were my own terms that did not originate from the participants. It is possible that my own wording may have impacted the thoughts and responses of my participants; however, through my interpretation of the data, the follow-up questions were specific to areas that emerged as foci of interest in the initial conversations and could not be expanded without specific prompts. For example, within our initial conversation, Jennifer mentioned the idea of being careful about with whom she shares private information.

I think most things that are private or sort of personal in that way, there may be a hesitation [to share] because that information could get misconstrued by somebody and who knows what type of direction they would take it or who they

would talk to. And really if you want to confide in someone, often you or I would say, you're sort of careful about what you might say to certain people.

After I reviewed Jennifer's comment in the transcripts, I interpreted that Jennifer was leading to the idea of being afraid of negative judgment when sharing private information, because of her "careful" nature about only sharing with "certain people" so that information could not become "misconstrued". In the follow-up questions, Jennifer acknowledged the concept of negative judgment by indicating that judgment was a fear that held her back from sharing with just anyone.

To feel relatively free of judgment from sharing personal information, I must have a trusting relationship with the other person. This may be developed through knowing someone over a long period of time or from an intimacy of knowing one another deeply and feeling safe to communicate openly, without fear of judgment. For people I know who I don't consider myself to have this level of trust with, I am highly unlikely to share personal information. This is probably because of fear of being judged negatively.

Based on the information found through the follow-up questions, one last conversation was conducted in April 2011 to finalize and validate the results that had developed from the previous conversations with the previous five participants. The topics discussed in the final conversation with Christine, evolved from my interpretations of the data with the initial five conversations and the three follow-up conversations. These topics included the sexual nature of the breast self-exam, societal norms about sexuality, and judgment regarding sexual topics.

Data collection and analysis were systematic and sequential beginning with data collection, followed by analysis, and then followed by more data collection until the categories had reached saturation. Saturation was determined when no new data was emerging from each new conversation (Charmaz, 2006).

Data Analysis

Grounded theory is a recursive process that uses continuous comparisons, where analysis and data collection is carried out simultaneously (Corbin & Strauss, 1990). The coding process followed methods of open coding outlined by Corbin and Strauss (1990), where the intent is to uncover and identify initial categories, axial coding to advance progress and correlate the categories through definitive properties, and selective coding to assimilate and enhance the theory by locating the commonly recurring theme.

These three coding techniques are not necessarily chronological steps and therefore, they did not occur one after another within the analysis stage. For example, open and axial coding overlapped as categories were identified, developed, and refined, whereas axial and selective coding overlapped as categories were related, refined, and integrated into a recurring theme and an explanatory theory. These coding techniques facilitated the overall analysis and progressed throughout the theorizing and interpreting phases; moving from perusing the data to theoretical description to segmenting the data conceptually, and then to an explanatory theme. Through the grounded theory process, alternating data collection with analysis offers a sense of direction and awareness, promotes greater sensitivity to the data, and enables the researcher to add, eliminate, or revise interview questions as the analysis proceeds (Corbin & Strauss, 1990).

Each transcript was read several times to gain an overall understanding of the content. Lists of common themes, such as ‘fear of being judged negatively’ and ‘sharing of private information’, were developed. This maintained the context of each participant’s description of their feelings, uncertainties, and experiences that became more significant within the coding process.

Questioning became more purposeful with each additional conversation because questions were more focused on relevant concepts as categories were refined. Conceptual leads were investigated in subsequent conversations. For example, the concepts ‘privacy factor’, ‘female comfort’, and ‘judgment’ generated from the initial conversations were more fully investigated by asking the next participant about these concepts, as well as in the follow-up questions with the three initial participants who were willing to participate.

What follows is a detailed description of how the three coding techniques—open, axial, selective—were used for analysis within this study, as well as other tools used to facilitate and illustrate further analysis (e.g., diagramming and memo writing) as outlined for grounded theory analysis.

Open Coding – Identifying Categories

The purpose of open coding was to determine preliminary categories of evidence from the data by separating the information (Creswell, 2005) and then dividing it into categories and subcategories of information that seemed prominent within the data. During open coding, data were fragmented into segments of information (e.g., words, sentences, paragraphs), were compared closely, and were observed for differences as well as similarities (Corbin & Strauss, 1990). Open coding began with the first interview by completing line-by-line analysis. Line-by-line analysis involved highlighting specific

codes, phrases, or words used by the participants (common cold, misconstrued, health scare) and making notes in the margins of the transcript, then followed by coding sentences and paragraphs as a whole. Some initial codes that were identified in the open coding section of the data analysis, included friendship qualities, honesty, time, closeness, life priorities, health scare, private, female relationships, female-to-female comfort, and normal. Coding progressed from categorizing initial codes and recurring patterns to organizing and designating names to categories.

During the analysis, questions were asked regarding the data, in order to facilitate constant comparison and correlations, such as “What makes the description of this experience or these emotions similar or different from previous ones?” For instance, with the code ‘privacy factor’, I questioned: “What does private mean? Why is the breast self-exam considered to be private information? How is the privacy factor distinguished among health information? How do we determine with whom private information is shared? Why is there a need to keep the use of the breast self-exam private? How does one determine what is private and should not be shared?”

Constant comparisons were used to discover variations and general patterns in the data (Corbin & Strauss, 1990). Constant comparisons between conversation transcripts facilitated the grouping of several codes into categories. Creating categories involved considering meanings from the context of the conversations and coding and reflecting on all related data. Incoming data from subsequent conversations were constantly compared with previous conversations and revisions were made to the categories based on these comparisons and reflections. For example, data from the initial conversation revealed hesitation to share private information and this ultimately transformed into a category

entitled *private matters* that will be discussed in more detail in the ‘Findings’ section of this thesis. Categories or concepts are ideas that come directly from the data, providing additional explanation and description (Hallberg, 2006). Category names were based on what represented the experience, thought, or emotion that evolved when examining data comparatively in context of the conversations and within the codes or the participants’ own words. Themes evolved into several different categories by coding text segments relevant to the category, while other, smaller themes pertaining or relating to the category became subcategories. As the process of analysis progressed, each reading of the transcripts became more focused, significant, and specific as data were theoretically sampled into emerging categories. For example, the category *private matters* was identified after the conversation with the second participant, but solidified itself as a main category after it was identified with each subsequent conversation.

Axial Coding – Relating Categories

The purpose of axial coding is to select an open coding category that was formed in the previous phase, label it as the core phenomenon, refine its properties, and then “relate the other categories to it” (Creswell, 2005, p. 398). This core phenomenon and its properties are determined based on what seems to be most prominent among the participants. The other categories are the “factors that influence the core phenomenon; they take an action response to the core phenomenon, specific and general situational factors, and the outcomes” (Creswell, 2005, p. 398). Since the categories influence the core phenomenon, or the category, there is always a direct relationship, described as an action response, between them. This relationship is viewed as the strategy for the purpose of this relationship.

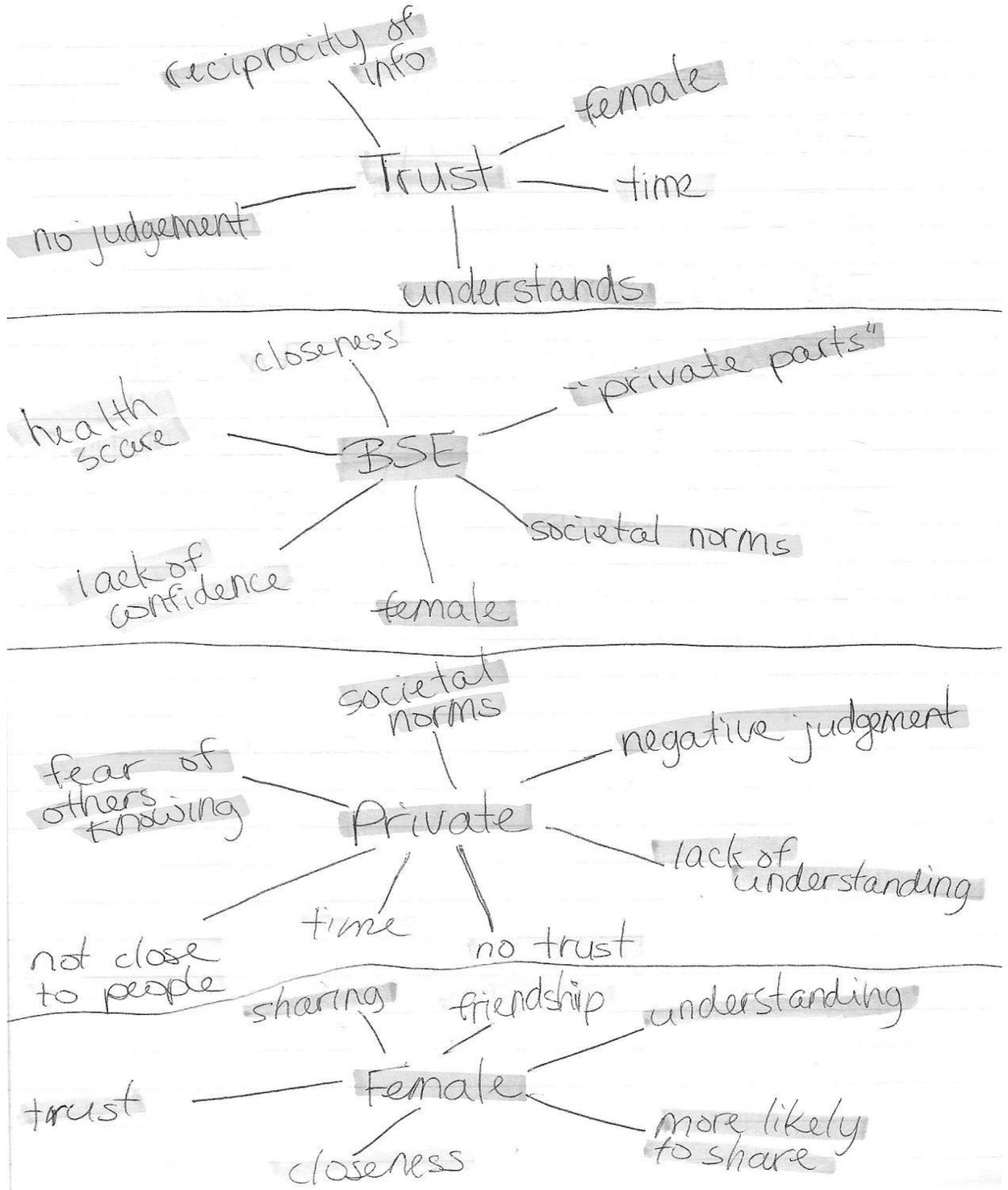
Hypotheses were interpreted from the data and continually revised with incoming data from subsequent conversations and follow-up questions. For instance, an early hypothesis was that the closeness of a female friendship and/or the length of time the friends had been close, determined what type of information a woman would share with that friend and how influential that friend would be on making decisions about women's health issues. This hypothesis was later refined and determined based on the initial categories that were identified in the Open Coding analysis section.

Diagramming

Drawing diagrams was an analytic tool that “can enable you to see the relative power, scope, and direction of the categories in your analysis as well as the connections among them” (Charmaz, 2006, p. 118) and into thinking more abstractly or ‘outside of the box’. For example, one section of the diagram illustrated the concepts that are involved in the category of *female friendship “safe zone”* and how this category determines what information is comfortably shared and with whom the women feel comfortable sharing the information. The entire category diagram provided greater depth and enrichment of the findings. Diagramming facilitated thinking about relationships between categories and how categories were related to one another theoretically (Charmaz, 2006). For instance, placement of lines in a diagram represented thinking about how concepts might be related or from where the concepts are drawn. Sharing my thoughts with my thesis supervisors throughout the analysis process facilitated my hunches regarding relationships among categories and subcategories and was the basis for formulating the diagram. The diagram was hand drawn initially (ultimately translated into

an electronic version) and was a valuable tool in facilitating the data, my thoughts, and memoing into a more abstract and concrete vision (see Figure 2-1).

Figure 2-1 – Preliminary Category Diagrams*



* The concepts and categories in these diagrams do not represent or reflect the end results of this study, but provide an example of what concepts emerged from the data in the preliminary analysis stages and how the categories evolved over time.

Selective Coding – Integrating and Refining the Theory/Centrally Occurring Theme

Selective coding is the process of inter-relating the theories (Creswell, 2005) through techniques such as writing out the data from the interviews that interconnect the categories. Through the practice of collecting data and developing and analysing the theory, five categories and numerous subcategories were identified through systematically integrating concepts through statements of relationship. The first step in integration was deciding on a core category, or a centrally occurring concept. The core category was identified as *exceptional conversation*. The *exceptional conversation* was a recurring theme within the data and fit well as a coherent interpretation and explanation of the purpose of the research. It has power in its ability to encompass the data as a whole, where all other categories and subcategories could be related to it (Corbin & Strauss, 1990).

The *exceptional conversation* was a concept and the core category that consistently emerged in the data that ultimately encompassed all of the categories and sub-categories in this interpretive research. The *exceptional conversation*, or an out of the ordinary conversation, is represented in this thesis as the discussion of the breast self-exam and has the possibility to influence behaviour. Selection of the core category was based on six criteria outlined by Strauss (1987, p. 36):

- (1) all other major categories can be related to it, (2) it must appear frequently in the data, (3) the explanation that evolves by relating the categories is logical and consistent, (4) the phrase or concept used to describe the central category should be sufficiently abstract, (5) as the concept is refined analytically through integration with other concepts, the theory grows in depth and explanatory power,

and (6) the concept is able to explain variation as well as the central idea of the data.

