PUTTING THE STAINED GLASS WINDOW BACK TOGETHER,

HELPFUL AND UNHELPFUL ASPECTS OF PSYCHOLOGICAL THERAPY WITH

WOMEN WITH BREAST CANCER: A GROUNDED THEORY ANALYSIS

A thesis submitted to the University of Manchester for the degree of Professional Doctorate in Counselling Psychology (DCounsPsych) in the Faculty of Humanities

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Abbreviations

Grounded Theory Analysis will be referenced in full on the first mention and then abbreviated to GTA
PUTTING THE STAINED GLASS WINDOW BACK TOGETHER: HELPFUL AND UNHELPFUL ASPECTS OF PSYCHOLOGICAL SUPPORT WITH WOMEN WITH BREAST CANCER.

The purpose of this study was to identify what women with primary breast cancer found helpful and unhelpful in psychological therapy. In-depth qualitative interviews were conducted with eleven women who had been supported post diagnosis, with psychological therapy. The women were, in the main, recruited from the Breast Cancer Voices network, set up by the national charity Breast Cancer Care. Data was analysed using Grounded Theory Analysis (GTA), from a social constructionist perspective. The women identified a range of helpful aspects in therapy: They all discussed their context, being thrown into the breast cancer world and analysis identified three helpful conditions; having the psychological need recognised by others, having easy access to ongoing flexible therapy and valuing the therapist’s personal qualities. Three helpful interactions were identified; being enabled to express self safely, being treated as an individual whole woman and accessing the therapist’s inner self. In addition, two helpful actions were identified, being helped to empower self and being taught new coping skills. The key theme was being helped to put active self back together again, which was the consequence of the therapy process. Analysis identified two unhelpful conditions, not having easy to access therapy and the therapist’s personal qualities being cold and harsh. Two unhelpful interactions were also identified, being unable to express self safely and not being treated as an individual. One unhelpful action was identified, the therapy being too short. The consequence, when therapy was not set up in the right way, was that the women were re-traumatised and remained shattered. Whilst sample size was small, nevertheless the aim of generating rich in-depth data was fulfilled. The findings have theoretical implications: Treating women as whole individuals, helping the women learn individual coping skills from a pluralistic perspective and helping to empower women can be as important as the medical care. The methodological implications are experiencing a therapeutic effect of research participation, valuing the women as active co-researchers, ethically considering participant benefits alongside risks and using GTA from a social constructionist philosophy helped to understand individual experience and at the same time that breast cancer is socially constructed. The practical implications are: Referral pathways to identify women who need psychological support, a safe therapeutic space to express real fears, normalising experience post breast cancer diagnosis and putting in place a flexible therapy contract are all vital to support women with primary breast cancer.
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1.

Introduction

1.1. The Position of a Counselling Psychologist within the Research

Counselling Psychology has grown as a discipline in Britain, as a result of an awareness of the importance of the helping relationship, a questioning of the professional-client relationship in terms of the ‘medical model’, a move to a more humanistic value base and an interest in well-being, rather than pathology (Woolfe, 1990). Counselling Psychology is connected with human science, as opposed to natural sciences and as such, views human beings as reflective, self-conscious, having a capacity for choice and responsibility (Strawbridge and Woolfe, 2010). The philosophy of Counselling Psychologists is based on enhancing self-determination, listening to client’s views and not treating people as passive.

Packard (2009) proposed 9 core values of Counselling Psychology, after interviewing 18 experienced Counselling Psychology educators:

1. Altruism is our foundation as we strive to enhance the welfare of others.

2. Positive relationships are a necessary condition for stimulating change in those we seek to help.

3. The synergistic integration of science and practice is essential to our work and includes use of various methods of inquiry.

4. We focus on healthy development across the life span, including work and career, and seek to prevent avoidable problems as well as optimize individual and societal growth.

5. From a holistic frame of reference, we emphasise strengths, resilience, and positive coping in the context of the person’s social and cultural environments.

6. We are committed to the respectful treatment of all. Inherent human dignity, inclusion rather than exclusion, and accepting and celebrating cultural and individual diversity.

7. We believe in social justice and the necessity, on occasion, of advocacy of just causes that promote the welfare of others.

8. We value collaboration, multidisciplinary practice and research, and sharing Counselling Psychology with colleagues in our own country and around the world.

9. In our remedial work with dysfunctional clients and systems, whenever possible we focus on strengths and positive coping in the context of a helping relationship.

(Packard, 2009, p.263)

This research fits well with the nine values of Counselling Psychology defined by Packard (2009). Firstly I wanted to represent the views of women with breast cancer, to try to enhance the welfare of women in the future, by disseminating and using the research learnings in practice. The research interviews aspired to be based on a trusting relationship, which could
help to create the environment for the women to openly discuss their experiences. The thesis examined clients’ views of practice, with the objective of presenting a thoroughly researched study, from a qualitative perspective. The research was focused on the experiences of individuals, whilst trying to ensure that societal influences were captured, in the analysis. The women were interviewed from a holistic individual frame of reference, with an emphasis on what specifically helped or did not help each person. The research was conducted respectfully and with dignity. The research was aimed at representing the women’s’ experiences and promoting understanding within the profession of counselling psychology and psycho-oncology, in order to help other women with primary breast cancer in the future. The research was conducted collaboratively with the women, looking at how they coped and what helped them, from a psychological therapeutic perspective. This thesis also fits with the definition of Counselling Psychology from Nelson-Jones, (1992) who described it as having the objective of helping people to live more fulfilled and effective lives.

I viewed the women’s struggles and experiences, in the study, as part of the human condition. The women were coping with traumatic human experiences and their problems were not a sign of pathology (Strawbridge and Woolfe, 2010). The women were affected by biology, society and life events, which presented them with a unique set of challenges at this point in their life. I appreciated the diversity, the personal, the subjective, and the individual experiences of the women. I also wanted to show their agency, within the research, which links to a core part of the identity of Counselling Psychology (Howard, 1992). I wanted to look at what was helpful and unhelpful, for people who have had psychological therapy, from their perspective, rather than examine the views of what health professionals thought helped. I wanted to investigate the experience of psychological therapy at a time when a person had been diagnosed with a significant life changing illness. I was specifically interested in the experiences of women with breast cancer. I wanted to explore their views of what helped them or didn’t help them with their wellbeing, in relation to psychological support.

In this thesis, I was keen to explore the reflections of the women I interviewed in detail. I wanted to attend to what it really means to be human (Deurzen-Smith, 1990). I wanted to achieve a depth of understanding and therefore chose to use a qualitative research methodology. A qualitative approach fitted my aims; as a Counselling psychologist I wanted to ‘be-in-relation’ to the participants, rather than ‘doing-to-them’ (Woolfe, 2001). ‘Doing to’ fits more with a ‘medical model’ and a quantitative approach, with the health professional or academic researcher being positioned as the expert.

1.2. Thesis Development

‘Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place’”

(Sontag, 1991, p.3)

I started working in an Oncology hospital (The Christie Clinic (TCC) at The Christie Hospital in Manchester) in February 2013, whilst undertaking my first year on the Counselling
Psychology Doctorate, at The University of Manchester. At TCC, I was struck by the enormity of the impact of both, a cancer diagnosis and the corresponding tough treatment on the person. I worked, and I still work with many people, providing psychological therapy for individuals, couples and families, in relation to being affected by cancer. During those first few months at the hospital I was also considering my research topic for my university thesis panel, planned for May 2013. I kept coming back to the same question, what do people with cancer actually experience as helpful and or unhelpful, in psychological therapy, as opposed to what psychotherapists or health professionals think?

As breast cancer is the most common cancer worldwide and in the UK, it affects 1 in 8 women over their lifetime, I wanted to focus on this type of cancer because of its prevalence, particularly in women (Cancer Research, 2015b). In addition, in my work at TCC, I was beginning to see more women transforming from diagnosis, because of the treatment, from well to ill (Cancer Research, 2015a). Most of the women who were diagnosed with a primary breast cancer were not ill at the beginning. The women became distressed and ill, because of the psychological shock of the diagnosis and then the treatment for the cancer. In a dialogue, between Stacey and Jain (2015) Stacey talks about this acute contrast, she describes two photographs of herself, as ‘being-sick-but-looking-well’ pre-diagnosis and in the other one, ‘looking–ill-but-free-of-tumour’ post-chemotherapy (p.6). This is a major difference in contrast to other cancers, like bowel or blood cancers. The women endure the crisis psychologically, from diagnosis and then often the physical struggle starts when the treatment begins. Psychological issues and physical side effects often continue long after treatment has finished.

At the time of writing this thesis, more women are surviving breast cancer, far beyond their treatment; incidence rates in Europe have increased +72% in 2009 - 2011 (vs. 1975 - 1977) and mortality rates in Europe have decreased by -36% in 2010 - 2012 (vs. 1971 - 1973), (Cancer Research, 2015a; Cancer Research, 2015b). Therefore one important area of focus, when thinking about how to support women with breast cancer, is on long-term wellbeing, rather than on just the medical treatment phase. This thesis focuses on psychological wellbeing as more women with breast cancer are surviving and living after treatment. As time has progressed and more is understood about the impact of breast cancer there is now more of a holistic concern around it, about the quality of life across a woman’s physical, social, spiritual and psychological wellbeing (Ferrell et al., 1996).

1.3. Reflexivity

I brought my self to the research, being also a woman, who has vulnerabilities, and a person who sees struggling as part of being human. My focus as a female Counselling Psychologist is on normalising not pathologising. I am compassionate to others and I try to be compassionate to myself too. The latter is a constant work in progress, for me and in talking to other women this feels like a general problem. I wondered what helps women to cope when they are not only struggling with day to day life, but also when they have been diagnosed with breast cancer, which often means thoughts of their own mortality emerge. I wanted to raise these experiences publicly, rather than leave them behind the closed doors of the therapy room.

This thesis created space and time to consider women’s actual experience of how therapy could not only be helpful but how it could be unhelpful. This was another important area to me rather than assuming psychological therapy is always helpful I wanted to learn about when
it didn’t help, what happened in the situations? My pragmatic approach to being a female Counselling Psychologist wanted to know what I could know from other women so I could improve psychological theory application, whilst also recognising my personal influence within the research process as a female researcher. From the beginning of the research process I knew I wanted to take responsibility for communicating the research analysis to a wider audience, through conferences and journals. To highlight the women’s lessons for Counselling Psychology. I was also keen to be open to my role in helping to construct the analysis, from the women’s words and this is discussed in more depth in chapter 5, the reflexive analysis.