Labelling the core category enabled me to think of the process of how all data is connected and related in some way. Techniques used to facilitate the process of connecting the findings included the line-by-line analysis, coding, diagramming, and memoing.

Reaching Data Saturation

The criteria for deciding when to stop sampling and analyzing is theoretical data saturation—a time in the analysis and development of categories where no new relationships, dimensions, or ideas emerge (Creswell, 2005). The concern is with representativeness of concepts and how concepts vary within the data. The decision that saturation had been reached was based on the research questions having been answered. The data (results) from the final conversation and the follow-up questions tie together to form a relevant and substantive grounded theory.

Memoing

Memo writing is an essential tool that provides researchers with an ongoing dialogue with themselves about the emerging theory (Charmaz, 2006). Through memoing, I was able to review thoughts throughout the entire data collection and analysis period, emerging concepts and ideas and explore hunches (Charmaz, 2006). The memoing process allowed me to be open about any values, preconceptions, or experiences that I had in relation to my research and it helped me to identify any biases and determine my own values, beliefs, and experiences that could have interfered with the data collection. For example, earlier in the study, I discussed my discomfort in

sharing my views about the breast self-exam with my friends. As a result, would I expect others to have the same reservations and reasons for not sharing? It is also significant to note that I fit within the inclusion criteria that I have designated for the participants to partake in my study and it is therefore expected that I would have similar thoughts and experiences as the participants. Memoing allowed for identification of these experiences and reflection of how they could have influenced my data.

Writing my own memos on themes emerging from the data and reflecting on how codes were being developed into categories advanced my analytical thinking as I began asking theoretical questions of the data and how everything was tying together. For example, a memo that was developed after the first conversation touched upon the idea of privacy in relation to the breast self-exam and the basis for why it is not commonly discussed in everyday conversations, even among close female friends. This memo allowed me to explore this concept further in my conversation with the next participant and moved into the development of societal norms and hidden sexuality for a partial explanation as to why women do not always feel comfortable sharing health information or participation in health practices. Though descriptive initially, these memos became more conceptual, concrete, and abstract as I learned more about each of the categories. For example, memoing in the open coding stage reflected the idea that female friendships do sometimes influence a woman's decision to discuss the breast self-exam (or engage in discussion regarding other preventive/early detection health practices). There was still curiosity as to why most of the participants did not currently discuss the breast self-exam with their female friends and why many of them did not feel that practicing the breast self-exam was a priority at this stage in their life.

A reflexive journal was maintained in a book separate from the memos and contained entries about my thoughts and feelings about the research process (e.g., thoughts about analysis, how I might be influencing interpretation of data based on my own experiences, feelings, and thoughts, and knowledge and interpretation of current and past literature). I also was able to discuss my memos with my supervisors and that enabled a safe space for different views, opinions, and suggestions to be brought forth.

Sample and Recruitment Procedure

Women who were invited to participate in the study were those who were in the age range of 20s and 30s and who were willing to provide written informed consent. Recruitment involved flyers posted at Brock University. The flyer was displayed on message boards throughout Brock University and was also given to friends, family members, and colleagues to distribute (see Appendix D). The desire for available and willing participants was also expressed through word of mouth by friends, family members, and colleagues because the processes in decision-making related to the breast self-exam are not limited to a student population. As each participant contacted me regarding their interest in the study, a copy of the consent form was sent through email so that they could read over the purpose of the study in further detail, along with the benefits and risks of participating before they fully committed to taking part in a conversation.

Women who met the study inclusion criteria, volunteered, and consented to participate, were invited to participate in a one-to-one conversation. The specific age of participants was not of concern to the study, but rather whether they belonged within the specified age range and were a representative sample of young women. Although all but one participant attended Brock University during their participation period, being a

student at Brock University was not an inclusion criterion for the study and participants outside of the Brock University student population were also invited to participate in the study.

Once the young women responded back to me that they were still interested in being a part of the study, I offered to conduct the conversational interview at a day and time of their convenience. Dates and times were arranged with each confirmed participant for an individual conversation that took place between November 2010 and April 2011.

Conversations occurred in a private study room on campus, due to the nature of the topics being discussed and the availability of an empty room. The conversation with the participant who did not reside in Ontario occurred through a private internet conversation as a back and forth exchange, using online instant messaging that was transferred to a computer document and then printed without any personal identifiers. The intent of privacy was to assist participants to feel safe and to be open, without the worry that someone else could hear our discussion or recognize that they were study participants.

The follow-up questions and the one instant messaging conversation were consistent with the aim of the study to respect the privacy of the participants. Since they were not face-to-face, these conversations could be viewed differently from the first four (and final) conversation that were face-to-face and allowed me to observe non-verbal behaviours; however, the electronic conversations were also respectful of privacy and may have allowed a freedom of expression that may not have been possible in face-to-face interaction.

Overall, a total of six young women participated in the study. Those who participated in the study were asked if they would like to review the transcript after it was completed, the analysis section in the thesis, and the final copy of the completed thesis. Every participant declined reading of the transcript after it was completed, but did wish to read and have access to the entire thesis upon completion. Participants were asked where they would like to receive this information and provided me with an email address where they could be contacted. The participants made no contact to me or my supervisors following completion of the data collection stage, regarding any questions or concerns.

The Participants

Melanie

Melanie is in her late 20s; she is married and is a university student. During our conversation, she shared that she has two, close female friends with whom she feels comfortable discussing private information. One friend was identified as living close by; someone she met at school. The other friend lives far away and is someone she has known for quite some time. She identified some key friendship qualities among her friends as being honest, kind, realistic, friendly, compassionate, and someone who does not gossip.

Melanie performs the breast self-exam very rarely because she is not concerned about the risk of developing breast cancer at this stage in her life. She feels that the importance of practicing it will grow as she becomes older and is more aware of the risks and how they may affect her. Melanie found out that one of her close friends does perform the breast self-exam when she approached her friend for advice because Melanie

thought she had found a lump in her own breast. Her friend was very supportive towards her and encouraged her to see her doctor to check the lump.

Melanie believes that information is private when it is risky to one's health and involves sexual matters. She also believes that people only talk about the breast self-exam and share other private issues when they have a concern and need advice. Melanie discussed the fact that she would be more vigilant with practicing the breast self-exam if someone close to her were to be diagnosed with breast cancer.

Jennifer

Jennifer is in her 30s, she is single, she does not have any siblings, and she is working while also attending university. During our conversation, she equated her closest female friendships with the length of time that she had known each friend. Her closest friends live in other provinces and countries, but she feels that the distance has not affected the closeness of the friendships because of the strong background and foundation that she has shared and built. Jennifer identifies some key friendship qualities among her closest friend as being similar experiences, shared interests, and having an ongoing support system.

Jennifer occasionally performs the breast self-exam but feels that there is less focus on it within society today than there used to be a few years ago. While she has concern that there should be more focus on the importance of knowing one's own body, she does not know if any of her friends practice the breast self-exam because she generally does not discuss private health issues with her friends unless someone is worried about something or had a concern. She stated that the breast self-exam is a

“funny topic for conversation” and would generally not bring it up without a need or reason to do so.

Jennifer strongly believes that society and societal norms shape our views and beliefs in terms of what we discuss, with whom we discuss it, and why. She believes that health issues become private when someone worries that information may get “misconstrued” or misinterpreted during conversations and this can then lead to hesitation to share private information with others.

Jennifer spoke very highly of her friendships and believes that everyone is influenced by their friends in some way or another, but good, close friendships should only influence someone in a positive way and feels that she would take health information and advice from a close friend.

Stacey

Stacey is in her 20s, she is in a long-term relationship, engaged, and is currently a university student. She revealed that her closest female friend is currently and has generally been her younger sister because she is in the process of mending a friendship with an old friend with whom she used to be very close when she was in high school. She identified key friendship qualities for her as being smart, motivated, professional, and educated.

Stacey was very open during our conversation and stated that while there are certain issues that she does think are private and would not want to share with others, such as family and financial issues, her health is something that she would openly discuss with almost anyone.

When asked about the breast self-exam, Stacey acknowledged that she currently practices the breast self-exam and believes it is an important tool for women to get to know their bodies. She knows that her sister performed the breast self-exam at one point, because she informed her sister of the positive effects of knowing her own body. She believes, however, that her sister no longer practices the breast self-exam because her sister feels she is too young to develop breast cancer and she does not take an active role in living a healthy lifestyle.

Stacey discusses the breast self-exam and other preventive/early detection techniques with not only her sister, but also her fiancé, other close friends, and even acquaintances, on a regular basis in hopes that they will recognize the importance of practicing significant health behaviours as well. Her health interests come from wanting to live a healthy lifestyle and encouraging others to do so as well.

Stacey stated that she can be influenced very easily by people because that is her personality and feels that she does not influence others very much, despite always having her friends' best interests in mind. While she revealed that her lack of strength can cause negative influence on her at times, when it comes to her health she is very actively involved and only partakes in activities and behaviours that affect her positively.

Melissa

Melissa is in her early 20s, she is in a new relationship, and is a university student. She has one particular female friend from school with whom she is very close and identified key friendship qualities as being non-judgmental, comfortable, honest, and supportive.

Melissa confided in her close female friend about a specific aspect of her personal health when she needed advice and support regarding a health scare. She expressed that this information became private when she felt that telling people other than her close friend could lead to judgment from others. As a result of the supportiveness of her friend during this situation, Melissa has developed greater trust in her friend and reveals that she would feel more comfortable sharing private information in the future because she knows she will not be judged negatively or be gossiped about behind her back.

During our conversation, Melissa stated that she had never performed the breast self-exam and did not know if her close friend did either. She never really thought about practicing it and she did not feel comfortable speaking to her doctor about, as her doctor does not come across as a nice person. She said that while her mother and sister live nearby, she does not feel a sufficient closeness or comfort level with them to discuss something related to her health.

Melissa stated that the breast self-exam has never come up in conversation with her friend in the past, but she would feel comfortable discussing information regarding the breast self-exam in the future if she was ever curious about it or if she needed her friend's advice again because of the positive experience she had when sharing other private health information.

Melissa believes that if her friend did practice the breast self-exam and discussed the importance of it with her, she would take the advice of trying it, knowing that her friend would only support her best interests and would not discuss anything with someone else.

Sarah

Sarah is in her mid-30s; she is married, and has a full-time career. She does not live in Ontario and has close friends all over the country. She feels that distance and age do not matter when it comes to closeness of a friendship, because her closest friends live out of province, range in age (up to 12 years younger than her) and yet they all keep in touch on a regular basis through phone, texting, and emails. She described significant friendship qualities as being truthful, easy to talk to, and having good listening skills, and similar interests.

Sarah shared that she used to practice the breast self-exam on a regular basis when she was younger and found out that her university roommate had detected lumps in her breasts by practicing the breast self-exam. This influenced her to want to perform it more regularly in case she was to develop any lumps as well. She eventually fell out of the habit of performing the technique and revealed that she now only performs it on rare occasions and does not even feel confident with her technique.

Sarah does see the significance in practicing the breast self-exam and thinks that she will most likely practice it more as she gets older and feels that she is more at risk. She does not discuss this technique with any of her close friends and is therefore unaware if any of them practice it themselves. She stated that they regularly discuss other women's health issues, such as their yearly physicals, their menstrual cycles, mental health issues, and pregnancy, and so she is unsure as to why the breast self-exam has never come up in conversation.

Sarah believes that if her friends expressed that they practiced the breast self-exam on a regular basis and felt that it was extremely significant, she would feel

influenced to begin practicing it again and she believes that her friends would be influenced by her as well if she expressed that it was something they should be doing.

Christine

Christine is in her early 20s and she is a university student. She identified her closest female friend as someone from her hometown who she has known since high school. She identified key friendship qualities as being trustworthy, genuine, caring, easy to talk to, not interested in gossiping, and non-judgmental.

She expressed that she shares all of her health issues with her friend because she seeks her advice before she would go and see her doctor. She feels that there is a comfort level for sharing private information with her because of the fact that they are both women and they are both the same age so Christine thinks that there is a better understanding of what a woman may go through at that age, as opposed to someone who is older.

Christine believes that people see sexual information and issues related to our breasts to be private because everyone has different views about sex in terms of what is appropriate, what is involved, and what is normal. She feels that when someone has a different view, judgment occurs and it is generally negative. Christine stated that she would consider information as private if she thinks someone is likely to judge her negatively about something that she shares. Further, she emphasized that she would only share information with someone that she trusted to not share the information with anyone else.

Christine revealed that she has never performed the breast self-exam. She does not know what to look for or how to perform it and does not know if her friend performs it

because they have never discussed it before, as it has never come up in conversation. She believes that it has never come up in conversation because she does not know a lot about it. She stated that she would be willing to talk to her friend about the breast self-exam, as well as her mother because she is female.

Trustworthiness of Findings

Credibility

Credibility indicates that findings are trustworthy and believable, that they accurately represent the data and describe the data being studied (Charmaz, 2006). In this grounded theory study, credibility was commonly demonstrated with the use of the data analysis process of the constant comparative method. The aspects of data collection and analysis were interrelated processes that continued until each category was saturated and continued to verify the data.

Meeting with my supervisors throughout the data collection and analysis period also enhanced credibility. I consulted with my supervisors to discuss my conversational interviewing technique and to review emerging codes, concepts, categories, and diagrams that emerged in the preliminary stages of data analysis (see Figure 5-1). For example, I showed my supervisors excerpts of the transcript data, related coding and analytic categories as they were developed and refined, and shared my interpretations and reflections about the data and they responded by offering validation or suggestions about the categories and emerging theory.

Transferability

The population in this study was women in their 20s and 30s who identified as having at least one close, female friend. All of the women who participated in this study

resided in Canada; five out of the six women resided in Ontario and more specifically, attended Brock University for post-secondary studies. The homogeneity of the population in this study may limit transferability because of a wider variation in beliefs and values in more diverse populations. Since the theory was derived from one substantive area, it is narrower in scope and abstraction than formal theories and limits its applicability. “Most grounded theories are substantive theories because they address delimited problems in specific substantive areas” (Charmaz, 2006, p. 8).

The theory was applicable to the young women who participated in this study. It is the judgment of the individual as to whether this theory is relevant and applicable in another context or to another group of young women who have different backgrounds, values, beliefs, and life experiences. Lincoln and Guba (1985) contended that advancing hypotheses, together with a detailed description of the time and context that they were found enables others to make decisions regarding transferability. Thus, it is the responsibility of the investigator to provide the database that makes transferability judgments possible for other investigators.

Detailed description was provided in Chapter Three of the Findings and several quotations from the transcripts were used and is consistent with Charmaz’s contention that “[r]ich data are detailed, focused, and full” (2006, p. 14). In addition, providing sample characteristics and an audit trail of how concepts and categories emerged and evolved over time (i.e., Figures 2-1 and 3-1) should assist the individual in making transferability or applicability judgments to other similar groups. It is likely; however, that experiences, thoughts, and feelings related to the breast self-exam may differ among young women of other cultures, religions, and backgrounds who have different values,

beliefs, and life experiences. Cultural and religious backgrounds were not topics for this study and therefore were not addressed.

Reliability

Reliability was established through an audit trail of detailed records of the research process and product (e.g., data, findings, interpretations). The audit trail included raw data (e.g., interview recordings and transcripts, written field notes), a list of codes, several types of memos (e.g., concepts, hypotheses, categories, and interpretations), and diagrams. It also included a reflexive journal that tracked thoughts about how I might be influencing interpretation of data based on my own thoughts, feelings, values, and experiences.

Chapter 3: Findings

The purpose of this chapter is to highlight the findings and the emerging theory for the reader, by explaining the relationships between the five main categories interpreted from the data and that comprise the theory: *exceptional conversation*, *germinal event*, *female friendship “safe zone”*, *unnecessary conversation*, and *private matters*. This chapter begins with a description of the grounded theory and the associated categories, followed by a detailed depiction of each category and its sub-categories. The chapter concludes with a summary statement to reflect the entire ‘Findings’ section.

Substantive Theory

A “substantive theory must enable the person who uses it to have enough control in everyday situations to make its application worth trying” (Glaser & Strauss, 1967, p. 245). The development of the substantive theory was an interpretive process that involved constructing an explanatory theory from data that systematically integrated various concepts through statements of relationship, a process that has been described previously by Corbin and Strauss, (1990).

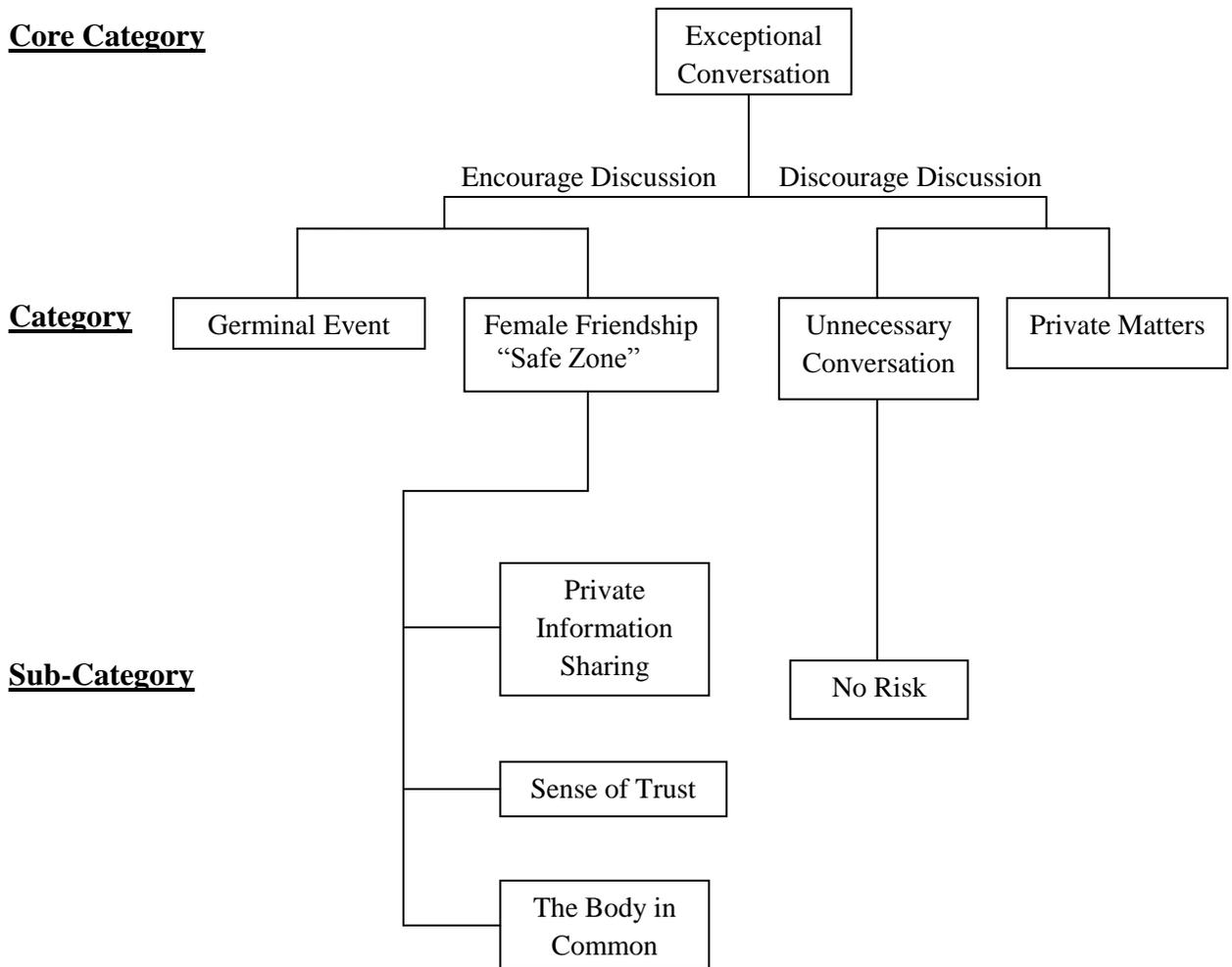
The core category, the four central categories, and the relevant sub-categories are visualized through a category diagram (see Figure 3-1) that summarizes the results of the interpreted data within this study and is a visual description of the substantive theory that has emerged. This diagram is not to be visualized as a hierarchy, where each category builds upon the category below it, but is to be viewed as a “top-to-bottom” diagram, where the top core category of *exceptional conversation* encompasses all of the categories and sub-categories below it. For example, in order for an *exceptional conversation* to occur among friends, the “*safe zone*” must develop or must already be

present within a friendship and without a *germinal event* (i.e., health scare) to promote sharing; the conversation is generally viewed as unnecessary. Similarly, if a *female friendship “safe zone”* is to be developed, the categories of *the body in common*, *sense of trust* and *private information sharing* should be acknowledged as qualities within that friendship to more easily create a safe environment. A category would not be likely to occur without all of the sub-categories that fall below it in the diagram and thus, a core category also would not be likely to occur without all of the relevant categories already present. Therefore, all categories and sub-categories work collaboratively to take action and fulfill the core category and act out the grounded theory.

The core category, *exceptional conversation* represents discussion about the breast self-exam and for young women, seldom occurs. When this conversation does occur, it is generally within extraordinary circumstances and under certain conditions. These circumstances and conditions are captured under the categories of having *the body in common*, feeling a *sense of trust*, and *private information sharing* within a “safe zone” among friends. Since the *exceptional conversation* is viewed as out of the ordinary, all of the other categories within the diagram should be present in order to increase the likelihood that the *exceptional conversation* will occur. These other categories include *germinal event*, *female friendship “safe zone”*, and the sub-categories of *private information sharing*, *sense of trust*, and *the body in common*. If the *exceptional conversation* does take place, it has the opportunity to influence awareness and practice of the breast self-exam among young adult, female friends. Since the *exceptional conversation* involves other factors that facilitate its occurrence or factors that ‘encourage discussion’, there are also other factors involved for the conversation not to occur or

factors that ‘discourage discussion’. The factors that ‘discourage discussion’ include the categories of *private matters* and *unnecessary conversation* and the sub-category of *no risk*.

Figure 3-1 – Category Diagram



Categories that Discourage Discussion

Private Matters

Private matters represents the idea that information surrounding the breast self-exam, women's breasts, and topics surrounding a woman's body, in general, are private. Many factors have shaped this idea of what is *private*, and these factors include social norms, sexuality, what is appropriate to be discussed in public, a feeling of dirtiness or shame, and the idea of women's breasts always being hidden from view. These factors and feelings that associate the breast self-exam with being private discourage discussion of the breast self-exam within close friendships because they make women feel that having a discussion about the exam is not allowed or is not normal. This further discourages the *exceptional conversation* of this topic among female friends.

Unnecessary Conversation

The category of the *unnecessary conversation* includes topics such as the breast self-exam, breast cancer, and women's breasts. These topics are deemed as 'unnecessary' or 'unimportant' because the young women who participated in this study felt that they were not at risk for developing breast cancer and had not discussed the topics of breast cancer or the breast self-exam with their female friends. Similar to the category of *private matters*, this category also discourages the *exceptional conversation* from occurring. When a young woman does not see herself as being at risk for something such as breast cancer, she is less likely to engage in discussion regarding preventive or early detection measures, such as the breast self-exam.

Categories that Encourage Discussion

Female Friendship “Safe Zone”

The category of *female friendship “safe zone”* represents a safe environment where young women can feel comfortable and willing to share private information, such as their views regarding the breast self-exam for early detection. The sub-categories that fall under *female friendship “safe zone”* in the diagram (Figure 3-1) determine the development or presence of the “*safe zone*” among close female friends. These sub-categories include developing a *sense of trust* through *private information sharing* and the development or awareness of a connection that occurs when both friends share *the body in common*. Having *the body in common* can enable comfort because the women know that each of them understands the physical, emotional and health issues that are particular to women.

Once the “*safe zone*” has developed or has been identified as existing among close friends, it supports an environment that facilitates the ability to share *private matters* within that friendship and ultimately encourages the *exceptional conversation* to occur.

Germinal Event

The category of *germinal event* represents an occurrence that produces or triggers another event to occur. From the participants within this study, the *germinal event* was commonly described as a ‘health scare’ or inferred as a particular circumstance where a prompt to seek help, medical care or advice had transpired. An event or circumstance such as a scare or a prompt does not always occur and does not always motivate someone to engage in discussion about behaviour, but it does support this likelihood.

From the descriptions of the participants within this study, the *germinal event* was often what initiated the sharing of private information because it introduced a topic that normally may not have been shared in an everyday conversation. The occurrence of the *germinal event* could lead to the *exceptional conversation*.

Description of the Categories

Private Matters

Private matters is a category identified through the interpretation and analysis of the research conversations with each participant. This category encompasses many recurring themes and patterns within the conversational interviews and articulates why the breast self-exam is considered to be private and why it is not freely discussed in public and among friends. The category also articulates other factors that are commonly associated with privacy, such as social norms, social media, sexuality, and negative judgment. For the purpose of this study, the terms *private* and *personal* were used interchangeably among the participants and represent the same meaning for all of the young women.

Data from within this study suggest that *private matters* are topics that are not readily shared with the public and are not considered to be open topics. The participants in this study suggested that they would only share *private matters* with those they consider to be close. According to the participants, women's breasts and the breast self-exam could be considered examples of *private matters* and therefore, would be discussed in discretion with others.

Because you are talking about your boobs you would normally talk to a friend one on one. It's an area of the body that we call a private area, and therefore everything in relation to those areas seems private. (Sarah)

I think we, as women, don't often talk about our breasts as commonly as other body parts. They are always hidden from view, considered "private parts" from our first experiences with the word in elementary school and I guess, somewhat because of this, they are not as easy to discuss as a broken leg or common cold. (Jennifer)

As noted by Sarah and Jennifer, when relating privacy to topics such as women's breasts, each individual determines her own idea of what is private and how she believes that others perceive the same topic. In my discussion with Christine, she shared her perceptions of how she believes others view women's breasts and how they relate to privacy, although she suggested that she does not necessarily share this viewpoint.

It [the breast self-exam] could be considered private because anything relating to breasts is often considered private, but I wouldn't consider it private.

For some of the participants, knowing *what* is considered to be private and knowing *why* something is considered to be private do not always go hand-in-hand. The topics of women's breasts, the breast self-exam, and breast health are private in nature. This may limit their discussion and thus, the possible influences from friendships. As private health issues, breasts and breast health were not discussed as openly with friends as other health issues, such as a broken leg as Jennifer suggested or, as Sarah suggests, Fibromyalgia.

You may tell all your friends on Facebook that you have Fibromyalgia, which I do, but you would not necessarily broadcast that you have a yeast infection.

A yeast infection is likely to be kept private because it commonly involves one of the “private parts” of women’s bodies and just as Christine and Sarah mentioned, anything related to the private areas of the body is generally considered private as well. Since Sarah did not feel able to openly discuss having a yeast infection, it could be inferred that she would be unlikely to openly discuss matters related to her breasts as well, at least not on Facebook.