I chose the research topic because it felt real, important and needed to me as a woman most importantly, but also to Counselling Psychology. I wanted to listen, learn and be helped by women to understand their experiences, which I had not experienced. I wanted to contribute to empowering women with breast cancer, to have a part in the social justice agenda of Counselling Psychology; hearing women’s voices, striving to represent them as faithfully as I could, in terms of what they wanted and did not want therapeutically. Throughout the thesis I also wanted to make visible ‘the processes involved in producing’ it (Burman, 1990, p.1). In order to help with this aim I have both incorporated a chapter on reflexivity into the thesis and refer to reflexivity within other parts of the thesis.

1.4. Aims of the Thesis

The aim of this thesis is to explore what aspects women with breast cancer experience as helpful or unhelpful in relation to psychological support after a cancer diagnosis.

Therefore, this piece of research sets out to explore two research questions:

1. What are the helpful aspects of psychological therapy, as identified by women with a primary breast cancer?
2. What are the unhelpful aspects of psychological therapy, as identified by women with a primary breast cancer?

1.5. Structure of Thesis and definition of terms

The focus of this research was on exploring what is helpful and or unhelpful with regard to psychological therapy with women with breast cancer. The thesis begins by presenting literature in relation to the examination of cancer and psychological distress. Then what makes psychological therapy helpful is discussed from the client’s perspective. The medical model of cancer is then reviewed, in contrast to the client as active self-healer. I look specifically at psychological therapy with cancer patients, highlighting the helpfulness of a pluralistic therapeutic approach, from a Counselling Psychology perspective (Cooper and McLeod, 2011). The literature then is explored with regard to breast cancer in women, as a
gendered issue. Finally I review the philosophy of social constructionism and my choice of grounded theory analysis.

Within the methodology, I provide the epistemological position of the thesis, followed by the research design, method and process. GTA is discussed in relation to why this form of analysis was chosen for this research study. In addition a social constructionist approach is justified, particularly in relation to utilising a feminist lens to review the findings.

In the analysis section, the findings are presented from the GTA, highlighting the key theoretical codes that were uncovered from within the corpus of the data.

Within the discussion, the findings are compared to previous research to highlight what the women with breast cancer experienced as helpful and or unhelpful in relation to psychological therapy. The implications of the findings of this research are then discussed in terms of the impact on women with breast cancer, Counselling Psychology and psycho-oncology.

The term Psychological therapy is used throughout this thesis rather than psychological support. In the literature, about cancer, detailed definitions about the difference between the terms psychological therapy and psychological support are hard to find. From a personal perspective it feels ‘support’ may have less depth than ‘therapy’ and support can be delivered by a broader spectrum of people including volunteers for cancer charities for example, who have not had extensive training and support can therefore be limited to a listening service. This has a place of course but sometimes this may not meet the needs of an individual, who is looking to gain a deeper meaning about their experience.

Breast Cancer Care (2014) did define therapy in a report they produced last year as being delivered by a trained professional, who is monitored by an appropriate body. In this thesis my aim was to interview women, with breast cancer, who had also had psychological therapy and therefore the participant information sheets and posters advertising the research were worded in this way. When reviewing the participants’ transcripts in terms of whom they said they had therapy with, it varied from talking about their Therapist, Cognitive Analytic Therapist, Counsellor, and Psychologist to Cognitive Behavioural Therapist. Counselling and Clinical Psychologists complete a three-year professional doctorate in order to provide therapy, have clinical supervision and are accredited by the Health Care Professions Council (HCPC). Counsellors are again trained professionally and are registered with the British Association of Counselling & Psychotherapy (BACP). Cognitive Analytic Therapists are trained by the national Association for Cognitive Analytic Training (ACAT) and the British Association for Behavioural & Cognitive Psychotherapies (BABCP) offers accreditation for Cognitive Behavioural Therapists.

In relation to Counselling Psychology and the definitions of therapy and support, the philosophy is more focused on what the individual needs and trying to help them with their distress through understanding and where possible encouraging change. Counselling Psychology wants to help people to improve their sense of wellbeing, although when working with people with cancer where the disease may get worse this can be difficult. Counselling Psychology does not distinguish between providing psychological therapy and psychological support in the literature, maybe because of the focus being on what the individual needs, be this support or therapeutic interventions. However for the purposes of consistency in this thesis I will refer to psychological therapy throughout it.
2. Literature review

Within this review of the literature I will provide the background to my research, firstly through the examination of cancer in relation to psychological distress and therapy provision. This has been a growing focus since the Department of Health’s Cancer Plan in 2000, and I will then discuss what makes psychological therapy helpful from the client’s perspective. In particular I review the medical model of cancer in contrast to the client as active self-healer and look specifically at psychological therapy with cancer patients, highlighting the helpfulness of a pluralistic therapeutic approach from a Counselling Psychology perspective (Cooper and McLeod, 2011). The introductory literature will then be discussed in relation to breast cancer in women as a gendered issue, the role of breasts for women within society and psychological therapy with women with breast cancer. Finally I reviewed the philosophy of social constructionism and my choice of GTA. Social constructionism is based on all human beings constructing their world by interacting with others in a social and historical context; constructions are their reality (Charmaz, 1990). A social constructionist perspective of GTA involves the researcher attending to the lived experience of the participants and creating theoretical categories, from the data and explaining the relationships between them (Charmaz, 1990). This literature review helps frame the specific focus of this study; helpful and non-helpful aspects of the therapy process for women with breast cancer.

In addition I want to make clear at the start of the literature review that there is more literature within the chapter 6, the discussion chapter, when I discuss the theoretical, methodological and practical implications of the research. In the discussion I discuss the roots of Counselling Psychology (Maslow, 1943; Rogers, 1951, 1957; May, 1961). In addition I outline literature on participant benefits of taking part in research (Mathieson, 1999; Murray, 2003; Morecroft, Cantril and Tully, 2004). There is also a discussion about post traumatic growth (Linley and Joseph, 2002, 2004) and the Counselling Psychology agenda of social justice (Kagen et al., 2011; Cutts, 2013).

2.1 Cancer in relation to psychological distress and therapy provision

‘You have cancer’ these words almost always cause devastation in the lives of their recipients.

(Arora, 2003, p.791)

As part of the Department of Health’s Cancer Plan (2000) it was acknowledged that cancer patients commonly experience psychological problems and they need access to services that can help them. It also explains that the services need to be integral to the cancer patient’s supportive care. In addition, the National Institute of Health and Clinical Excellence (NICE, 2004) stated that to enhance the quality of life and coping mechanisms for a person with cancer, psychosocial interventions are important and they need to be tailored to their individual needs.
The recognition of how cancer affects the psychology of patients’ may account for the rise in the study and practice of ‘psycho-oncology’, which is concerned with the relationships between cancer and the mind (Barraclough, 2000, p vii). Psycho-oncology is concerned with two dimensions: Firstly, the impact of cancer on the psychological functioning of the patient, their caregivers and the staff and secondly the role that psychological variables may have in cancer risk and survivorship (Holland, 1990). My thesis is concerned with the first dimension of psycho-oncology, the psychological functioning of the person.

The socio-cultural context of cancer has a major influence, on the person with cancer. In the western world, cancer meanings are linked to fear of growth, inferences of invasion, of uncontrollability and uncertainty (Sontag, 1989; Stacey, 1997). In addition, historically cancer was surrounded by concealment, which was constructed by cultural anxiety and motivated by a public sense of horror (Saywell, Beattie and Henderson, 2000). As a result individuals may regard the cancer diagnosis as a challenge to battle against, whilst many others, will perceive it as a major threat, that they don’t have the resources to deal with, (Moorey and Greer, 2012). Willig (2009) who was diagnosed with cancer said that her experience was an emotional and intellectual process ‘of wrestling meaning from meaningless’ (p.181).

Cancer threatens a person’s beliefs about who we are and about survival, it challenges ‘schemas relating to a person’s very existence’ (Moorey and Greer, 2012, p.26). Taylor and Armor (1996) suggested that positive assessments of self, control and optimism are challenged when a client faces a threatening event. A person may see the cancer as a punishment for something they have done, for example, as they may have a belief that they are bad and incompetent, as a result of disruption to the more normal pattern of child development, (Moorey and Greer, 2012). Equally a person may have a belief that to be valued, they need to be productive in life, but if the cancer causes their physical health to deteriorate, their productivity may go down and this in turn can make them feel angry and worthless.

There have been many studies trying to quantify the psychological need of people who have cancer. A range of between 34% and 44% of people, who have cancer, fit the criteria as having a psychiatric disorder (Farber, Weinerman and Kuyper, 1984, Derogatis et al, 1983). Other researchers have suggested that prevalence can be even higher, Croyle and Rowland (2003) state that major depression, which is the most common issue, is present in up to 50% of people with cancer. In addition there are often other issues including increased anxiety, a reduction in quality of life, relationship problems, sleep disturbance, and coming to terms with the end of their life (Hopko et al, 2008).

A person with cancer often suffers a forced transformation of their identity because of their diagnosis, the treatment they have, poor physical health, complex psychological adjustment and changes in their role at work and at home (Mathieson and Stam, 1995). There is uncertainty with the illness and this is often felt continuously and is unremitting (Mages and Mendelsohn, 1979). There can be significant psychological distress either as an anxiety state or depressive illness or from both because there are many psychological hurdles in a person’s cancer journey. Faulkner and Maguire (1994) highlighted six hurdles, uncertainty about the future, the search for meaning, loss of control, the need for openness, the need for emotional support and the need for medical support. Faulkner and Maguire (1994) also outline key physical and psychological issues that can arise from cancer treatment; the loss of a body part, the loss of a bodily function, fatigue, skin soreness, nausea, vomiting, diarrhoea, body image problems, relationship issues and sexual problems.
Despite the Department of Health (2000) acknowledging the psychological distress people with cancer suffer and the need for access to therapy, the provision is still patchy. Sharpe et al (2014) stated in their journal article in the Lancet last autumn that we still don’t know how to integrate psychological therapy into people’s cancer care. They called for more integration and collaborative care approaches, following their successful therapy research study with people with cancer, who were also suffering from depression. In addition they highlighted the small cost of psychological therapy in comparison to the cost of the medical treatments for cancer. A live example of how patchy specific psychological therapy for people with cancer is can be illustrated in the commissioning guide for cancer care in London that was published this year. In this report, NHS (2015) the provision of emotional and psychological therapy across the capital was found to be often limited and certainly inconsistent. This commissioning guide found that 58% of people with cancer did not find their emotional needs were looked after as much as their medical needs and only 13% of the Improving Access to Psychological Therapies (IAPT) services in London had specific cancer psychological therapy pathways, which included shorter waiting lists than generic mental health provision.