Some of the participants in this study had views on *what* is considered to be private information and with *whom* they prefer to share information. Jennifer and Stacey discussed their views on what type of information they considered to be private and how this could affect what they would or would not share.

Personal information, to me, would cover quite a lot I think. Anything that I wouldn’t want to be public knowledge; even within my own friends...I would likely choose not to share something if this information could potentially show me reflected in a bad light. (Jennifer)

I would say family matters and financial problems should not just be shared with anyone. I’ve determined these as private since it would allow others to view your family as flawed. (Stacey)

From the conversations with both Jennifer and Stacey, it could be inferred that they fear negative opinions of others and this ultimately affects their decision to disclose private information. “Privacy is sometimes necessary to protect people’s interests...in other cases someone may want to keep some aspect of his life or behaviour private simply because it would be embarrassing for other people to know about it” (Rachels, 1975, p. 323). This resonates with Stacey’s comment about controlling *what* is shared and with *whom* it is

shared, regarding certain family and financial issues that she prefers to keep private from others.

For Melissa, sharing information is perhaps defined by the significance of the information and its implications for those who share and those who know, as well as *why* something may be considered to be private.

My mom just, I would feel uncomfortable, like I wouldn't want to talk to her about stuff [women's health issues] like that. It would just be an awkward conversation and she would just bother me about it after and nag me, so I would feel much more comfortable talking to my friend about it.

As the quotations demonstrate, the idea of privacy was described differently by each participant. Some may feel comfortable to share certain pieces of information that others may not feel comfortable to share. This can depend upon the nature of what each person considers as private. For example, Jennifer expressed that anything that she would not want to be public knowledge is personal, whereas Stacey felt comfortable to share health information but kept family and financial issues private.

With the participants in this study, the circle of disclosure for sharing information varied from person-to-person. Some shared with only one friend, some shared with more than one friend, and others shared with partners or family members. Jennifer mentioned a particular friend with whom she would be most likely to discuss the breast self-exam and described the comfort she felt when someone had a similar background.

The person I would most likely to speak about this with would be a friend of mine who is an only child and I'm also an only child and I'm just thinking if I wonder

if maybe some of these issues you might be more likely to speak to a sibling, if you had an older sister or something instead of some of your friends.

Stacey described her openness to share private information with almost anyone, but generally with her fiancé in particular.

I could tell you everything [other than financial matters], so I'm pretty open with everyone...I talk to my fiancé about everything. We both talk a lot and are very open and I teach my fiancé everything I learn.

Sarah mentioned the impact and influence that social media has on decisions regarding *what* to share openly about personal health and privacy. She highlighted the potential of social media to affect privacy when she mentioned the idea of Facebook and how this channel of social media affects what she decides to share online. Her concern was specific to the number of people who may see something that she considers private and would not want others to know.

I tend to assume that personal equals private and therefore I would not blindly share these things on a Facebook status, where everyone can read it. I would instead send a message or text to a friend privately, or call them on the phone.

The issue of how many people with whom information is shared and with whom the information is shared in particular, as well as the avenue information is shared (e.g. face-to-face or social media), has been challenged by today's focus on technology. While social media was not a recurring theme in the conversations with the participants in my study, it is relevant when discussing the idea of privacy and *how* that information is shared. Social media widens and expands the distribution of messages and statements and thus, creates increased concerns regarding privacy. The potential and intense lack of

privacy in social media results in questions about what should not be shared openly with everyone, just as Sarah expressed in regards to posting private information in a Facebook status. If someone worried about others knowing their views and practice of the breast self-exam because the technique relates to private body parts, it may then be a concern as to whether or not this type of information would be shared on an internet site and who would be permitted to see the information. This perhaps reflects why Sarah felt that posting specific, more private, health information on her Facebook status, such as having a yeast infection was not a great decision and could presume that other young women feel the same way.

The idea of privacy in terms of *what* is shared and *why* it is shared was expressed by some of the participants as a reason to not discuss certain issues openly among friends. Another factor that was discussed among some of the participants as an inhibitor to the discussion or practice of the breast self-exam was social norms. In reference to Jennifer and Stacey, it could be inferred that norms were represented as ideas that shape societal views and often determine what information is appropriate to share and what information should be kept private.

From a young age, we are exposed to many societal norms that will likely form our future assumptions and perceptions regarding both how to talk about more concrete things like our bodies, health, and wellness, but also the importance of social dynamics and learn early how difficult but important it can be to be able to keep certain things secret... These norms right or wrong are followed as young people attempt to fit in with social groups. (Jennifer)

Perhaps people go along with it [social norms] to fit in or be what society believes is normal. Some social norms can be determined by religion, culture, and upbringing. (Stacey)

Jennifer discussed the idea of being exposed to societal norms at a young age and how these norms shape us as we grow. Stacey suggested a similar view about our upbringing where we follow social norms to try and fit in and that some of these norms can be predetermined based on our religion or culture that we are also generally exposed to initially when we are young. These norms shape us as we grow and shape what we think is private or not.

Sarah alluded to the idea that discussing women's private matters on Facebook is possibly too obvious and too exposed for society to handle and stated, "I think society is not ready for women to 'air their dirty laundry' in so blatant a fashion." Her view could be interpreted to mean that sharing information through social media outlets, such as Facebook, tends to reach more people than sharing one-on-one in a face-to-face conversation. As well, social media users often connect with acquaintances or people that they barely know and this could regard information to be "blatant", as Sarah expressed or viewed as an 'overshare'. The association with sexuality can make the breast self-exam seem like an uncomfortable topic and could lead women to feel as though they are oversharing *private matters* by choosing to discuss these matters in a public way. The association to sexuality and the connection to Sarah's comment also reflect the idea that privacy is not just in reference information sharing, but it is also closely associated with behaviours and feelings.

The concern that there is discomfort discussing sexuality or that society should not be privy to a woman's sexuality suggests that the young women in this study have a connection to what society thinks and how it determines what they feel able to discuss and what they feel society is not ready to hear. By talking about such issues, women might worry that sharing something that is important to them, such as concerns about their breast health, may be negative, unwanted, and even shameful or dirty, such as Sarah's connection of "dirty laundry" to sharing that someone has a yeast infection. This thought seemed to resonate from social norms and views from others about what is appropriate to share and what is not.

When something becomes public knowledge and is linked to sexuality or private matters, judgment from others, whether negative or positive, seems often to be present. For many of these young women, breasts and sexuality as public knowledge would be judged negatively and this negative judgment is what they fear, as Stacey and Christine expressed through terms, such as "uncomfortable" and "self-conscious".

Judgment seems like a negative connotation. If I believe people will judge me harshly, I would keep things to myself. Being judged or believing people are judging me makes me very uncomfortable and self-conscious. (Stacey)

Breasts are associated with sexuality and sometimes people aren't comfortable talking about their sexuality. (Christine)

Stacey and Christine expressed that it was difficult or uncomfortable for them to discuss private information specific to women's health because of the sexual connotation and judgment that tends to correspond to this topic in society. This societal association between women's breasts and sexuality could be the reason that some of these women

felt unable to discuss the breast self-exam or anything related to their breasts in public. This lack of discussion in public could explain why Jennifer, Christine, and Melissa expressed that the topic of the breast self-exam had not generally come up in conversation with their close female friends. Although the breast self-exam was not brought up in conversation, Sarah articulated how she might feel comfortable around some friends rather than others if sexually-laden topics did arise in conversation.

Some of my other friends I would probably not feel comfortable telling them about issues with my sex life that may be health related.

It seemed possible that the development of discomfort arose from the judgment associated with sexuality when discussing topics related to the female body that could reduce regular discussion of these topic areas. A lack of regular discussion of private health topics among close friends could be an example of women making a decision that they are expected to make. Whether they realize it or not, lack of engagement in discussion is a passive decision that might not reflect an emancipated decision. An emancipated decision is a freely made choice that should reflect a person's knowledge, values and beliefs towards an issue and should not be pre-determined through a lack of information (Wittmann-Price & Bhattacharya, 2008). In this study, the decision to not discuss private health matters developed as an expectation from society because of the uneasiness that private health matters cause when they are brought into conversation. If the young women feel this similar uneasiness from society and choose to not discuss private health matters, they are passively deciding against the breast self-exam without considering the options that the breast self-exam offers.

Concepts that seemed to emphasize the uneasiness of the discussion of the breast self-exam and women's breasts were related to sexuality and were discussed throughout some of the conversations with the participants. The relation of sexuality to women's private parts seemed to negatively affect the young women's open discussion of the breast self-exam and might have undetermined their emancipated decision-making through not feeling able to discuss these topics. They mentioned concepts of shame and feeling inappropriate when relating the idea of sexuality to women's breasts.

Attitudes might even stem back to school when you're a young kid and you're in sex-ed class and someone says penis and everybody's like "oh, so funny!" I guess just sort of a bit of a sense of, I don't know if its shame or maybe a sense of being guarded about those [sexual] topics that it's something that's polite to talk about or common to talk about. (Jennifer)

It's considered inappropriate for women to show their breasts in public, so that may relate to why it is inappropriate to talk about breasts openly. (Christine)

Since the discussion of private parts in general can be deemed as inappropriate at times, this could perhaps be linked to the negativity that is associated with these private areas of the body.

Some women within Kearney's (2006) study also discussed "the shame and concealment associated with the breastfeeding breast, a stark contrast to the open display of the sexual breast" (p. 815). Perhaps women's health issues related to women's private parts, such as breastfeeding and the breast self-exam are kept hidden because of their lack of emphasis on sexuality. Since the sexual breast was seen to be freely displayed and the breastfeeding breast was commonly concealed, it makes the discussion of the breast and

the breast self-exam, other than for sexual purposes, difficult because it counters societal views of women and breasts.

A focus on societal views was a theme within the television series, *Sex and the City*. It became a top-watched television series from 1998 to 2004 (Markle, 2008) and followed the lives of four women in their 30s and 40s as they developed strong friendships and journeyed through self-discovery, in New York City. It yielded extensive scrutiny and focus because of the concentration on women's sexuality and the overtness and explicitness of its content (Markle, 2008). When describing the show, some would say that *Sex and the City* had challenged "commonly held cultural beliefs about what constitutes appropriate sexual desires and behaviours for women" (Markle, 2008, p. 45).

What is interesting about *Sex and the City* is that it focused on the idea that each of the four women had different ideals than what were expected from societal norms and that the women did not want to conform to the expectations of society. They were opposed to settling down in a marriage with just any man, to not achieving the best they could be in their careers, and they were opposed to being treated like *women*, in terms of being judged negatively by society because of the decisions they made and the behaviours they enacted.

The ideas that came from the show *Sex and the City* regarding societal norms, double standards, and inner thoughts and feelings about negative judgment from society are examples that provide similarities to the views expressed by the participants in my study. As articulated in previous quotations, some of the participants also quarrelled with societal views, as well as with the burden of unwanted negative judgment.

Yes indeed [societal norms determine what information is shared]. Perhaps this is why gay people have a hard time telling the world that they are gay. (Stacey)

This fear of negative judgment could ultimately impact what each woman decided to discuss or not to discuss, even with close, female friends. This does not make it easy for young women to engage in discussion about their bodies if they have learned something different growing up, without the fear of a sexual connotation, followed by negative judgment and unwarranted views.

Negative judgment and unwarranted views are ideas that have commonly been held within society regarding women's sexuality and were explored within *Sex and the City*. The very first episode of *Sex and the City* explored the idea of "women having sex like men" (Star & Seidelman, 1998). The women in the show determined that "having sex like a man" is to have sex with many partners and not have any feelings afterwards, such as attachment or commitment (Star & Seidelman, 1998). Men would be 'slapped on their backs' and congratulated for acting in such a manner, while women would be judged and portrayed in a negative light. Even though the women wanted to be treated like men and chased after the idea of banishing this double-standard societal norm, each character still had her insecurities about being judged negatively by society. These inner thoughts and feelings were so powerful, that they all ended up 'conforming' by the end of the series, each in a happily committed relationship with one man, while throwing away their fears of expressing their feelings and emotions, and of becoming too attached. Pender, Murdaugh & Parsons (2011) suggest that "interpersonal influences involving behaviours, beliefs, or attitudes of others" (p. 48), such as those inferred by the participants in my study, are powerful influences on health behaviours.

Within this study, the tendency to view breasts as private limited discussion of breast-related matters and thus, may have restricted sharing of information and concerns related to breast health, even among close friends. This internalized perception of negativity from society may offer an explanation as to why these young women did not discuss the breast self-exam amongst themselves and why they felt afraid to discuss anything considered to be private.

Unnecessary Conversation

The category of *unnecessary* or *unimportant conversation* was interpreted as a recurring theme within the data, because the discussion of the breast self-exam was not a topic that came up in everyday conversation. Even though the breast self-exam can be seen as significant to some, for a young woman in her 20s or 30s, it is not an issue that is generally discussed in everyday conversation.

For some of the participants, breast health was not a topic that was commonly introduced by their health professionals. Without a sense of ‘permission’ to talk about it in conversation, it seemed that some of the women would keep quiet until they felt a *need* to discuss their breasts or until someone else started a conversation—often a rare occurrence. Jennifer mentioned that the breast self-exam would be more likely to come up if there were a concern; otherwise it was unlikely to be discussed.

I feel like it might possibly come up if someone was concerned from something they found or just concerned in any way about that process. But it’s not something I have discussed before.

Christine shared her lack of discussion about the breast self-exam with her close friend, “No we have never talked about it, probably because it has never come up.” Further,

Jennifer expressed the idea that she did not commonly discuss the breast self-exam with others, mainly her family members, and this made it seem even less significant. She also discussed why there might be a hesitation to share information.