The needs of a person with a physical illness, like cancer, which is often contributing to deteriorating physical and mental health are often different to services for people with mental health problems, for example people with cancer may be asking existential questions in the face of their own death or struggling to cope with the effects of harsh chemotherapy. Against this background often charities try and fill the gap for psychological service provision for people with cancer. For example Macmillan professionals provide psychological and emotional support and they have found that although psychological therapy has proven benefits, in terms of social and health care cost reduction, when timely effective interventions are available, there are still large gaps in services across the UK: ‘There are still cancer patients who never get appropriate specialist psychological support because there is no service to refer them to’ (Macmillan Cancer Support, 2011 p.1). In addition, there is a concern that the medical care teams are missing the psychological impact of cancer. A study in 2009 of 442 people with cancer found that 40% of those with emotional problems had not sought help and of those who did, only 50% of doctors mentioned their cancer as a possible cause (Macmillan Cancer Support, 2009). People with cancer often feel abandoned by the health system, they are often too distressed to seek help and their physical symptoms can mask the extent of the psychological distress (Carlson L et al., 2004; Mitchell, 2009). Screening routinely for people with cancer for psychological distress is not commonplace and healthcare professionals often do not know who to turn to for advice for patients (Carlson L et al., 2004; NICE, 2004).

The UK is also in a period of austerity as a result of the economic crisis that engulfed Europe in 2008, this includes targets of making efficiency savings in the NHS, in the provision of psychological therapy services, in contrast to demand for these types of services rising when the social climate becomes difficult (McDaid, 2010). Against this backdrop the need for access to specific psychological therapy pathways for everyone who has cancer, which includes shorter waiting times, is therefore a challenge. This social context is important to note in relation to women with breast cancer, who are the focus of this research, as individuals can feel responsible for their distress, even though access to psychological services is
dependent on how society is arranged at any given time. Psychology is understandably not
divorced from the political and as a result the Counselling Psychology agenda of social
justice, in terms of advocating access to psychological therapy that helps vulnerable
individuals, is a focus of this study when representing the experiences of the women with
breast cancer who were interviewed (Vera and Speight, 2003).

2.2 What makes psychological therapy helpful from the client’s perspective?

This thesis is located within the philosophy of Counselling Psychology and the key helpful
aspects of therapy from a client’s perspective. In terms of the specific types of events in
psychological therapy that matter, Snyder (1945) first studied this is the 1940s. After Snyder
there was, at first, a focus on events in therapy on the basis of the therapist’s actions or
intentions (Frank and Sweetland, 1962; Goodman and Dooley, 1976). However, since the
1980s, research examining client’s perspectives on what is helpful in therapy has become a
key focus, as client’s views can differ from those of therapists (Elliott and James, 1989).

A pioneering study by Elliott (1985) analysed the helpful and non-helpful change events in
therapy from the perspective of the client, in terms of immediate therapeutic impact, post brief
one-session therapy, with 24 participants using Interpersonal Process Recall (IPR). Elliott
(1985) used the Helpful Aspects in Therapy (HAT) form to capture which aspects were
helpful. Eight helpful events in therapy were uncovered; clients gaining a new perspective,
being helped to problem solve, clarification of a problem, focused attention on a client and
their issues, understanding, client involvement in the therapy, reassurance and personal
contact. Building on this study Elliott and Shapiro (1988) used brief structured recall to study
the impact of significant events in therapy and found helping to clarify a problem, increasing
personal insight and problem solving to be the most common positive impacts. Clients were
asked to identify the most helpful impact and they usually prioritised the task impacts
associated with their presenting problem, for example insight or problem solution, rather than
interpersonal impacts, understanding or personal contact.

Task and interpersonal impacts of therapy have been found to be helpful from a client’s
perspective and it appears a need for both elements to be present is ideal when looking at the
research. A meta-synthesis of 40 years of literature about client experiences further
strengthens this point: Elliott and James (1989) found five common perceived helpful aspects
of therapy that were relational: facilitative therapist characteristics, client self-expression,
experiencing a supportive relationship, achieving self-understanding and the therapist
encouraging extra therapy practice. The first three fall under interpersonal aspects of the
therapy and the last two fall under task aspects. In addition more recently Paulson, Truscott
and Stuart (1999) have studied helpful experiences in therapy with 36 clients and reported
nine thematic clusters through concept mapping which also focus on both task and
interpersonal aspects of therapy; the facilitative style of the therapist, the therapist’s specific
interventions, how the client is helped to realise their own resources, gaining new
perspectives, the level of self disclosure by the client, the client’s level of emotional relief, the
knowledge acquired, accessibility of the therapist and the client reaching resolutions.
In 2004, a research study by Clark, Rees and Hardy (2004) widened the view of what was helpful to clients in therapy from interpersonal and task impacts, to also include how clients felt better after therapy. They used GTA and examined how cognitive therapy helped five clients with depression. They found 10 categories from the coding analysis, these 10 then clustered into 3 superordinate categories, the listening therapist, the big idea and feeling more comfortable with self. The listening therapist seemed to highlight the interpersonal and emotional part of the therapy; resistance and fear, excited and absorbed, and safety. The big idea related to specific techniques; the cognitive model, dealing with thoughts, understanding patterns and core beliefs, and testing things out. Feeling more comfortable with self included ways in which the client felt better after the therapy, confident and comfortable, responsibility and positive feedback.

A further meta-synthesis of client experiences of the helpful impacts of therapy was conducted by Timulak (2007). The research produced 48 categories which were reduced to 9 core categories: (1) Awareness/insight/self-understanding, (2) behavioural change/problem solution, (3) empowerment, (4) relief, (5) exploring feelings/ emotional experiencing, (6) feeling understood, (7) client involvement, (8) reassurance/support/safety, and (9) personal contact. The findings of helpful impacts in this study link to clients being helped to take a new perspective (awareness/insight/self-understanding), or engage in new behaviour (behavioural change/problem solution) or having new experiences and motivations (exploring feelings/emotional experiencing, empowerment, relief). These correspond well with different emphasis on helpful change processes in main theories of psychotherapy (i.e. psychodynamic, cognitive behavioural, experiential).

What is interesting in the research by Timulak (2007) is that the helpful significant therapy events, processes and impacts were found across therapeutic approaches, which indirectly confirms a meaningfulness of integration in psychotherapy. These findings link to Counselling Psychology’s pluralistic philosophical therapeutic stance of therapy in that multiple therapeutic techniques and tools from different therapeutic approaches are helpful to clients, rather than needing to stick to one therapeutic philosophy (Cooper and McLeod, 2007). It supports an approach where one therapeutic approach does not suit everyone and one size does not fit all clients (Cooper & McLeod, 2011). A multitude of therapeutic methods can therefore ‘be most helpful for different clients in different instances’ (Cooper and McLeod, 2007, p.6). Processes for successful therapy have therefore been summarised as building a strong therapeutic alliance incorporating key relational skills, focusing on the needs of the individual client and tailoring therapeutic interventions (Cooper and McLeod, 2007; Hubble, Duncan and Miller, 1999).

When examining unhelpful aspects in research, they often are located in a lack of interpersonal attunement in the therapeutic alliance. Elliott (1985) found six kinds of non-helpful events; misperception, negative counsellor reaction, unwanted responsibility, repetition, misdirection and unwanted thoughts. A study by Timulak and Lietaeer (2011),
worked with six participants using Interpersonal Process Recall (IPR) and they found that clients had reservations about the therapeutic relationship, from the perspective of uncertainty, deference and examination towards the counsellor.

The research outlined above helps to locate this thesis in what is helpful and unhelpful in psychological therapy, from clients’ perspectives. Task and interpersonal elements seem to be vital for therapy to be helpful and a poor therapeutic relationship appears to lead to therapy being unhelpful, regardless of task elements. However the research examined above did not look at a specific population, the studies considered helpful aspects generically with clients. The research studies form a useful starting point for my thesis, but I was specifically interested in the experience of women with primary breast cancer and what they felt were the helpful and unhelpful aspects of therapy. I will now go on to explain psychological therapy in relation to the medical model and the role of the active client, and then look at helpful aspects of therapy specifically with people who have cancer.

2.3 The medical model of cancer, in contrast to the client as active self-healer

‘If each woman with breast cancer understood medicine’s limited ability to control the disease, our reliance on physicians, tests, and medical interventions would be enormously reduced. The power of these institutions over us would dwindle accordingly. Without the rosy filter, women with breast cancer would gain the right to map our own future, within the very real constraints imposed by a life-threatening disease.’

(Batt, 1994, p.237)

Historically, the paternalistic medical model of patient-physician interactions was central to cancer treatment. This medical model relates to the role of the patient to report their symptoms, rather than have theories on what the problem was. The treatment, chosen by a health professional, was then applied to the problem and the person was the ‘site’ of the disorder. Therefore ‘a skin cancer tumour would be treated fairly much the same regardless of whose skin it is on’ (Bohart and Tallman, 1999, p.7). Foucault (1973) argued, that the medical gaze socially constructs disease, it constructs bodies as diseased or not, as pathological or normal and has power to diagnose, define and control disease. Therefore the person, in the sense of active sentient engagement, does not really have to be present, for the treatment to work and often people can be unconscious, because of medication. The testing and treatment for cancer used to typically happen relatively independently of the patient’s psychological state, sufferers were grouped together into a homogenous category defined by the type of cancer they had (Potts, 2000b).