I've never thought about the idea of talking about breast self-exam without any, "like hey, did you do that this month?!" Um, yeah it just seems kind of like a funny topic for conversation.

The unnecessary conversation represents topics that generally do not come up in everyday conversation, and for the purposes of this study, involve women's breasts and the breast self-exam. If the breast self-exam continues to be seen as unnecessary, uncommon and not important enough to be discussed even among women, they will not evolve into topics that are included in everyday conversations, where women feel comfortable to seek information and advice. More significantly for young women, the lack of emphasis on these topics could make them less aware of the information that is pertinent to them, at their age and life stage, and this continues to understate the risks for breast cancer.

No Risk

There are many reasons as to why breast health is not an everyday conversation, why young women might not discuss the breast self-exam with their close female friends and why they may or may not be practicing this early detection technique on a regular basis (if at all). What seemed apparent in the conversations with some of the participants was the uncertainty about breast self-examination and breast awareness. For example, Melissa and Melanie expressed their lack of confidence in the technique and Christine expressed her lack of knowledge and limited information.

Yeah, I figure, I would hope that I would notice if something was abnormal but I would not know how specifically to check. (Melissa)

I just don't know exactly what to look for and something that might feel like a lump might just be a duct of some sort and that was the case before and I don't think I would detect lumps as well as my doctor would. (Melanie)

I haven't heard very much about the topic. (Christine)

Awareness of risk factors for breast cancer and the benefits of the breast self-exam could vary from person-to-person, especially because it is a private issue that tends to not be discussed with just anyone. If it is not brought up in conversation, the young women might feel that it may not be important to them or that no one else is practicing the technique.

Five of the young women who participated in this study did not regularly practice the breast self-exam at the time of the research conversations, or discuss the technique with their close friends because they did not feel they were at risk for breast cancer at their age. Some of the women expressed reasons for not examining their breasts, such as underestimating their risk for breast cancer, uncertainty of the technique, and not having a reason to do it. As Kearney (2006) describes in her study, "a woman who is making the decision whether to do [the breast self-exam] is negotiating through a web of meanings associated with individual responsibility for a disease she knows is both not well understood and lethal" (p. 817). The complexity of decision-making and the meaning around breast cancer is reflected in the conversations with Melanie and Sarah, whose apparent lack of concern could represent negotiation within themselves in regards to the

severity of breast cancer and determining *if* and *when* it would be appropriate to make the decision to perform the breast self-exam.

It's something that I do very rarely, just because I'm not that concerned about the health risks. Maybe in the future I'll be doing that a little bit more, but I do breast exams, every once in a while, yes. (Melanie)

It is probably something I should be doing especially as I get older. So yes I see an importance in it. (Sarah)

During our conversations, Melissa stated that she had never performed the breast self-exam, but when she was asked if she thought it was a beneficial technique, she stated "I'm sure it is, but I don't know enough about it to actually do it."

According to the Breast Self-Examination Practice Model (BSEPM), "a woman's readiness to practice the breast self-exam is determined by a) her perceived susceptibility to breast cancer and perceived seriousness of the consequences of breast cancer, and b) her perceptions of the benefits and barriers to the breast self-exam" (Rutledge, 1987, p117). Since some of the participants have expressed their lack of risk for breast cancer at their age (*perceived susceptibility*) and the lack of confidence in practicing the breast self-exam (*barrier*), the findings from my study are supportive of the BSEPM and why my participants would not feel a need to discuss the breast self-exam among their close friends or be aware of any risk factors associated to their age group.

A study by Bowen, Alfano, McGregor, and Anderson (2004), suggested that while perceived risk is not necessarily a reason for women to practice the breast self-exam, worrying about cancer development and anxiety in general were both possible predictors for breast self-examination performance. For the young women in this study,

anxiety about breast health and cancer was minimal or absent perhaps because of a perception that they were not at risk for developing cancer; hence, similarly to the findings from Bowen et al. (2004), motivation to discuss breast health or to perform breast self-examination was low.

Many factors contributed to why the young women in this study felt they were not at risk for developing breast cancer during their current stage of life. If they did not feel they were at risk for breast cancer, then they did not have a need for early detection. This ultimately determined whether they believed it was important for them to discuss or practice the breast self-exam. Since the main reason for the young women in this study to believe they had *no risk* for developing breast cancer were their age and life stage, it could be presumed that other women of the same age may have similar views. Overall, this presumed belief from young women does not enable women to share information about health behaviours that they do not feel are needed and does not motivate them to make their own decisions regarding the breast self-exam.

Female Friendship “Safe Zone”

Many factors contribute to the development or presence of the *safe zone* among friends, since not all female friendships are considered close enough to share all types of information. Factors described by the participants as significant to determine friendship closeness included the same gender, similar age or life stage, and the length of time that two people have been friends.

The idea of feeling close to a friend and feeling safe to share specific information in a close female friendship as opposed to within a relationship with a parent or someone of the opposite gender was a recurring theme in the conversations with the participants.

I would share my health issues with my friend before sharing it with my parents...I think I am more comfortable talking to her about it because she is the same age as me...If the health issue was something to do with sex I would probably talk to my friend because she knows details about my personal life, but if it was a health issue about anything else I would talk to my parents about it. My friend knew details about my sex life with my boyfriend and therefore I wouldn't have to explain it to her again when explaining my problem. If I went to my parents first, they would likely have a whole bunch of questions about my sex life, and not about the problem itself. (Christine)

There are some things that you can talk to a girl about that you could never say to a guy; they just understand better. The person I go to talk to about everything would be like a girl over a guy. I just trust her more than anything...girls have such complete different relationships than guys do. (Melissa)

Christine discussed how she was more comfortable sharing health issues with her friend than with her parents and Melissa explained the difference between speaking to a girl and speaking to a guy. Both women touched upon the idea that a more appropriate understanding would be received from their female friend than from their parents or a male partner, demonstrating that the type of the relationship as well as the age or life stage and gender of the person receiving the information are the key factors.

These close relationships that develop with friends, as discussed by Christine and Melissa, can be seen as a “*safe zone*”, where the friendship becomes closer and feels safer because of the degree of the elements of information that have been shared. Some of the participants suggested that the comfort in sharing information with their female

friends allowed for a stronger understanding of the topic, feelings, and emotions. Through conversations with Christine and Melissa, this is what seemed to develop trust in their friends and enabled them to feel safe with sharing private information.

For Jennifer, the idea of time, as described in terms of how long a person has been considered to be a close friend, seemed to be much more significant for development of a close friendship as opposed to where friends reside and how often they are able to see each other or speak to one another.

I would say certainly friends that I have had for a long time, say over 5-10 years, um, it's a lot easier even if they're far away or if we don't talk even for a period of a few months, to know that you're still friends and you'll catch up at some point when life gets less hectic or when they come to visit or that sort of thing.

(Jennifer)

Rachels (1975) suggested that people divulge more about themselves to those perceived as close, in order to enable a type of relationship that is more connected than what would be developed with someone not as close. Therefore, friends who do not share intimate information would not develop a *safe zone* among each other and are likely not as close as a friendship where both people would feel able to divulge private information with one another (Rachels, 1975).

Once these factors, such as time, being the same gender, and being of similar age or life stage are present and the "*safe zone*" among friends is developed or acknowledged as already existing, women feel more comfortable sharing certain types of information and develop an even stronger connection through sharing, as Rachels (1975) described. This element of feeling able to share specific information with friends could then develop

a stronger sense of trust in that friendship and is an element of significance, as expressed by the participants.

Sense of Trust

The topic of trust was mentioned during some of the participants' conversations as being a significant quality among close friendships. Trust may develop over time, as Melanie mentioned, or through understanding, as mentioned by Melissa, but ultimately facilitated sharing and sharing enabled the *sense of trust* to grow stronger.

The one that I've known for a longer period of time, um, I trust her more and I'm completely open with her and she's never turned on me in any possible way. So I'm quite confident about being in a close friendship with her. (Melanie)

I've never really had a close friend like that, someone who understands me. That and just that I can trust her. There are a lot of girls that are not nice and she's not like that and so I really like that about her. I know that if I ever needed anything she would do what she can for me. (Melissa)

There is a common expectation that information should be kept within the "*safe zone*" due to trust that has been developed within that friendship. The sense of trust implies that private information should not be shared with others, unless permission has been given. When discussing their close female friends, some of the participants suggested that trust was a very important quality that they would look for in a friend. For example, Christine spoke of her close friend and suggested that

She can better relate to the topic than I feel my parents may be able to...if I could trust them I would share personal information.

While Christine discussed having trust in her close friend, Melanie discussed being able to trust her friend's advice to seek the knowledge and professionalism of her doctor to give her the right information.

When I had my concern that I thought I had a lump, that's when I called her [my friend] and she said to go see the doctor because she does it [the breast self-exam] as well.

Christine and Melanie suggested that the *sense of trust* developed through the ability to share private information by feeling safe and understood. Christine felt safe to share personal information with her friend because she believed her friend could understand her better than her parents could, whereas Melanie felt trust in her friend because she gave her the right advice about speaking with her doctor and feel the ability to share private information. Sarah and Jennifer discussed the idea that they would only share private information with someone whom they trusted, but did not need to specify a certain type of person, because a number of relationships can develop trust.

I won't share personal or private information with someone if I didn't trust them in the first place. (Sarah)

To some extent I will worry about this [sharing private information] in every case. However, I think that I require myself to have a great deal of trust with another person in order to share personal information with them in the first place.

(Jennifer)

A desired factor in adult relationships is the idea of trust and the confidence level that one might feel in a partner or friend to consider one's needs and wants (Mikulincer, 1998). Friends who can identify a secure friendship generally experience higher aspects of trust

(Mikulincer, 1998). What Christine, Sarah, and Melanie shared demonstrates examples of the concept discussed by Welch and Houser (2010), that trustworthiness enables us to engage in the risk of sharing private information and the hope to enhance the relationship with a positive outcome. In regards to the fear of negative judgment, Jennifer described that unless she has developed a *sense of trust* with the person, she is not likely to share certain pieces of information.

To feel relatively free of judgment from sharing personal information, I must have a trusting relationship with the other person. This may be developed through knowing someone over a long period of time or from an intimacy of knowing one another deeply and feeling safe to communicate openly, without fear of judgment. For people I know who I don't consider myself to have this level of trust with, I am highly unlikely to share personal information. This is probably because of fear of being judged negatively.

When Melissa had her health scare, she described how her friendship became closer with the friend with whom she shared private information because of what developed afterward and how her friend had demonstrated trustworthiness.

I didn't expect her to be like that. Like I feel bad but I really didn't expect her to be so great about everything and it just kind of showed me that like you know it doesn't matter what I do. She won't hate me or think I'm stupid. It just showed me that.

Differences in disclosing private information may differ with the type of relationship and the amount of trust that has developed (Welch & Houser, 2010). This resonates from the data when Melissa, Christine, and Melanie described being more at ease to share with

their close female friends, as opposed to parents, or other family members. In the study, they previously discussed with whom they would share private information and revealed that trust is a factor for sharing. Determining with whom they would prefer to share information indicates *who* they believe is trustworthy.

I very much know what my parents think about sex and everything. I don't know what she [my sister] feels about it and I don't want to say anything about myself that like, I don't know, like she makes me feel dumb. Like that's the difference between my friend and my sister, she's not scared to be like, you're an idiot. So that's why I just wouldn't tell her anything because I know that she'd think I'm an idiot. (Melissa)

I don't feel comfortable sharing with my parents because I worry they may get mad at me for having sex instead of accepting that I have sex and helping me with my concern. My friend knows about my life and we have the same beliefs therefore I know that if I tell her she will give me advice without getting mad at me. (Christine)

I wouldn't call my mom it was very private. Any sexual things I would not call her for that, I would call my friends. If it was minor like headaches or blurry vision or not private in that sense and nature then I would call my mom and get her opinion on those health issues. (Melanie)

Melissa determined that her friend was more understanding and less judgmental than her sister and that made her friend more trustworthy than her sister when Melissa chose to disclose certain information. Christine and Melanie differentiate between the relationships they have with their parents and the relationship with their friends and it can

be inferred that age and the type of relationship that someone shares with another person are common factors to consider when they choose to disclose information.

While the participants in this study discussed the idea that private and sexual information is shared selectively with certain people, it is possible that trustworthiness regarding the idea of sharing personal issues could be expected in a close friendship. In a friendship, the *sense of trust* has most likely already been developed through factors such as someone's age and how strongly they understand certain issues, as opposed to a relationship with a family member such as parents or siblings where the relationship may not reflect the same sense of trust if there have been past issues that arose through sharing information.

The Body in Common

Having *the body in common* or women's "private parts" and the health issues specific to these parts and women in general, seemed to be areas of comfort for these young women and emerged as a regularly recurring sub-category interpreted within the data. The close female friend may or may not have had similar experiences but there is the idea that she can comprehend what her female friend may be going through because they share the same gender and body parts and through these shared experiences and *body in common* promotes credibility that her friend's advice and knowledge is accurate.

The study by Borrayo and Jenkins (2001), refers to *the body in common* as the "female commonality" (p. 544) and describes it as a unique attachment that a woman feels to another woman because sharing the same body can allow for similar experiences. Christine revealed a thought similar to that of Borrayo and Jenkins when she articulated

why she would be more likely to discuss the breast self-exam with her mother as opposed to her father.

I'm comfortable with my dad and wouldn't have a problem discussing it [the breast self-exam] with him, but my mom can relate to it better and would be more interested in hearing about it.