Spence (1986) who died from breast cancer, talked to medical audiences about how the medical profession controls women’s bodies and depersonalizes the person. Through phototherapy, an approach combining photography and therapy, (that she largely initiated), Spence (1986) explored how powerless she personally was as a patient; she felt ‘infantilisation, whilst being managed and ‘processed’ within a state institution’ (p.156). Fosket (2000) pointed out that the power of the medical gaze, to produce legitimate
knowledges about the body could mean that ‘women’s productions of knowledges’ about their own bodies, their embodied experience, could be dismissed (p.21). The dominance of science, medical and technology, within breast cancer care, can structure what counts as legitimate knowledge, around breast cancer with women.

Faced with a medical world, Stacey, (1997) responded by reading as much about cancer as she could when she was diagnosed with an endodermal sinus tumour, she turned it into an academic project, to try to gain control. Stacey (1997) went on to describe the added pressure from the influence of the cultural horror of cancer, in Western society; cancer violates ‘boundaries, generating anxieties about the certainty of boundaries between subject and object, normal and abnormal, inside and outside and between life and death’ (p.77). In addition the loss of control Stacey felt, when diagnosed with cancer, was further exacerbated by the alien medical world that she found herself in. Jain and Stacey (2015) described this experience as the ‘‘cancer complex’. For as well as feeling out of control of our bodies, we are thrown by cancer into a place of ontological uncertainty, rewriting our histories and our futures through its shifting narrative and discursive orderings and dis-orderings’ (p.1). When in the ‘cancer complex’ Stacey (1997) noted that ‘the appeal of the masculine hero narrative of science cannot be overestimated. Trust the doctors, they know best. Your body becomes the battleground between good science and bad disease. If you give yourself up to their wisdom and follow their instructions, you stand the best chance’ (p.11-12).

More recently the information culture now encourages ‘participatory patients’ who want to know, who are obsessively curious and welcome any new explanations (Stacey, 1997, p.3). The medical model of cancer treatment is therefore now giving way to a more shared relationship focus, particularly where there is now more of a focus on shared decisions, good interpersonal relationships and facilitated information exchanges (Arora, 2003). People with cancer often need and want information and reassurance, because there are many uncertainties. They also want to be validated and be understood, this can relate to wanting their reactions to be normalised and legitimised. However, unfortunately people with cancer can often struggle to gain adequate and desired consistent support over time (Rose, 1990). In addition they may find it difficult to disclose concerns about psychosocial issues to their physician, because they may feel that depression, fatigue and pain are inevitable consequences of the disease and the harsh treatment (Maguire, 1999). This is where specific psychological therapeutic support can help.

Psychological therapy can help to unlock a person’s agency within a medical setting (Bohart and Tallman, 1990). In this thesis, this specifically relates to people with cancer, because their agency is often diminished elsewhere. Psychologically, the person can be viewed as an active-self-healer and the therapist as a supportive person, who assists and promotes change by helping the person to mobilise their own resources, to gain new life solutions. The active self-healer concept fits well with Counselling Psychology’s focus on empowering the client. Therefore the person’s full individual experience is the most important part, rather than just the type of cancer they have.

Within the model of the client as active self-healer, the person with cancer must be seen as a whole person. It the therapist works with just a part of the person, the cancer part, they may misinterpret and be unhelpful to their client as ‘therapy is a whole-person enterprise’ (Bohart and Tallman, 1999, p.18). The therapeutic work to define the client’s problems is a collaborative process and there is often a meeting of minds. Therefore, this can feel in sharp contrast to the traditional medical model of cancer treatment, where the physician is clearly
leading the discussion and direction of the medical consultation. In addition, the context of the person is extremely important as the psychological problems emerge from a person, who is embedded in various social systems. As such, the context cannot be ignored in psychological therapy.

From a Counselling Psychology perspective, power resides with the individual client and the healing force comes primarily from the person. The focus is on the quality of the therapeutic relationship with the individual, rather than concentrating on efficient, manualised and standardised therapy (James, 2011). The client is also active within the therapy room, whilst the therapist provides a safe psychologically held place, with the opportunity to have exploratory dialogue, provide resources to help the person, help them to create their own solutions and advise on specific skills, where they are required. Bohart and Tallman (1999) saw no problem in using a psychological therapeutic model, where the client is an active self-healer, in a medical model context and this could relate to working with people with cancer in a hospital setting.

This thesis is designed to contribute to the growing body of work in psycho-oncology, particularly the place of psychological talking therapies to help support people with cancer, in a traditionally very medical forum. The outcome of psychological therapy is to help to relieve part of the suffering for people with cancer. I will now talk about how psychological support has been found to help people with cancer.

2.4 Psychological therapy with cancer patients, a pluralistic approach?

As previously stated, it is widely recognised that the psychological needs of people with cancer are paramount as they adjust to their cancer diagnosis and continue on their individual treatment plans. In addition, as there are increasing numbers of people with cancer, who have a longer survival, because of advances in medical care, learning to live psychologically with cancer is an important focus of study (Fawzy et al., 1995). People with cancer are usually distressed, often anxious and they are unable to use their normal coping styles effectively. The adjustment process can be aided by many different support mechanisms, for example the quality of the medical care people receive, educational and information resources provided, the strength of the social structures around them, a person’s spirituality, group support and psychological therapy (Arora, 2003; Fawzy et al., 1995; Swartz and Sendor, 1999; Walton and Sullivan, 2004; Tomas and Retsas, 1999).

Psychological therapy has been shown to be effective for patients with cancer in helping to reduce emotional distress, enhance coping and improve adjustment (Anderson, 1992). Studies have illustrated that therapy also helps people with cancer obtain information about the disease, diagnosis and treatment, (Houts et al., 1986), provides them with a safe place to get emotional support to address anxieties about cancer (Cain, Kohorn, Quinlan, Latimer, & Schwartz, 1986), facilitates behavioural and/or cognitive coping strategies (Davis, 1986; Redd and Andrykowski, 1982), and aids relaxation (Edgar, Rosberger, & Nowlis, 1992).

On reviewing the literature around cancer and psychological therapy (PsycInfo, Medline and CINAHL, using the search terms ‘cancer’ and ‘psychological therapy*’25/5/15), I found the
majority of the research studies within this search used quantitative methods. For example there were Randomised Controlled Trials (RCTs) (Cunningham, Edmonds, Jenkins, Pollack, Lockwood and Warr, 1998) or questionnaires (Boulton et al., 2001). Different therapeutic approaches to therapy were explored and were found to be helpful; illustrating that no one approach is best. The therapeutic approaches varied from imagery rescripting (Whitaker, Brewin and Watson, 2010), psychological therapies over the internet (Owen, 2004), cognitive behavioural therapy (Watson, Fenlon, McVey and Fernandez-Marcos, 1996; MacCormack et al., 2001), group psychological therapy (Cunningham, 2002) adjuvant psychological therapy and counselling (Moorey, Greer, Bliss and Law, 1998; Boulton et al., 2001) and relaxation (MacCormack et al., 2001).

I will now discuss four specific published research studies on therapy with people with cancer in detail: The first study examined the experiences of people who had differing types of cancer, together with their friends and their family. This research found that emotional relief, advice on specific medical situations and examining the person’s own individual emotional responses were all helpful (Boulton et al., 2001). This study was quantitative and 142 completed evaluations forms were analysed, the forms contained both closed and open questions. Counselling helped the participants work through powerful thoughts and feelings, which in turn helped them to come to terms with cancer and gain a sense of control over their lives. Boulton et al., (2001) also stated that the clients identified benefits that fitted with the aims of humanistic counselling and they would advocate using these client-defined outcomes for assessment of cancer counselling rather than psychiatric assessments, because the former provide a client led approach to what is helpful, which maybe a more sensitive way of gauging the value of psychological therapy. This research study unfortunately did not look in depth at the experiences of the individuals affected by cancer. Instead it only provided a top line view using a quantitative questionnaire tool.

The second research study reviewed 66 patients with chronic medical conditions using face-to-face or telephone interviews (Agnew et al, 2011). This project included people with cancer and found nine helpful themes; talking to a trusted professional, the therapeutic relationship, specific therapeutic interventions, confidentiality, cathartic experience, raised self-awareness, openness, feeling listened to and the positive personal qualities of the therapist. In addition Agnew et al (2011) asked their participants what they felt would have happened if they had not been referred for psychological therapy. The key themes in answer to this second question were, would not have been able to cope, poorer psychological well-being, might not be alive, relationships would have worsened, might have required psychiatric admission and physical health would have worsened. This study showed the benefits of psychological therapy and the perceived problems if therapy had not been made available to the participants of this study. Finally, this study also found that the main focus of psychological improvements was a better ability to cope with their situation through a supportive relationship, rather than in terms of a reduction in psychological symptoms. Therapeutic benefit in this research study was not limited to one specific therapy orientation. This research used short interviews so again did not access the depth of experience of the people with cancer however it did illustrate the importance of the therapeutic alliance in helping the person to find a way of coping.

A third study, MacCormack et al., (2001), interviewed patients with metastatic (secondary) cancers, using a qualitative approach. The patients had been offered two different approaches
to psychotherapy, (Cognitive Behavioural Therapy (CBT) or relaxation therapy). The findings were then analysed using grounded therapy and they illustrated that there were similar benefits in both the CBT and relaxation therapy; valuing a safe relationship where they could share and explore their thoughts and feelings with someone who was experienced, cared and was genuinely interested in understanding their individual cancer experience. This research also corroborated the central role of the therapeutic relationship in psychological therapy and the clients were more interested in ‘being’ in the relationship, rather than ‘doing’ things (Yalom, 1980; Spinelli, 1999). This research also pointed to attending to cancer patients’ perspectives, when looking to improve psychological interventions, in a cancer care setting. MacCormack et al., (2001) summarised their working hypothesis from their GTA as, ‘from the cancer patient’s perspective their psychotherapy is primarily a relational or ‘being with’ experience that offers them a unique conversational space to explore and discuss thoughts and feelings with an experienced and understanding professional who cares’ (p. 61). They do not discount techniques of ‘doing’ as these are vital skills of psychotherapy. However their study found that their participants were more focused on ‘being’ with another in therapy. Again, in this study differing therapeutic change methods were found to be beneficial.

Another more recent qualitative research study examined specifically helpful processes in psychological therapy with 8 patients who had a primary cancer using semi-structured interviews (Omlinska-Thurston and Cooper, 2014). This study was a departure from the top line analysis as it provided an in depth investigation, using interviews with the 8 people with cancer. The research discovered six underlying helpful processes: talking and expressing their feelings to someone outside the family, forming a relationship with their therapist, normalization through the therapists’ expert knowledge, problem solving and Cognitive Behavioural Therapy (CBT). The study by Omlinska-Thurston and Cooper (2014) found a variety of processes helpful with primary cancer patients, which were again not limited to one specific therapeutic orientation. Methods and practices from a wide range of therapeutic change models were of benefit and this study therefore provided strong support for Counselling Psychology’s pluralistic therapeutic orientation, with people who have a primary cancer (Cooper and McLeod, 2007). This finding echoed the results of the previous research studies discussed above (Agnew et al., 2011; Boulton et al., 2001; MacCormack et al., 2001). In addition it links to the finding that all therapies are for the most part equally effective, this has been called the ‘dodo bird verdict’, here the relational component of the therapy is of greater importance than the technique employed (Rosenzweig, 1936). It is interesting to note that these studies found that a pluralistic approach to psychological therapy, rather than one therapeutic approach was helpful. Cooper and McLeod (2007) defined a pluralistic approach when they presented a new framework for psychological therapy, which moved away from an orientation-specific way of therapy. They argue that there is no one right way of doing therapy and that different clients, need different things, at different times. The focus is on engagement in the client’s view and collaboration. Tailoring approaches to individuals in a humanistic progressive way is key.

A pluralistic approach to psychological therapy is a basic foundation of Counselling Psychology, where professional training does not focus on one particular theory (James, 2011). This pluralistic approach has been shown to be helpful for people with cancer and this leads us onto the specific focus of my thesis: How therapy is helpful and or unhelpful to women with a specific cancer type, primary breast cancer. It is acknowledged that the
participants were all individuals at different stages with their primary breast cancer, post diagnosis and as such there will be differences, but in addition there may be findings that are common with this population.

2.5 A qualitative research approach to understanding the process of psychological therapy

As opposed to the majority of the previous quantitative research studies examining how psychological therapy is helpful to people with cancer, my thesis is focused on a qualitative research design. I adopted a person-centred holistic approach in order to develop an understanding of the depth and breadth of human experience (Polkinghorne, 2005). This links to the roots of Counselling Psychology, which have humanistic values and are inspired by the work of Maslow, Rogers and May (Strawbridge & Woolfe, 2011). Humanism is focused on the individual’s subjective experience and the therapist and client work together to gain an understanding of a person’s situation that is leading to distress. Cooper summarises the focus of Counselling Psychology as being about the client’s subjective and inter-subjective experience, focusing on facilitating growth in the client, empowering clients, a commitment to a non-hierarchical client-therapist relationship, an appreciation of the client as a unique being and an understanding of the client as a socially- and relationally-embedded being (Cooper, 2009).

My goal was to gain an interpretation of the phenomenon, this reflected a hermeneutic approach and this was linked to the double hermeneutic that all social sciences are engaged in, there is no universal truth to be discovered and our theories alter practice (McLeod, 2001; Giddens, 1982). Semi structured interviews were used with open-ended questions, to allow the women to respond in their own unique way (Knox and Burkard, 2009). There was an acceptance in this qualitative research of my role, as the researcher in the findings and my perspective influencing what was seen within the data. As a result, the tabula rasa view of inquiry was dismissed in this thesis (Bulmer, 1979). Many researchers are in the position of having knowledge of the processes involved in the research area they are studying and the key focus in this thesis was to try to ensure the findings all came directly from the women’s transcripts (Rennie, 2002; Rennie 2006). There was a delicate balance between the researcher having some knowledge of the research area but not being wedded to it (Charmaz, 1990). This will be discussed in more detail in the reflexive analysis chapter 5.

I used the five-dimensional model of the therapy process, which was devised by Elliott (1991) to help me to be clear in my thesis, about the different types of processes involved in therapy and specifically what can be studied. Firstly I will discuss the perspective from which the information derives. In my thesis I was interested in data generated by and with the women with breast cancer; that is, in documenting their perspectives, as client’s views have been shown to differ from therapists, in terms of what went on in therapy and how change happened (Llewelyn, 1988). Secondly, it is important to look at where the process comes
from; this can either be the client, the therapist or the therapeutic relationship. In my research, I was interested in the whole range of possibilities in terms of the source of change for the client. I wanted to know what and how the client experienced the therapy as helpful and/or unhelpful.

Thirdly, therapy process can be looked at in different units; sub-episode like speaking turns or midsize basic units like episodes or session units or at the top of therapy process units e.g., the therapeutic relationship as a whole. This thesis looked at a wide range of key units of the therapy process, because the interviews took place mainly at the end of therapy and they were focused on what the women recalled freely, as helpful and non-helpful. Fourthly, temporal phase refers to whether the therapeutic process is studied, vs. the context or its effects. This research examined all three phases in an attempt to look specifically at psychological therapy with a specific population, namely women with breast cancer. The women could not be separated from their context and the context of the therapy. In addition the women explained helpful aspects as processes and effects. Finally, the fifth dimension is the aspect of the process examined, content (what is talked about), action (what the client or therapist is trying to do), style (how the person is saying or doing something) and quality (how skillful the therapist is or how deeply the client is working). In my thesis, the women were asked openly what made the therapy helpful and/or unhelpful; therefore this fifth aspect was reviewed across all aspects.

2.6. Breast cancer in women, a gendered issue

‘There is a commonality of isolation and painful reassessment which is shared by all women with breast cancer... I do not forget cancer for very long, ever. That keeps me armed and on my toes, but also with a slight background noise of fear.’

(Lorde, 1997, p.8-12)

“Each women responds to the crisis that breast cancer brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived. The weave of her every day existence is the training ground for how she handles crisis... I am a post-mastectomy woman who believes our feelings need a voice in order to be recognised, respected and of use...I do not wish my anger and pain and fear about cancer to fossilize into yet another silence, nor to rob me of whatever strength can lie at the core of this experience, openly acknowledged and examined. ”

(Lorde, 1997, p.7)

As discussed earlier, my thesis is focused on the first dimension of psycho-oncology, looking at how cancer impacts on the psychological functioning of the person, in this case, the woman with breast cancer who took part in the research. It is important to state however that cancer ‘is not one disease but several separate ones, each with multiple etiologies and disparate outcomes... There is not a prototypic ‘cancer patient’” (Anderson, 1992, p.552). In addition, breast cancer is not one disease, it is many, ‘it is experienced physiologically in very different ways by the women afflicted. Add to this the complex variables through which women
experience their body and femininity – such as age, class, race and sexuality’ and breast cancer certainly should not be reduced to one norm (Saywell, Beattie and Henderson, 2000, p.51-2).

This thesis is focused on examining the experience specifically of women, with a primary breast cancer. Breast cancer is the most common cancer for women worldwide and is the most common UK cancer overall. In 2010 the lifetime risk for women in the UK was 1 in 8, incidence rates in Europe have increased +72% in 2009 - 2011 (vs. 1975 - 1977) and mortality rates in Europe decreased by -36% in 2010 - 2012 (vs. 1971 - 1973), (Cancer Research, 2015a; Cancer Research 2015b). With increasing numbers of women surviving breast cancer, far beyond their treatment, there has been a shift from the focus of care being the acute treatment-related side effects to long-term changes in quality of life (Ferrell et al., 1996).

I could not ignore breast cancer as a gendered issue, in this research. It is the most common cancer for women and I wanted to understand signs of a gendered social life, for the women I interviewed. I was looking for structured expressions of gender in the relation to the women’s experience of breast cancer and psychotherapy (Harding, 1986). Harding (1987a) called for a wider view of research on women and has criticized the three basic kinds of focus as being too simplistic: Recovering and re-examining the work of women researchers and theorists, examining women’s contribution to activities in the public world and the study of women as victims of male dominance. Harding (1987a) characterised the three best criteria for feminist analyses as generating ‘its problematics from the perspective of women’s experiences’, generating research findings for women to explain social phenomena and ‘insisting the inquirer... be placed in the same critical plane as the overt subject matter’, the ‘researcher is visible, real and has concrete, specific desires and interests’ (Harding, 1987a, p7-9). My research was focused on satisfying Harding’s three features of feminist analyses: I wanted a strong focus on understanding women’s experiences from their perspective, my analysis is for women with primary breast cancer, as much as it is for healthcare professionals and I have acknowledged my role in this research, as being active and influencing the process, this is specifically discussed in my reflexive analysis chapter 5.

I wanted to produce research that was not unaware of its necessarily ‘partial and distorted’ features in its ‘descriptions, explanations and understandings’ (Harding, 1987a, p.12). My role as a researcher, in this research, was as a passionate, interested and socially visible woman (Maynard and Purvis, 1995). I was keen for the research to not censor out ‘the mess, confusion and complexity’ of the research process (Kelly, Burton and Regan, 1995, p.46). I wanted the analysis to bear a relation to what happened in the interviews, rather than the research being cleansed and turning out hygienic.

As my research was undertaken by a woman, interviewing women, I was conscious from the outset that I would be open to notice any androcentric biases (Harding, 1987b). I attempted to provide a clear perspective of the women’s views ‘rather than inferring them from observation and experiment’ (Phoenix, 1990, p.89). This research marks a specific point in time, from the women’s viewpoints, with regard to psychological therapy being helpful and/or
unhelpful. This research does not imply there is a reality but to acknowledge that there are many ‘subjugated knowledges… the female subject is a “site of differences”’ (Harding, 1987b, p.188).

In women’s stories of breast cancer, three distinctive areas of meaning seem to stand out: Breast cancer equals death or as survivable, treatment compromises the femininity and identity of the women, and experiences should not be discussed (Rosenbaum and Roos, 2000). In the 1980s, breast cancer support groups were created for the first time, breast cancer was no longer a personal secret and psychological experiences could be shared (Brenner, 2000). However the social lens on women means that women with breast cancer grapple with the meaning of what is happening to them, with the pervasive ideas regarding women and their bodies. I will now specifically look at how women are forced to look at the meaning of their breasts in relation to breast cancer.