Many factors are common among women, and some are unique to each person. This idea of the bond between women and female friendships in particular—sharing the same gender, body parts, and experiences—can be described through the narrations of the television show *Sex and the City*, just as with the category of *private matters*. For example, the women on *Sex and the City* discussed many issues related to women's health, such as breast cancer, menopause, menstruation, and pregnancy and these discussions generally did not include their partners or male friends. One episode depicted Carrie trying to determine if she would like to have children someday. She was in a relatively new relationship at the time with her much older boyfriend and she was afraid to mention the topic of having children with him, because she did not know how he would react. She told her girlfriends that she did not know what she wanted and therefore did not want to even consider mentioning this type of topic with her boyfriend. She could not fathom the idea of speaking to him about it because of what he might say, despite being able to talk about it with her female friends (Star & Engler, 2004).

This female comfort is an important factor to note because the participants in my study also expressed that their comfort level for sharing specific information was highest with their close friends who were women. This idea of relying on a woman, as opposed to a man, to give support and advice represents the comfort and familiarity that can most

effectively be achieved through the body in common, whether it is that of a close friend or of an acquaintance. Sarah and Melanie described the differences between sharing with their husbands and sharing with a female.

Well I know my husband tries to give me advice and help me with issues but he is more of a fixer than a listener. Whereas my female friends listen, think about what I have to say and give appropriate advice if required or needed. Or sometimes they just listen to me vent whereas my husband gets annoyed. (Sarah)

I don't know why but personal, I wouldn't want my husband to know, like not to upset him in a way if there was something I should be worried about and in another way I don't think he can render a lot of information about topics that I'm concerned about because he's not female. (Melanie)

Even though Stacey's sister could represent a relationship that is different from a friendship, she feels the same towards her sister as she would a friend, and demonstrates that *the body in common* does not just pertain to friends, but also to other females such as family members. Sarah and Melanie expressed the closeness that they felt with their partners, but despite the close relationship they may have, sharing information with a male (such as a husband or boyfriend) would never produce the same understanding as sharing with another female. Certain issues that are not common to women and men are better understood by those who can potentially encounter similar experiences.

Health issues such as arthritis and myocardial infarctions are common in men and women, but breasts are only common to women. Having this significant part of the body in common allows women to share this physical understanding with one another, just as

Stacey expressed when she described the difference between the common cold and the breast self-exam.

The common cold, anyone and everyone can get whereas the breast self-exam is shared among only women.

Having *the body in common* can allow women to connect with one another in ways that are important to them and that only they could understand. This understanding develops through shared experiences and it provides a sense of community among women. It could open the possibility for more comfortable and common discussion about topics women's health related topics, such as the breast self-exam, if an understanding and *sense of trust* can develop.

Germinal Event

Within this study, the category of *germinal event* came to be defined as an event that produces or triggers another event to occur. The germinal event is often what initiates the sharing of private information, because it brings up a topic that may not normally be shared in everyday conversation. The *germinal event* was described as a "health scare" by some of the participants, and for Melissa it followed a night of drinking.

I had a little worry one time, I was drunk and was stupid and I wanted to go to the clinic and make sure everything was good. Nothing really bad happened and I brought my friend with me...I was worried that she'd be like, you're an idiot, what are you doing, but actually she wasn't at all. She was like, ok I'll pick you up, we'll go, don't worry about it. So she came and was really good about it...I really didn't expect her to be so great about everything and it just kind of showed

me that like you know it doesn't matter what I do. She won't hate me or think I'm stupid. It just showed me that.

Melanie experienced a situation that had a similar result to that of Melissa, where a specific event happened that lead her to one of her close female friends for advice regarding private health information.

I think at one point I did a breast exam and I thought I had a lump but it wasn't. I didn't know what it was...She recommended that I go to my doctor. She said, well I'm not really sure what to look for because I never had that, anything like that before. You should get it checked out. So I did and it was nothing.

Here, Melanie and Melissa had unfamiliar and frightening experiences that warranted advice from someone with whom they felt close; someone they could trust. For some of the participants, a *germinal event*, such as health scare initiated a reason for them to turn to their friends for advice. In a time of need, they felt that their friend would be the most relatable and most trustworthy person with whom to share information.

Jennifer, who had not experienced a health scare, thought that a concern related to her breasts, such as finding a lump, would initiate discussion of the breast self-exam with her close female friend, if it were to happen in the future. She discussed the impact of such event on the topic of breast self-exam.

I feel like it might possibly come up if someone was concerned from something they found or just concerned in any way about that process. But it's not something I have discussed before...I guess it's something to do with the way we view maybe health or healthcare. You know, we tend to go to the doctor when something's wrong, not to just to say "hi, everything's great!" I think it's sort of a

larger societal view that medicine is there to help, you know to tell you this is really a concern or this is not a concern and you don't need to worry about it if you're worried. (Jennifer)

Society may wonder why there is a need for a health scare to occur in order for young women to even decide to discuss the breast self-exam with one another, even though it could be beneficial to their health. Some of the participants felt the same way. They described such event as advice that they received from their family doctor to practice the breast self-exam. Melanie articulated a situation when her family doctor recommended that she perform the breast self-exam. Even though she still relies on her doctor to check for her, it was this instance where she saw the importance and expressed the benefit of seeing her doctor because she felt comfortable that the detection would be accurate.

She recommended it and she said every once in a while when you're in the shower or when you have the opportunity to do one, it doesn't have to be every week or every month, but just whenever I think about it. Then I mostly rely on the doctor performing it yearly, just because I'm more confident in her ability to detect it.

Sarah also mentioned that her doctor initiated the moment when she first started practicing the breast self-exam.

I think it was in my 20s after I moved to Calgary and my doctor there showed me how and that I should be doing it in between yearly physicals.

The *germinal event*, whether it is a scary circumstance that affects our health or someone encouraging self-awareness in regards to the importance of health, it can provide the nudge that women need to decide to share information or seek medical advice. When they

share with the right person, it is possible that their fears will subside with a positive outcome and they will be more likely to share private information in the future. The *germinal event* may be the only possible prompt that leads to the *exceptional conversation* of the breast self-exam.

Exceptional Conversation

The *exceptional conversation* represents the discussion of the breast self-exam among close female friends. It is considered *exceptional* because it reflects the notion that this conversation does not happen regularly, or is out of the ordinary, and that it takes special circumstances, such as a *germinal event*, a “*safe zone*”, a *sense of trust*, and having *the body in common*, for it to take place.

As noted from the descriptions of the other categories, the young women from this study admitted that they do not discuss the breast self-exam with their female friends. When asked why, they are uncertain, but state that it generally does not come up in ‘everyday conversation’. This lack of appearance in everyday conversation could be attributed to many reasons, such as the connection of the breast self-exam to a private area of the body, social norms determining what should be discussed or not discussed, and even the fear of being judged negatively by those with whom information is shared.

This is the core category that was interpreted through the data and encompassed a relationship between the other categories that recurred throughout each conversation.

Summary

The original purpose of this study was to explore the influence of female friendships on the practice of the breast self-exam. In looking at the substantive theory represented by the category diagram and its description, as well as the detailed data from

the participants, the categories interpreted within this study suggest that women find significance and comfort in sharing private information with other women. They also feel a strong influence by societal norms in terms of with whom they share private information. It is possible that close female friends may influence the decision to practice the breast self-exam, but before that decision occurs, there are many factors that influence the decision just to discuss the breast self-exam.

The participants expressed that they respond to societal norms and hence, see the breast self-exam as private, meaning that they feel less comfort in discussing it with non-females or in public. Although these women do feel comfort in sharing private information with their friends who are women and other women whom they trust, in general, there seems to be a fear of judgment that is holding them back from being completely comfortable with this early detection technique. If women feel that they need to keep their practice of the breast self-exam private because they fear that others may judge them negatively, they are less likely to discuss these issues with just any woman and may not even seek assistance if they need it.

This has implications, not only for the breast self-exam, but also for other health behaviours where there is a strong overlay of potential social judgment and concerns about privacy. The categories of *private matters*, *unnecessary conversation*, *female friendship “safe zone”*, and *germinal event* are factors that impact on decisions to share information about topics that are exposed to social censure and judgment. Such topics are limited in their expressions by young women because of the perception that they increase vulnerability within this population through exposure of their views and practices. The effect of the female friendship involves providing safety, comfort, areas of commonality,

and previous private information sharing in order for the exceptional conversation to occur.

The grounded theory can be described through the category diagram (Figure 3-1), where the core category of *exceptional conversation* represents the discussion of the breast self-exam and the categories beneath it represent factors that either encourage or discourage this discussion to occur. Without the other categories and sub-categories, the *exceptional conversation* will not occur. While having the presence of some or all of the categories and sub-categories increases the likelihood that the *exceptional conversation* will occur, there is no certainty that it will occur. Moreover, influence from having a conversation is always likely, but will not happen if the *exceptional conversation* does not transpire.

Chapter 4: Discussion

The complexity of the uncommon topic of the breast self-exam is suggested even in the way that this study evolved. The result was a transformation from a focus on the influence of friendship on breast self-examination *practice*, into a more appropriate focus of examining the influence of friendship on *discussion* of the breast self-exam. The focus of discussion versus practice was discovered as being more appropriate for this study when the conversations began to reveal that the majority of the participants did not currently practice the breast self-exam and had not discussed the breast self-exam with their friends. It was possible that emphasis on the practice of the breast self-exam was too presumptuous because it assumed that the young women in this study had already engaged in conversation about the breast self-exam with their female friends.

Influence may occur within conversations among female friends. Influence on health behaviours can only occur if uncommon topics such as the breast self-exam are actually brought into conversation. Study findings indicated that the *exceptional conversation* among close female friends may or may not influence the decision whether or not to practice this technique, but that the initiation of the conversation is a significant starting point for the possibility of influence to occur. One implication of this study could be to attempt to assist women to become comfortable to engage in what is currently classified as the *exceptional conversation*. This comfort may enable them to discuss their thoughts, values, and fears around private health topics so that they can make a choice that is appropriate for their own health and their own bodies.

The idea of the *exceptional conversation* is not to change the ways of society and make women feel as though they are now required to discuss or practice the breast self-

exam, but to promote awareness of the impact that a lack of open discussion can have on emancipated decision-making around the breast self-exam and other health issues that young women may consider as sensitive or private.

Tannahill (1985) suggests that health promoting behaviours encompass aspects such as education, protection, and prevention. These practices can be identified as beneficial for a population or subset of a population, such as the young women in my study. Health promotion is not meant to pre-determine what is right for every person but is meant to provide awareness and promote options for more informed decisions regarding health issues. Health promotion can involve early detection methods, such as the breast self-exam and can provide awareness of options that may not have been considered previously if they had never been brought up in discussion. For example, without awareness and information sharing, young women may not know the benefits and harms of the breast self-exam and how it may or may not contribute to their health.

Health promotion methods, such as the promotion of the breast self-exam for early detection, cannot be 'free' from pre-conceived notions and values of what is expected within society but involves awareness of what choices are available, as health promoting behaviours are often guided by peers, family, and social norms (Pender, Murdaugh & Parsons, 2011). This awareness may promote young women to engage in the *exceptional conversation* about the breast self-exam or other private health behaviours. Furthermore, awareness can provide young women with the informed knowledge to make emancipated decisions according to their own views and values, with the possibility for some guidance from social or cultural norms.

Transferability to Other Female Populations

The perceptions of the participants were similar to each other and to mine, despite differences in living locations, backgrounds, and life experiences. This suggests that the results of this study could be transferable to other young women who may not reside in the same locations as the participants and me, or who grew up with different life experiences but could also benefit from knowing the results. Women may find value in knowing what other women think and feel regarding discussion of the breast self-exam and may also experience a feeling of discomfort in sharing private information. Women may also benefit from understanding the importance of creating a safe environment with a close friend where they can discuss private health information such as the breast self-exam.

Due to the broad nature of these results, it is possible that women who live anywhere in the world and who are of any background, occupation, and age *may* find insight from the results of this study and develop their own views about *private information sharing*. The results also indicate qualities in a friend that women deem as important within a friendship, such as being trustworthy and non-judgmental. This demonstrates a bond that young women may be able to develop with other women, in order to share private information that they may have previously kept hidden. There is significance to enabling young women to develop a close enough bond with other women in order to share private information without the fear of negative judgment. If a woman cannot share information with someone who shares *the body in common*, with whom would they feel able to share? Promotion of the breast self-exam and comfort level with

its discussion is significant because this is where results on paper can turn into practice and education in reality.

Implications for Practice

The development of an environment where women can feel comfort in sharing their thoughts, views, and insights about private health behaviours is essential. It can enable an informed decision regarding discussion of the breast self-exam and other health behaviours that may be viewed as private. From a health promotion perspective, development of a *female friendship “safe zone”* for discussion should be promoted before women reach their 20s, so that they grow up knowing that it is acceptable to discuss private health concerns with other women. Just as some of the participants in this study mentioned the impact of social norms as we grow up and how they define what is appropriate to discuss or not, promoting awareness of these norms or promoting acceptance of discussion could help women to determine what is right for them, as opposed to what society believes is right for them. As previously discussed, ‘promotion’ is meant to encourage awareness and information-seeking in order to support women to be able to make emancipated decisions at a young age.

The main area for practice implications needs to focus on making young women aware of these cultural and societal views around privacy in order to facilitate the conditions for the *exceptional conversation* to take place. These conditions include feeling safe to share private information, developing trust with those with whom information is being shared, awareness of norms and values that affect decisions, and having the ability to a freely made choice. As noted from the findings within this study, social and cultural norms will always be present and in some way will always influence

beliefs, values, and behaviours. If awareness of these social and cultural norms can help guide health promoting behaviours away from the commonly associated sexual connotations such as with the breast self-exam, in order to facilitate the conditions for the *exceptional conversation*, it can open the possibility for more specific practice implications and interventions to occur.