2.7 The role of breasts, for women with breast cancer

“Feminism’s brilliance is found in the recognition that the body is not simply personal, that there is a politics to sex, that personal and political life are intermeshed”

(Eisenstein, 2001, p.3)
When embarking on this research study, I was struck by the relationship between breast cancer and the sociocultural role of breasts for women. Many women have received messages, throughout their lives, about how they ‘are defined by, and primarily valued for, their appearance, and that a women’s appearance is largely defined by her breasts’ (Rosenbaum and Roos, 2000, p.154). ‘Breasts are iconic, both of female sexuality and maternity, and as such, are often the currency though which feminine value is attributed’ (Saywell, Beattie and Henderson, 2000, p.39). Therefore, when a woman is diagnosed with breast cancer, her social identity can be under threat, which in turn can challenge her self-worth. The cancerous breast ‘can be neither erotic or maternal’ (Saywell, Beattie and Henderson, 2000, p.40). In addition, treatment may involve surgical alteration, which may result in the loss of a part, or a whole breast, or both breasts. This can lead to women to question what meaning breasts have. Women can feel they are being viewed, or even view themselves, as less feminine and less of a woman when they have had surgery, which is often disfiguring to their breasts. They don’t feel like a whole person, they can somehow feel they are ‘damaged goods’ (Rosenbaum and Roos, 2000, p.166).

From a feminist perspective I found many views, expressed by women with breast cancer, about their breasts and losing a breast. Batt (1994), who had breast cancer, stated that ‘a woman with cancer who confronts the world with her baldness or breastlessness has tremendous power to effect change’ (p. 236). Batt (1994) was concerned about the promotion of prostheses and cosmetics; she agreed with Wolf (1991) that the beauty myth subverts women’s power. There is a ‘dominant discourse of the desirability of retaining a woman’s ‘wholeness’ and ‘femininity’ by conservative surgery and the construction of a prosthetic breast’, there is still ‘an ideal of two-breasted symmetry’ (Potts, 2000, p.8-9).

Lorde (1997) who died of breast cancer, felt sadness and rejection after her mastectomy, from other women, she said ‘the absence of my breast is a recurrent sadness, but certainly not one that dominates my life. I miss it, sometimes piercingly. When other one-breasted women hide behind the mask of prosthesis or the dangerous fantasy of reconstruction, I find little support in the broader female environment for my rejection of what feels like a cosmetic sham’ (p. 14). Lorde (1997) also talked about the pain of separation from her breast as ‘at least as sharp as the pain of separation from my mother. But I made it once before, so I know I can make it again...Now I really see it as a choice between my breast and my life and in that view there cannot be any question’ (p.24-33).

Spence (1986) who died of breast cancer, said no to a mastectomy, because she was extremely frightened about the prospect of losing her breasts, she said ‘it took immense amount of courage initially to say no, that I didn’t want to be mutilated...now I could lose first one then another breast, terrified me beyond all reason, beyond anything that ever happened to me before’ (p.152). Spence (1986) thought about women’s bodies as fragmented, beauty objects, that were even competed over in medical care situations, she stated ‘given women are expected to be the objects of the male gaze’, they ‘are expected to beautify themselves in order to become loveable’, they ‘are still fighting for the basic rights over their
own bodies, it seemed to me that the breast could be seen as a metaphor for our struggles’ (p.155).

Photograph 2 & 3: Jo Spence post a lumpectomy, first photographed by Spence and Dennett (Spence, 1986, p.157) and second photograph by Spence (Spence, 1986, p.161)

Women often spoke of not feeling like a woman, anymore after losing a breast, to breast cancer. Women felt dissatisfaction; the loss of a breast was an assault on perceptions of normality (Saywell, Beattie and Henderson, 2000). This area is complex, some women have a hatred of the external prosthesis, Lorde (1980) decided not to wear a prosthesis because she felt she did not want to imply that she was the same as before with ‘a little puff of lambswool, and/or silicone gel’ (p.57). Other women are disappointed when they have breast-conserving surgery, as they did not expect the removal of a lump to lead to, asymmetry in their breasts. In addition, other women find that although reconstruction leads to an improved body shape they are distressed by the actual breast appearance. The meaning of a breast and the loss of one is an individualised experience (Fallowfield and Clark, 1991). However socio-culturally the ‘overt sexualizing of illness sites separates breast cancer from other cancers, such as lung and blood cancer’ (Saywell, Beattie and Henderson, 2000, p.41).

There is undoubtedly a sociocultural process surrounding post-operative recovery from breast cancer surgery that emphasizes and reaffirms sexual and gender identities; ‘to keep one’s femininity intact requires elaborate efforts on the part of the women with cancer: above all, energy should be directed into covering up the signs of this stigmatized disease and the effects of its treatment’ (Stacey, 1997, p.71). The breast is an icon of feminine worth in western society and this is emphasized in the media around breast cancer (Saywell, Beattie and
Henderson, 2000). This specific focus can add to the pressure on women with breast cancer and should not be underestimated in terms of the psychological effects.

2.8 Psychological therapy with women with breast cancer

This thesis examines the experience of women with a primary breast cancer in relation to psychological therapy. Historically, many studies have focused on helpful aspects of therapy, across all cancers, rather than focusing specifically on breast cancer. There is now an increasing body of evidence that illustrates that certain issues faced by women with breast cancer are specific to this group; poor body image, impact on the self concept, distress from surgery, sexual and relationship issues (Shimozuma, Ganz, Petersen and Hirji, 1999; Ferrell, Grant, Funk, Garcia, Otis-Green and Schauffner, 1996; Hopwood, Keeling, Long, Pool, Evans and Howell, 1998; Pistrang and Barker 1995). As a result, women with breast cancer have differing experiences psychologically and may have differing thoughts and feelings about psychological therapy, than the broader cancer population.

Research has shown that the experience of significant psychological problems may be as many as 30% of women with breast cancer, which is higher than expected for women in the general population (Glanz and Lerman 1992; Hopwood, Keeling, Long, Pool, Evans and Howell, 1998). Psychological wellbeing concerns, with women with breast cancer, have been summarised into four themes; concern for the future, survivorship (and worries about reoccurrence), sources of psychological distress (specifically dealing with the treatment) and emotional responses to breast cancer ranging from fear, depression to an increasing sense of control (Ferrell et al., 1996). Breast cancer is still the most common cause of cancer death in Europe for females and it is also heavily exposed in the media, particularly in relation to cancer deaths in prominent individuals (Cancer Research, 2015b). Therefore fear of death is heightened in women with breast cancer, even though mortality rates are declining (Ferrell et al., 1996).

Having reviewed the literature on how therapy is helpful to people with breast cancer I have found that much of the research is quantitative in nature. When I looked specifically at CBT interventions, with women with breast cancer, for example, across three different databases (PsycINFO, CINAHL Plus and Medline), I found that out of 16 studies, since the Department of Health’s cancer plan in 2000, 14 were RCTs (Groake, Curtis and Kerin, 2013; Mann et al., 2012; Dirksen and Epstein, 2008; Cohen and Fried, 2007; Qiu et al., 2013; Ferguson et al., 2012; Schnur et al., 2009; Montgomery et al., 2009; Montgomery et al., 2014; Duijits et al., 2012; Mefferd, Nichols, Pakiz and Rock, 2007; Savard, Simard, Ivers and Morin, 2005; Tremblay, Savard and Ivers, 2009; Matthews et al., 2012). The other two studies were still quantitative in nature, but not RCTs (Quesnel et al., 2003; Savard et al., 2011). On looking at these studies I found 9 themes around what was helpful or unhelpful: (1) Easy to use tools, (2) positive personal transformation (3) physical benefits, (4) attendance and adherence, (5) psychological effects, (6) length of impact, (7) not everyone benefits, (8) therapist qualities and (9) group processes.

In this research project my guiding interests could not be addressed via a quantitative
paradigm. I wanted to take a qualitative approach to the research area to examine the richness of the women’s experience of psychological therapy. I felt that a positivist approach would have been too narrow and value neutrality, in the research process was impossible for me to achieve as a researcher (Harding, 2007). I wanted to focus on depth and rich insight, rather than a more top line quantitative approach to the research area. I wanted to find out from the women’s perspectives, which therapeutic processes and aspects they specifically experienced as helpful and unhelpful. As discussed earlier, I do not believe that clients are passive recipients of therapy and therefore this research was focused on bringing the voices of women with breast cancer, to the foreground and examining what they felt helped them and didn’t help them in their distress from a psychological therapeutic perspective (Bohart and Tallman, 1999; Elliott, 2008). The research was therefore focused on the intimate aspects of the women’s cancer experiences from their perspective in order to increase understanding and care for women with breast cancer. The women’s individual unique needs and experiences are the area of study; however patterns did emerge across all participants. In addition I acknowledge that there are complex debates in qualitative research in relation to the researcher’s voice vs. the participant’s and this is discussed in greater detail in the methodology chapter 3.

2.9 Philosophy of social constructionism and grounded theory

At this point it is important to consider the qualitative research approach taken in my thesis with specific regard to the social constructionism view I adopted. Constructionism is the view that ‘all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context’ (Crotty, 1998, p.42). Social constructionism is based on the view that whilst all humans engage in their world in a constructivist spirit, this must be seen in a genuinely historical and social perspective. Humans are born into and operate in a world of meaning; all meaningful reality is socially constructed. Therefore culture can shape the way people see things, think about things and feel things. Social constructionism is both realist and relativist; meaningful reality is constructed, but at the same time it is also real and what we say about the way things are is just about the sense we make of them now (Crotty, 1998). Charmaz (1990) specifically described social constructionism in relation to how people who live with illness experience their constructions as reality. The constructions reflect ‘their understandings of their experiences as well as the diverse situations in which they have them’ (Charmaz, 1990, p.1161).

I adopted the approach of social constructionism because breast cancer in women, is socially constructed. Women’s experiences of breast cancer are much broader than managing the physical issues of cancer progression, treatment and recovery. Women also have to handle these physical changes and experiences, in relation to inextricably linked social worlds (Rosenbaum and Roos, 2003). When women face breast cancer, they must face the dominant pervasive cultural meanings that surround their bodies, which they have grown up with. They
experience breast cancer in relation to the pervasive ideas of feminine appearance and therefore as a threat to self. They may experience the struggle between the threat to womanhood of a mastectomy vs. the preservation of their health and life (Kasper, 1994). Pressures come from a threat to their femininity and self-worth; individual women will vary in how they deal with this from embracing to challenging these meanings (Rosenbaum and Roos, 2003). Socially women have learnt bodily standards as children and how they can conceal their bodily deviations (Haug, 1987). This continues in breast cancer treatment through the use of prosthesis and surgery involved in reconstruction.

The GTA method provides a useful set of research strategies for examining the experience of disease and illness, like breast cancer in this thesis (Charmaz, 1983). GTA was originally based on the work of Glaser and Strauss (1967) and this analytic framework offers an explicit, structured and logical approach, with the findings being grounded in the data (Strauss and Corbin, 1998). A social constructionist perspective of GTA offers a way of constructing social reality by creating theoretical categories from the data and explaining the relationships between them, ‘the researcher constructs theory from the data’ (Charmaz, 1990, p.1162). The researcher attends to how the participants construct their worlds, by focusing on data from the lived experience and the research questions are general in nature. The process of categorization is active and about discovery, not passively observed by a trained researcher (Charmaz, 1990). The researcher is interested not only in experiences, but how they develop, change and give rise to consequences. Process is the focus of study and therefore the theories created using GTA are not frozen.

This thesis is designed to examine the following research questions from a social constructionist perspective, using GTA:

- What are the helpful aspects of psychological therapy as identified by women with a primary breast cancer?
- What are the unhelpful aspects of psychological therapy as identified by women with a primary breast cancer?

2.10 Chapter Summary

Within this chapter, literature in relation to psychological distress with people with cancer was discussed, including what makes psychological therapy helpful from the client’s perspective, the medical model of cancer in contrast to the client as active self-healer, psychological therapy with people with cancer looking at a pluralistic approach and my qualitative research focus. I then specifically outlined breast cancer in women as a gendered issue, the role of breasts for women with breast cancer and psychological therapy with women with breast cancer. Finally, I reviewed the philosophy of social constructionism and GTA.

Research to date examining helpful and unhelpful aspects of therapy has used a broad range of clients as participants, which is one of the reasons why I wanted to focus on asking this question to a specific population: women with breast cancer. In addition, the majority of
research has examined how psychological therapy is helpful to people, with cancer, using quantitative methods and this is why I wanted to focus on a qualitative approach, to generate the analysis from the rich experience of the women with breast cancer, using in depth interviews.

The results of my research will be useful to women with breast cancer, when considering whether to have psychological therapy. The findings will also be practically useful in relation to the creation of training for psychotherapists and other health care professionals in cancer settings and in the preparation of psycho-educational materials for women with breast cancer (Fawzy et al, 1995). This study with women with breast cancer examines helpful processes and unhelpful processes and will be a valuable resource in terms of guiding psychological therapeutic practice with women with breast cancer, through understanding what can be helpful and what may not be helpful.
3. Methodology

3.1 Introduction

As outlined in the previous chapters, the purpose of this research was to consider the reported helpful and unhelpful processes in psychological therapy, for women with breast cancer using two research questions. Within this chapter, I shall firstly give my epistemological positioning as the researcher and present the current methodology in consideration to the different stages of the research procedure. Details of the recruitment, data collection and analysis will be explored, with reference to qualitative trustworthiness, authenticity and validity standards.

To answer the research questions I used a qualitative research design, in order to focus on the idiographic experience of the women with primary breast cancer, who had also chosen to have psychological therapy. My thesis examined the reflections of eleven women, focused on what they found helpful and/or unhelpful. I used semi-structured interviews to generate the qualitative data, which was audio recorded. The recordings were transcribed and analysed using GTA (Strauss and Corbin, 1998; Charmaz, 2000; Charmaz 2006a). In addition, I looked at the relationship between qualitative research and feminist psychology. Finally, the ethical issues within the research are discussed, to illustrate that, I adhered to procedures put in place by the British Psychological Society (BPS).

3.2 Epistemological Positioning

In this section I will give an overview of my epistemological positioning within the current research. It is important to make this positioning clear, as it influenced my methodological decisions and then I will go on to discuss how it influenced the research.

3.2.1 Social constructionist approach

In this research I wanted to study meanings, I examined individual processes and then produced a theory of what was happening for the women with primary breast cancer, in relation to psychological therapy. Epistemologically, I approached the study from a social constructionist perspective, which ‘places priority on the phenomena of study and sees both data and analysis, as created from shared experiences and relationships with participants and other sources of data’ (Charmaz, 2000). Crotty (1998) defined constructionism as focusing on all knowledge and meaningful reality being constructed out of interaction between people, which is shaped and communicated in a social context. Social constructionism, as discussed in the literature review chapter 2 focuses on humans engaging together in a constructionist spirit, whilst a historical and social perspective. Therefore all meaningful reality is socially constructed and culture can shape the way people see things, think about things and feel things.

It was important for me to study how the women with breast cancer, in the research, constructed meanings and actions, in their social and historical contexts. Women with breast cancer can feel the breast cancer as a threat to self, their identity and their femininity as a woman in their society. The research approach utilized was designed to get close to the experiences of the women, but with the understanding, that I could not completely replicate their experiences, in the thesis. As a result I believe strongly that there are ‘knowledges’,
rather than ‘knowledge’” (Willig, 2006, p.7). This approach sits within the interpretive tradition, acknowledging the research findings are an interpretation, which depends on the view of the researcher as well as the interactions between themselves and the research participants.

3.3 Methodology

Silverman (1993) defined methodology as a general approach to studying research topics, whereas method refers to a specific research technique. My goal was to gain an interpretation of the women’s experiences which reflected a hermeneutic approach, linking to the double hermeneutic of social sciences, that there is no universal truth to be discovered and our theories can alter practice (McLeod, 2001; Giddens 1982). To do this, a qualitative methodology was selected to gain insight into the depth and breadth of human experience (Polkinghorne, 2005). I used GTA, with a social constructionist approach; this approach adopts GTA guidelines, but does not hold on to the original assumptions of objectivity and positivism (Charmaz, 2000). This approach recognises that no qualitative method is purely inductive, the researcher has a role and will influence the research; the research does not take place in a social vacuum (Charmaz, 2006a).

3.4 Research design and the concept of voice

In the current research, I wanted to explore the women’s accounts of how they found psychological therapy helpful and/or unhelpful after they had been diagnosed with a primary breast cancer. A qualitative approach helped to gain detail of the women’s experiences and to give a voice to the authenticity of human experience. By hearing the women’s stories of their experiences and presenting them in this thesis, I wanted to let readers hear the women. ‘By listening to the tales of others we are able to make connections with other women’s lives’ (Potts, 2000b, p.100).

I note at this point in the thesis, that there are big debates over the concept of voice in research. Firstly I recognise that to a large extent it is my voice in the research, in the end, as I have analysed the data and written up the thesis. I have made decisions on what to include and not include. Secondly, we cannot take the words spoken as completely revealing. Atkinson and Silverman (1997) stated we do this ‘at our peril’ (p.322). There is an important distinction to make between the authenticity of a person and the transcription of their voice (Back, 2012). The person in the interview is narrating their life and this is linked to the ‘interview society’, where the self becomes an object of narration (Atkinson and Silverman, 1997). Therefore, we cannot completely take this ‘socially shaped account’ as ‘the authentic voice of truth’ (Back, 2010, p8). Voice is not stable, it is ‘there’ but it does not completely represent a single truth (Mazzei and Jackson, 2009, p.1).

Lorde (1980) who died from breast cancer stated ‘imposed silence in any area of our lives is a tool for separation and powerlessness’ (p.9). The aim of this research was that the collective voices of the women interviewed would combine to form ‘a coalition of insight and perspective that’ could be analysed and would be ‘stronger than the sum of its parts’ (Potts, 2000b, p101). The research design aimed to produce an interpretation of a connective project, in terms of both shared and unique experiences (Potts, 2000b). I agree with Silverman (2007) who argued for the need to view interview data as valuable ‘activity awaiting analysis’ rather than ‘a picture awaiting commentary’ (p.56).
This means, in this research, I am acknowledging the different voices, the researcher’s and the 11 women’s, in addition to noting that the interviews are an interactional product (Passerini, 2012; Ten Have, 2012). I recognise the women’s individuality and subjectivity and my situated position as a UK female Counselling Psychologist, working in a cancer hospital. The interviews are situated actions, in the specific context of this research (Ten Have, 2012). However, the voices from the interviews can help identify social resources, judgments and tools used to form society, which links well to the position of this research, as social constructionist (Back, 2010).

3.4.1 Selection of participants

When the research was proposed to The University of Manchester in May 2013, I aimed to recruit between 8 and 20 participants, in keeping with the recommendations in previous GTA research projects (McLeod, 2001), (for ethics approval see appendix a). However there is no set rule on how many interviews are appropriate for qualitative research (Baker and Edwards, 2012). Mason (2010) cites a review of 50 articles based on GTA, where sample sizes varied from 5 to 350.

The target number of interviews was linked to the internal research factors and external limitations (Flick, 2012). Internally the target interview range of between 8 and 12 participants was set because the research questions posed were fairly narrow in focus, the aim of the thesis was to answer these by gaining a subjective understanding of the key features of the women’s experiences and the analytical method chosen was focused on meaning making; a social constructionist approach to GTA. I approached the interviews and analysis with care and dignity, which took time rather than focusing on a large quantity of interviews (Jenson, 2012). The external limitations were the time available for the research, it had to be completed between panel sign off (May 2013) and submission date (September 2015) and only having one researcher, these two areas limited the number of interviews practically.

A GTA study is an inductive process, in the main and therefore the research proposal was not precise about the number of participants. Strauss and Corbin (1998) stressed that several forms of sampling are appropriate at different stages of the research: It is key to choose participants who can contribute to an evolving theory and participants whose credential is experiential relevance. Therefore the sampling was not open; participants had to be women with a primary breast cancer diagnosis, who had also chosen to have psychological therapy after their diagnosis. This process was based on discriminate sampling, more participants enhanced the possibility of comparative analysis, to help to saturate categories and complete the research study. This meant returning to previous interviews or sources of data, as well as drawing on new ones. The sampling in the research was not for population representativeness, the aim was for theory construction. Therefore although saturation in GTA research is an important part of this method, I recognised that because of the project’s time limit and only having one researcher this might not be possible (Glaser and Strauss, 1967). The research needed to be written up by the end of September 2015 and therefore I set an end date for interviewing participants of early September 2014, to allow adequate time for the GTA and write up. Josselson and Lieblich (2003) noted that it is usually the researcher who becomes saturated and that it is important to collect sufficient data, to represent the breadth and depth of the phenomenon, without becoming overwhelmed.
Josselson and Lieblich (2003) also stated that saturation, that is, stopping data collection when the results start to become redundant is the key determinant of sample size, however they question whether real saturation ever occurs, because each new respondent has something unique to contribute to the research. There is also an interesting point to make here about how the GTA concept of saturation fits with a social constructionist approach, as human beings are constantly constructing meanings and new meanings, therefore there is a doubt whether saturation is ever achievable, possible or desirable.