An example of a practice implication that can promote awareness of social and cultural norms around topics that are sensitive in nature and also facilitate the conditions for health conversations to take place could involve the creation social groups for young women, with the specific purpose of discussing women's health topics. These groups can be created within the school setting where girls can associate with one another in a safe environment and discuss their concerns. For those who want to share information and seek advice but do not feel ready to speak to their friends or to speak publicly about private issues, mentoring programs that promote sharing can be developed for women to discuss their concerns in a private, one-on-one environment. These types of programs may not include all aspects of a "safe zone" because it may take time to develop the *sense of trust* with one another but each student would be able to determine what they feel comfortable sharing as they build a longer and stronger relationship with the mentor or mentee. For example, many post-secondary schools already provide peer-mentoring programs but these programs are generally available to assist students with course work or getting to know the campus and how to become involved in extracurricular activities. *The body in common* could be achieved through female-to-female mentoring, *private information sharing* could occur if the mentor and the mentee disclose private

information to each other and a *sense of trust* could develop over time when information has been shared from both participants.

The decision to practice an early detection technique such as the breast self-exam is a self-decision that only a young woman can determine what is appropriate or not for her body and her health. She may be more likely to make an informed emancipated decision if she has someone to whom she can turn for guidance if she feels the need and desire to do so. She could achieve this through the relationship with her healthcare professional. A “*safe zone*” may not always be possible to fully emulate with a healthcare professional-to-patient relationship because while a woman and her healthcare professional may sometimes have *the body in common*, they would not be able to reciprocate *private information sharing* and further, findings from the study suggest that young women do not have the same *sense of trust* with their doctor as with their friends. Despite this, an important healthcare practice may simply be to discuss the significance of breast cancer diagnosis to the young, female population. This could include a description from their healthcare professional of the harms and benefits to performance of the breast self-exam and promotion of the facilitators that allow for the *exceptional conversation* to more easily take place. The healthcare professional can also encourage the *exceptional conversation* between young women and their friends.

Healthcare professionals are also persons who are exposed to the same norms as young women regarding sexuality and what is private or not. Thus, it is important for healthcare professionals to confront their own ideas about sexuality, women’s health, and breast cancer risks for young adult women in order to determine if their views affect what they feel comfortable to discuss with their patients. While the breast self-exam may not

be a topic that readily comes into conversation between healthcare professionals and young women because of the association with sexuality, this lack of regular conversation can be something worth overcoming. Overcoming this barrier can help to adjust the culture between the healthcare professional and young women that makes sharing private information such as the breast self-exam seem uncomfortable or insignificant. This could also include discussion of other potentially sexually laden early detection techniques and health concerns such as the Pap test, the HPV vaccination, STI barriers and treatments, abortion, menstruation, and pregnancy. Overall, the goal of the healthcare professional is to encourage communication of these types of health behaviours.

This study suggests that women are different in regards to the circle of sharing since some participants would share almost anything with anyone and others expressed comfort in sharing only the most basic of conversation with those whom they trust, such as family members. This is where encouragement of discussion amongst friends becomes significant. It would be ideal for the *exceptional conversation* about private health behaviours to become common, at least among female friends and for social and cultural norms to promote the conditions for these sensitive health conversations to take place. Furthermore, it would be ideal to enable women to share their experiences and views in a safe environment without feeling judged negatively by others, whether in woman-to-woman conversations or in conversations with their healthcare professionals.

Implications for Education

From a health promotion perspective, future education could promote a positive self-image and the conditions for sensitive health conversations to take place. Educating young women about the impact that social norms have on their health decisions is

important. The findings from this study determine that cultural and societal norms often influence women's decisions whether they realize it or not and this can prevent them from making emancipated decisions about their health.

Awareness campaigns could be developed to provide knowledge of these norms and promote informed decisions about women's health through slogans such as "Do What's Right for You" (i.e., make an emancipated decision), "Take Back Your Own Body" (i.e., know what is normal for you), or "You Have the Right to Know" (i.e. awareness and information-seeking informs better decisions). These slogans and possible future awareness campaigns can educate women on how to empower one another to make their own decisions and how to gain the courage to speak to other women who may have similar experiences. They can also emphasize the importance of the conditions that facilitate the *exceptional conversation* to more easily take place so that women can determine with whom they may feel safe sharing information of a sensitive nature.

This education can also be provided by their healthcare professional, where yearly assessments can include educating women about their own bodies and taking a look at what values and priorities are appropriate for them. For example, as the physician examines each body system during the physical exam, the physician could ask their patients whether they currently engage in health promoting, preventive or early detection behaviours, in order to assess what each woman values about her health. These questions could inquire about physical activity, healthy eating, stress-reduction techniques, substance use, and would make discussion of the breast self-exam seem less invasive since the questions would correlate with the physical exam that physician would concurrently be conducting.

The idea of educating healthcare professionals on how to discuss breast image and a healthy lifestyle by creating a “safe zone” or a “caring presence” (Covington, 2005) is an implication that is suggested from the results of my study, because some of the young women felt that they could not be open with their healthcare professional. It is important to focus on the development of trust in the relationship between young women and healthcare professionals, because gaining this trust is especially important for promoting conversation and raising issues about breast health and other sensitive topics without young women fearing that they will be judged negatively.

Implications for Future Research and Further Theory Development

From this study, future research directions might include further exploration of the factors that lead young women, who might not otherwise see themselves at risk for ill health, to engage in preventive health behaviours. Research might also focus on effective strategies to promote overall wellness and early disease detection among young women in areas that they regard as potentially sensitive in nature, such as breast self-examination. Exploring avenues such as social media, educational workshops, and one-to-one counselling with Public Health professionals could help to determine what health promotion techniques may be beneficial.

Further research is also needed to determine the feasibility of implementing the suggestions for future practice and education into the everyday care that healthcare professionals’ provide patients. With the increasingly busy and demanding environment that healthcare has become, do nurses and physicians have the time to spend with each patient in order to create the “*safe zone*”? Future research may also involve ways to implement this into practice in a timely manner that fits into the workday of the

healthcare professional but also does not seem rushed and insincere to the patient. Ongoing studies may further illuminate the benefits of *the body in common* around sensitive health topics and the benefits of *sharing private information* with female friends.

Further studies could also explore other areas for possible influence such as the relationships between spouses and family members. Could same-sex spouses or same-sex family members provide similar benefits to the female same-sex friendship? With these relationships, aspects such as *the body in common*, *sense of trust*, and *private information sharing* may be present but would the same grounded theory be interpreted? Exploration could also delve further into the involvement of different religions, backgrounds, and age groups and whether these aspects affect the importance of the female friend, how *private information sharing* is developed, and who provides the *sense of trust* in different religions, backgrounds, and age groups.

Study Limitations

There are important study limitations to note. There is potential for respondent bias. Those who participated in the study may have been more willing to share their perspectives, experiences, and feelings and articulate their thoughts surrounding the breast self-exam as opposed to those that did not want to participate. Since those who chose to participate in this study may have values and beliefs that are aligned with the research questions, results may not be reflective of those who have differing views and beliefs.

There is also the potential for social desirability bias in participants' descriptions and responses. Social desirability response bias involves the tendency of study

participants to misrepresent their responses by giving answers that are consistent with reigning social norms and values (Polit & Beck, 2004). To reduce the potential for social desirability bias, participants were assured prior to the conversations that their responses would be kept confidential and that there were no responses that were right or expected. Through the face-to-face conversations, participants may have been more likely to respond according to social desirability than those who participated through instant-messaging and email conversations. Furthermore, some of my interview questions and more specifically, the follow-up questions that were sent through email may have increased social desirability bias because the wording of the questions may have implied specific answers that were desired or expected.

A reflexive journal and continuous memoing were maintained throughout the data collection and analysis period to uncover any possible biases and assumptions throughout this process. Some of these biases stem from my own background as a healthcare professional, where I have come to value health promotion and early detection of disease. As a Registered Nurse I have cared for women who have a breast cancer diagnosis and through this I have seen positive and negative prognoses and early detection has almost always been the determining factor for a positive prognosis. This has ultimately determined my view as a supporter of the breast self-exam. This view may have become apparent to the participants in the study during the conversations. Furthermore, since I possessed the same inclusion criteria for the study as all of the participants and had a strong interest and curiosity in discovering my own thoughts and feelings towards the breast self-exam, researcher bias was also to be expected.

A final limitation for this study surrounded the idea of privacy and how it related to the breast self-exam. Privacy seemed to be a factor regarding young women's apprehension to share and discuss this topic. Since I had only met my participants for the purpose of the conversations, our relationship would not be considered close and we did not have any previously shared experiences or backgrounds. It is therefore quite possible, based on the findings of this grounded theory study that the participants did not share with me, as a stranger, deeply held thoughts or more private concerns that they may have shared with a close female friend. The ability and comfort of the participants in discussing private health matters, such as the breast self-exam may have been limited.

Concluding Reflection

One of the reasons for conducting this study and for showing interest in the topics of female friendship and the breast self-exam developed from curiosity about my own beliefs and choices regarding the breast self-exam prior to commencement of this study. Prior to this study, I did not practice the breast self-exam at all and I had never discussed the technique with my close female friends. Following completion of this study, I now find value in discussion of this technique, among other women's health issues, with my close female friends and I now have performed the breast self-exam.

As a Registered Nurse, a public health professional, a master's degree candidate, and a young adult woman in her 20s, I had developed my own views of the breast self-exam. From the standpoint of the Registered Nurse and public health professional, I saw the importance in the technique for early detection of breast cancer. I believed it was something that should be able to be discussed in any environment and at all stages of life, whether a woman decided to practice it or not. These views have remained, but have now

developed into a stronger understanding of the issue and the factors or circumstances that impact whether the discussion or practice of the technique would actually occur.

This understanding developed throughout this study, as I reflected on all of the data from my participants, as well as from my own views. I have come to realize the importance, comfort, and feeling of safety that a *female friendship “safe zone”* provides when discussing private health information. Women prefer to speak to one another regarding certain information, as opposed to a member of the opposite sex, because of the deeper understanding that comes from having *the body in common*—the possibility that another woman could have experienced something similar because of the commonalities that are shared. Just as my participants have experienced situations where they have been uncomfortable speaking to a family member or someone of the opposite sex, I have experienced this as well.

An example from my experience occurred a few years ago. I was getting dressed one morning and as I was applying deodorant to my underarm, I noticed a small, hard lump on my underarm. My initial thought was that perhaps it was an irritation from shaving but as I examined it more closely, I became worried that it may be an actual lump formed on one of my lymph nodes adjacent to my breast. I wanted to speak to someone about it to seek their opinion, but I assumed my boyfriend would not understand or think it is nothing to be concerned about and that my mother might overreact and ask too many questions, as opposed to listen to my concerns. This was when I decided to call a close friend of mine and ask her if she had ever experienced a similar circumstance. After speaking with my friend, she confirmed that she had noticed this type of lump before and when she spoke to her doctor about it, she was reassured that it had likely been an

irritation from shaving and it eventually went away. She suggested that my lump was likely the same thing but encouraged me to see my doctor to help ease my mind. After seeing my doctor, I was reassured that my initial thought was correct and the lump did resolve within a few days. Looking back, I was glad that I had decided to speak to my friend in that circumstance because it was a reassuring moment to discover that a woman of my age had a similar experience and that I did not have to deal with it alone.

There are issues and circumstances that are more easily discussed with another woman who is of a similar age or at a similar stage in life, such as a close, female friend. These issues are often pieces of information that I would generally not share openly with just anyone, because of the private and sensitive nature that relates to them. After conducting the study, topics that I now consider to be private or sensitive in nature would include sexual topics, as well as topics specific to women's private parts or to women's health in general. The realization of these topics as *private matters* developed through discussion with my participants where the similarities between the views of these young women and my own views became clearer.

After completing this thesis I have now more openly discussed the breast self-exam and other women's health related topics with other women in my life, such as close friends, and family members. I see the importance of feeling able to express my thoughts and feelings about my own health and of having someone to speak to that may have gone through the same experiences as I have. This connection among other women of my own age has allowed for more appropriate advice to be provided to me from my friends and it has motivated me to think deeper about my behaviours and my decisions. This empowerment developed from this study through highlighting the importance of

emancipated decision-making and feeling the ability to determine what is important for me and my health and knowing that I have informed myself and made myself aware enough to make the most appropriate decision for myself and my life. For me, this has changed my view from *no risk* to wanting to know and understand that there actually are risks for breast cancer at my age and how early detection could affect my life. I have performed the breast self-exam following completion of this study and this decision to start performing the technique resulted from numerous discussions about the breast self-exam with a couple of my close, female friends.

Reflecting on my research question, I do believe that female friendships can influence decisions regarding health behaviours such as the breast self-exam. While friends may not directly affect practice of the technique, they promote awareness of its harms and benefits through open discussion and provide value to a more informed and emancipated decision. This is something that my participants communicated would likely happen if they were to openly discuss the breast self-exam with a close, female friend and it is something that I personally experienced upon completion of this study. This open discussion is not just important for me and for my own health, but it is also significant to the female friends with whom I engage in conversation. Following completion of this study, two of my close, female friends now regularly perform the breast self-exam and admitted that discussing my thesis with them is what initiated thinking about the technique but that our continued discussion afterwards is what ultimately is what ultimately promoted their decision to engage in breast self-examination.

My passion for promotion of this thesis and awareness of the breast self-exam revolves around all of the women I have met as a nurse and as a friend that are struggling

with illnesses or risk for illnesses such as breast cancer. Many of these women are young or were young at the time of diagnosis and their cancer may have been detected at an earlier stage if they had known what to look for. Knowing one's own breasts and what is normal for them promotes awareness and the empowerment that embodies the reason why this study began. The examples from two of my friends, my current practice of the breast self-exam and passion for knowing one's own body, and the reflection on the discussions with my participants makes me believe that promotion of discussion about private women's health behaviours, as indicated through this grounded theory study, can make a difference.

References

- Ali, M. M., & Dwyer, D. S. (2010). Social network effects in alcohol consumption among adolescents. *Addictive Behaviours, 35*, 337-342.
doi:10.1016/j.addbeh.2009.12.002.
- Allen, T.L., Van Groningen, B.J., Barksdale, D.J., & McCarthy, R. (2010). The breast self-examination controversy: What providers and patients should know. *Journal for Nurse Practitioners, 6*, 444-451.
- Aries, E. J. & Johnson, F. L. (1983). Close friendship in adulthood: Conversational content between same-sex friends. *Sex Roles, 9*, 1183-1196.
- Bartholomew, K. & Horowitz, L.M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.
- Bidonde, M. j., Goodwin, D. L., & Drinkwater, D. T. (2009). Older women's experiences of a fitness program: The importance of social networks. *Journal of Applied Sport Psychology, 21*(Suppl1), S86-S101. doi:10.1080/10413200802595963.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and Method*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc.
- Borrayo, E. A. & Jenkins, S. R. (2001). Feeling indecent: Breast cancer screening resistance of Mexican-descent women. *Journal of Health Psychology, 6*, 537-549.
- Bot, S. M., Engels, R. C. M. E., Knibbe, R. A., & Meeus, W. H. J. (2005). Friend's drinking behaviour and adolescent alcohol consumption: The moderating role of friendship characteristics. *Addictive Behaviours, 30*, 929-947.
doi:10.1016/j.addbeh.2004.09.012.

- Bowen, D.J., Alfano, C.M., McGregor, B.A., & Andersen, M.R. (2004). The relationship between perceived risk, affect, and health behaviours. *Cancer Detection and Prevention, 28*, 409-417.
- Brown, J. B., Carroll, J., Boon, H., & Marmoreo, J. (2002). Women's decision-making about their health care: Views over the life cycle. *Patient Education and Counselling, 48*, 225-231.
- Charmaz, K. (2006). *Constructing grounded theory. A practical guide through qualitative analysis*. London: Sage.
- Coleman, L., Cox, L., & Roker, D. (2008). Girls and young women's participation in physical activity: Psychological and social influences. *Health Education Research, 23*, 633-647.
- Corbin, J., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*, 3-21.
- Covington, H. (2005). Caring presence: Providing a safe space for patients. *Holistic Nursing Practice, 19*, 169-172.
- Creswell, J. W. (2005). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research*. Upper Saddle River, NJ: Pearson Education Inc.
- Elmore, J.G., Armstrong, K., Lehman, C.D., & Fletcher, S.W. Screening for breast cancer. *Journal of the American Medical Association, 293*, 1245-1256.
- Fagan, P., Eisenberg, M., Stoddard, A. M., Frazier, L., & Sorensen, G. (2001). Social influences, social norms, social support, and smoking behaviour among adolescent workers. *American Journal of Health Promotion, 15*, 414-421.

- Fancher, T.T., Palesty, J.A., Paszkowiak, J.J., Kiran, R.P., Malkan, A.D. & Dudrick, S.J. (2011). Can breast self-examination continue to be touted justifiably as an optional practice? *International Journal of Surgical Oncology*, 2011, 1-5.
- Finnerty, T., Reeves, S., Dabinett, J., Jeanes, Y. M., & Vögele, C. (2010). Effects of peer influence on dietary intake and physical activity in schoolchildren. *Public Health Nutrition*, 13, 376-383. doi:10.1017/S1368980009991315.
- Gaughan, M. (2006). The gender structure of adolescent peer influence on drinking. *Journal of Health & Social Behaviour*, 47, 47-61.
- Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for Qualitative research*. Chicago, Illinois: Aldine Publishing Company.
- GLOBOCAN (IARC) (2008). Breast cancer incidence, mortality and prevalence worldwide in 2008 summary. Retrieved on November 1, 2012 from <http://globocan.iarc.fr/factsheet.asp>.
- Gnerlich, J.L., Deshpande, A.D., Jeffe, D.B., Sweet, A., White, N. & Margenthaler, J.A. (2009). Elevated breast cancer mortality in women younger than age 40 years compared with older women is attributed to poorer survival in early-stage disease. *Journal of American College of Surgeons*, 208, 341-347.
- Guba, E. G., & Lincoln, Y. S. (2004). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Approaches to qualitative research* (pp. 17-38). New York: Oxford University Press.
- Hallberg, L. R-M. (2006). The “core category” of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-Being*, 1, 141-148.

- Hurdle, D.E. (2001). Social support: A critical factor in women's health and health promotion. *Health and Social Work, 26*, 72-79.
- Kearney, A.J. (2006). Increasing our understanding of breast self-examination: Women talk about cancer, the health care system, and being women. *Qualitative Health research, 16*, 802-820. doi: 10.1177/1049732306287537.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, California: Sage Publications.
- Liukkonen, S., Leidnius, M., Saarto, T., & Sjostrom-Mattson, J. (2011). Breast cancer in Very young women. *European Journal of Surgical Oncology, 37*, 1030-1037.
- Ma, I., Dueck, A., Gray, R., Wasif, N., Giurescu, M., Lorans, R., ... Pockaj, B. (2012). Clinical and self-breast-examination remain important in the era of modern screening. *Annual Surgical Oncology, 19*, 1484-1490.
- Markle, G. (2008). "Can women have sex like a man?": Sexual scripts in *Sex and the City*. *Sexuality and Culture, 12*, 45-57. doi:10.1007/s12119-007-9019-1.
- Mercken, L., Candel, M., Willems, P., & de Vries, H. (2007). Disentangling social selection and social influence effects on adolescent smoking: The importance of reciprocity in friendships. *Addiction 102*, 1483-1492.
doi:10.1111/j.13600443.2007.01905.x ER.
- Mikulincer, M. (1998). Attachment working models and the sense of trust: An exploration of interaction goals and affect regulation. *Journal of Personality and Social Psychology, 74*, 1209-1224.
- Papalia, D.E. & Olds, S.W. (1992). *Human development* (Fifth ed.). New York, NY: McGraw-Hill.

- Paterson, J.E., Field, J., & Pryor, J. (1993). Adolescents' perceptions of their attachment relationships with their mothers, fathers, and friends. *Journal of Youth and Adolescence, 23*, 579-600.
- Pender, N.J., Murdaugh, C.L., & Parsons, M.A. (2011). *Health promotion in nursing practice* (6th ed.). Boston: Pearson.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Appraising evidence for nursing practice* (7th ed.). Philadelphia: Wolters Klower/Lippincott Williams & Wilkins.
- Rachels, J. (1975). Why privacy is important. *Philosophy and Public Affairs, 4*, 323-333.
- Rutledge, D.N. (1987). Factors related to women's practice of breast self-examination. *Nursing Research, 36*, 117-121.
- Smith, K.P. & Christakis, N.A. (2008). Social networks and health. *Annual Review of Sociology, 34*, 405-429.
- Star, D. (Writer), & Engler, M. (Director). (2004). Sex and the city [Television series, Season Six, Episode 15]. In D. Star (Producer), *Sex and the city*. USA: Darren Star Productions.
- Star, D. (Writer), & Seidelman, S. (Director). (1998). Sex and the city [Television series, Season One, Episode 1]. In D. Star (Producer), *Sex and the city*. USA: Darren Star Productions.
- Statistics Canada. 2013. *Health Trends*. Statistics Canada Catalogue No. 82-213-XWE. Ottawa. Released January 29, 2013.
- <http://www12.statcan.gc.ca/healthsante/82213/index.cfm?Lang=ENG> (accessed February 20, 2013).

- Strauss, A.L. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press. [Electronic copy]. Retrieved on March 25, 2013 from <http://books.google.ca/books?id=y16ww5ZsJ0AC&printsec=frontcover&dq=qualitative+analysis+for+social+scientists&hl=en&sa=X&ei=2YFYUfPIBJTCyAHY-oDoBA&ved=0CC8Q6AEwAA#v=snippet&q=core%20category&f=false>.
- Tannahill, A. (1985). What is health promotion? *Health Education Journal*, 44, 167-168.
- Urberg, K. A., Luo, Q., Pilgrim, C., & Degirmencioglu, S. M. (2003). A two-stage model of peer influence in adolescent substance use: Individual and relationship-specific differences in susceptibility to influence. *Addictive Behaviours*, 28, 1243-1256.
- Welch, R.D. & Houser, M.E. (2010). Extending the four-category model of adult-attachment: An interpersonal model of friendship attachment. *Journal of Social and Personal Relationships*, 27, 351-366. doi:10.1177/0265407509349632.
- Wittmann-Price, R.A. (2004). Emancipation in decision making in women's health care. *Journal of Advanced Nursing*, 47, 437-445.
- Wittmann-Price, R. A., & Bhattacharya, A. (2008). Reexploring the subconcepts of the Wittmann-Price theory of emancipated decision making in women's healthcare. *Advances in Nursing Science*, 31, 225-236.

Appendix A. Study Consent Form

Principal Investigator: Sondra Davis, Graduate Student
Department of Applied Health Sciences
Brock University
sl04nw@brocku.ca

Faculty Co-Supervisor: Lynn Rempel,
Professor
Department of Nursing
Brock University
lrempel@brocku.ca

Faculty Co-Supervisor: Joyce Engel,
Professor
Department of Nursing
Brock University
jengel@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to explore young adult women's perceptions on friendship and health.

WHAT'S INVOLVED

As a participant, you will be asked to participate in conversations that will involve discussion about ideas and experiences related to health and friendship, specifically, the breast self-exam (BSE) among other possible health related behaviours. Each conversation will be audio-taped and transcribed. Participation will take approximately one hour of your time.

POTENTIAL BENEFITS AND RISKS

Possible benefits of participation include insights on women's thoughts and perceptions to those who are providing care to patients as well as insight to participants on one's own thoughts and perceptions about friendship and health. There are no known or anticipated risks associated with participation in this study.

CONFIDENTIALITY

The information you provide will be kept confidential. Your name will not appear in any thesis or report resulting from this study. After the conversation has been completed, you will be given the option to review a copy of the transcript, allowing you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish.

Data collected during this study will be stored on audio-tape, computer format, and hardcopy. Data will be kept for a minimum of five years, after which time the data will be removed from any audio or computer format and hardcopies will be shredded. Access to this data will be restricted to the principal investigator and the co-supervisors.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits that you are entitled.

PUBLICATION OF RESULTS

In addition to the thesis, results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available from Sondra Davis, Lynn Rempel, and Joyce Engel. Participants have the option to receive feedback from the researcher after the analysis process is completed and/or to receive a copy or to be instructed as to where they can retrieve a copy of the completed thesis.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact the Principal Student Investigator or the Faculty Supervisors using the email addresses provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (file #: 10-048). If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____

Date: _____

Appendix B. Initial Conversation Question Guide

1. Could you describe to me the qualities of some of your significant female friendships, as well as how you met and what you do together?
2. Do you speak to your friend about the breast self-exam?
3. Do you perform the breast self-exam?
4. Do you find the breast self-exam to be important or significant?
5. Do you know if your friend performs the breast self-exam?
6. Do you find your close female friendships to be influential on the decisions you make?
7. Do you discuss health issues with other females, such as family members, colleagues, your healthcare professional, or acquaintances?
8. Do you consider the breast self-exam to be a private health issue?
9. Has there ever been a time where you found your friendship to be influential on your health?
10. Do you feel comfortable speaking to your friend about women's health issues, including the breast self-exam?

Appendix C. Follow-Up Questions

1. How do you determine whether information is private? What defines "private" and how does it affect what you choose to share with others?

2. What makes information regarding the breast self-exam (BSE) private? And how does it differ from sharing information about your health such as a common cold or stomach problems?

3. Does judgment play a factor in what you perceive to be private?

4. If you share information that you consider to be private, do you worry about being judged by the other person?

5. What does judgment mean to you and how does it affect what type of information you share and who you share it with?

6. Do you feel that societal norms determine what information is shared and who it's shared with?

7. If yes, what are these societal norms and how are they determined? How do you think they are developed and why are they followed?

8. Do you worry about what other people think when you share private information? If yes, do you worry more with certain people over others? Is your worry due to societal norms?

Appendix D. Study Invitation Flyer

If you're a young adult woman in your 20's and 30's, you're invited to participate in this study!

I'm a **graduate student**, from the Department of Applied Health Sciences, Brock University, and I invite you to participate in a research study that is interested in exploring your friendships and their links to your health.

The expected duration is **approximately one hour of conversation time**.

This research should benefit **participants by allowing increasing insight into your own thoughts and perceptions about friendship and health**.

Conversations will take place on the Brock University campus.

If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext. 3035, reb@brocku.ca).

If you have any questions or are interested in participating in this study, please feel free to contact me by my email listed below.

Thank you

Sincerely,

Sondra Davis

Sondra Davis
Graduate Student, Principal Investigator
Professors
Please contact me at: sl04nw@brocku.ca
jengel@brocku.ca/lrempel@brocku.ca

Joyce Engel/Lynn Rempel
Supervisors/Brock University

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board (file # 10-048)