Eleven participants were eligible for the study and were interviewed. They were all women with a confirmed diagnosis of primary breast cancer for over one month, were not cognitively impaired, were over 18 years of age, spoke English and had chosen to have psychological therapy after diagnosis. More participants did apply for the study, after I had stopped recruiting in early September 2014 and I politely let them know that recruitment had come to an end, because of the time limitations of the research.

3.4.2 Data Collection

3.4.2a Semi-structured Interviews

Semi-structured interviews were used with open-ended questions to allow participants to respond in their own unique way (Knox and Burkard, 2009). Semi-structured interviews employ a mix of structure, to elicit specific information and open-ended elements, to elicit unexpected types of information, in the organisation of the questions, with the aim of interest (Rubin & Rubin, 1995). The semi-structured interviews helped me to develop a relationship with each of the women, based on their individual experiences. The aim was that the relationship that developed would help to gain a more transparent, in depth view of their experiences. Grafanaki (1996) stated that a relationship that is trusting in a research project, helps to gather data that is grounded in the participant’s experience, which in turn is more rich and complete in nature.

The specific skills, which are important to build a trusting relationship with a research participant, are also critical to the client-therapist relationship; active listening, warmth and genuineness (Kvale, 2008). The research at the interview stage was kept open for the women to bring any helpful or unhelpful experiences of psychological therapy they wanted to. They could also spend time elaborating on their experiences and I could ask more detailed questions if required to gain detail insights. I will now discuss the interview questions.

3.4.2b Interview Questions

Within this section the interview questions can be found which were used with the participants (a full copy of the interview schedules can be found in the appendix b and c). Questions from the Helpful Aspects of Therapy (HAT) form enabled me to gain an understanding of which therapeutic components helped and these were incorporated into the interview schedule, to capture the experience of the women with breast cancer, whilst
ensuring that the data collection method was not too onerous. (Elliott, 1985; Elliott and Shapiro, 1988).

Following the first interview, I added more questions to probe the women’s experience of psychological therapy further. The interview questions asked in the first interview were as follows:

1. Of the events that occurred in your Counselling Psychology therapy sessions, describe the ones that you feel were most helpful or important for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)
2. Please describe what made the events helpful/important and what you got out of it.
3. How helpful were these particular events?
4. Did anything else particularly helpful happen during your therapy sessions?
5. What events happened that were unhelpful?
6. What made these events unhelpful?
7. How unhelpful were these particular events?
8. Did anything else particularly unhelpful happen during your therapy sessions?

Additional interview questions that were added, these were used for the second to eleventh interview:

- Would you recommend therapy to someone else who had breast cancer, if yes/no why?
- How did seeing someone for therapy add or take away from the medical treatment you received?
- What characteristics did you feel your therapist had?
- Was your therapist a woman or a man?
- How many sessions of therapy did you have?
- How close to your diagnosis/ treatment was the therapy?

In addition, depending on the participant, supplementary questions were asked to probe specific individual experiences in line with a semi-structured interview approach of employing structure and open open-ended elements to elicit unpredicted types of information (Rubin & Rubin, 1995).

### 3.5 Process of Research

Originally I wanted to recruit participants from The Christie Clinic (TCC), which is owned by Hospital Corporation of America (HCA) International and The Christie NHS Foundation Trust. I discussed the research with their research approval board, via a telephone conference and they were happy for me to conduct the research at TCC, but the research proposal would need to firstly be approved by the NHS National Research Ethics Service. This would have unfortunately taken too long, for this study and therefore I then tried to recruit participants from a local cancer charity, Beechwood cancer care centre (Chelford Grove, Stockport, SK3 8LS). Beechwood were happy to advertise a poster to recruit participants (see appendix d for the poster). However, unfortunately I did not get any participants from this poster.

I then recruited eleven participants between Oct 2013 and Sept 2014, from two sources: I recruited three participants through my own professional contacts and then eight were
recruited from the national charity Breast Cancer Care (5-13 Great Suffolk Street, London, SE1 0NS). I provided Breast Cancer Care with a summary of my research proposal for their research panel to consider. The research panel came back with questions, which I answered and the research was approved to advertise to their ‘Breast Cancer Voices’ (see appendix e for correspondence with and approval from Breast Cancer Care). Breast Cancer Care has over 650 women who volunteer to be ‘Breast Cancer Voices’. These women share their experience and expertise to inform the charity’s work, by shaping the direction of services and taking part in research.

A written description of the study was provided to all participants in advance of agreeing to take part in the research, in the form of a participant information sheet, by email (see appendix f for initial email sample to participant, participant information and consent sheet). Participants were then given two weeks, to consider the information sheet and those who agreed to participate signed the consent form, returning it to me, before they were interviewed.

3.5.1 Obtaining Appropriate Interviewees

Participants were only interviewed if they had a primary breast cancer diagnosis and had taken part in psychological therapy, after their diagnosis. One woman contacted me about being interviewed for the research, who had primary breast cancer, but had chosen to not have psychological support. She wanted to talk about her decision not to have therapy and I agreed to interview her, after all the other interviews were complete. I did not include her interview in the analysis, but I did reflect on it in the reflexive analysis chapter.

3.5.2 Conducting the Interviews

The completion of interviews took place either face to face or over the phone. Six interviews were face to face, with five being at the women’s home and one taking place at the University of Manchester. The other five interviews took place over the phone. The interviews were all audio-recorded, with the women’s advance consent and then transcribed. The original audio recordings were destroyed. The interviews lasted between 18 minutes and 60 minutes, depending on the participant (see appendix for interview times and locations). At the start of each interview, I briefly talked about who I was as the researcher, the research project’s aims and then chatted to the participant. This introduction helped put the participants at ease. The audio recordings were then imported, onto a laptop and encrypted to protect the data in the files.

3.5.3 Pseudonyms, Participants’ Descriptions and therapy experiences

I asked each participant to choose a pseudonym that would be used in the write up of the thesis, to maintain confidentiality; eight of the women chose a pseudonym and three decided they wanted to keep their own name, in the thesis. The women who kept their own name said they made this decision because they wanted to be heard, as themselves and had nothing to hide.
In addition I asked them each to write their own brief description of themselves to be included in the thesis. The women wrote the following ten descriptions, and I have added a description of the eleventh participant:

**Jane**

‘At the time of my cancer diagnosis I was a 43 year old, married mother of two young adults, and under the age bracket for breast cancer screening. I worked full time in the travel industry and held a managerial role. The prospect of having to take a long enforced break from work due to a serious illness therefore came as a complete and utter shock!’

**Vanessa**

‘57 year old white married woman with 2 teenage children. A qualified counsellor and social worker employed in a palliative care setting and as a counsellor in private practice.’

**Eliza**

‘White British woman diagnosed in her 40’s, with young family and working in a helping profession. Diagnosis of breast cancer not in the plan.’

**Mary**

‘I was 58, working full-time as a senior nurse when I had a routine mammogram....... I am now retired and have 2 adult children and 5 grandchildren. I am now living life to the full, and enjoying every day.’

**Sophie**

‘I was a normal twenty something when I was diagnosed with breast cancer; after graduating university I went travelling and had some amazing experiences then came home and started working hard in my chosen career. Breast cancer has devastated my life both personally and professionally.’

**Vinnie**

‘I’m a 53 year old gay woman who was diagnosed with breast cancer 9 years ago. It was a shock & it was scary but I was lucky because I had such fantastic support from my partner and friends. Most importantly I took positive things from the experience and didn’t let it define me.’
Lola

‘White British woman, diagnosed at 43 years old, mother of two - a son who was 16 and going through GCSEs and a daughter of 11 years old. I work for our family coach business.’

Elizabeth

‘A-level English teacher with three children and fourth due in December 2014. Age 40 at diagnosis, with no family history or genetic link to breast cancer, so it was a bit of a surprise.’

Lucyna

‘I was diagnosed when I was 47. I have 2 sons, who are now in their early 20s. I am white, British and have studied music at university. I have been a teacher for 32 years - both in the school classroom and a private piano teacher.’

Shirley

‘I am 46, white, single, no kids. Employed as a Business Management Lecturer to post-grad (international) students, part-time, with the other 2 days a week dedicated to my freelance accounting business. I partied my way through the late 80’s and early 90’s and thought I was invincible despite an undeniable affiliation to family history breast cancer.’

Hannah (no description provided by participant)

‘Diagnosed with breast cancer in 2012, had a mastectomy and then had to have a second mastectomy because another primary lump was found.’

The psychological therapy experiences each participant had are detailed below as there were variations in experience, in terms of who provided the therapy, the location and type of therapy:

**TJ01 Jane:** The therapy took place at a local cancer support centre with a female therapist, three months into Jane’s treatment for breast cancer. The one-to-one psychological therapy lasted for four months to the end of treatment incorporating two follow up sessions after Jane struggled when she returned to work. The psychological one-to-one therapy was part of a wider programme of support. The therapist had worked with people with cancer before.

**TV02 Vanessa:** In the past Vanessa said she had taken part in therapy that was Freudian, lying on the coach, which was quite persecutory. However the therapy she received following the cancer diagnosis was attachment based from a female therapist who sat opposite her. Vanessa described herself as needing human warmth at this time. She found the therapist
through someone who worked in her GP practice and therapy started quickly at the start of treatment with no delay. Therapy was round the corner from Vanessa at the therapist’s house and this helped because Vanessa could walk round, as she often exhausted. Vanessa saw her therapist all the way through her treatment. Vanessa said she was actually still seeing her therapist now. The therapist did not have much knowledge of cancer.

**TE03 Eliza:** Eliza’s therapy started before she was diagnosed and continued after diagnosis. Therapy was face to face and via email. There were 24 therapy sessions in total. The flexibility to communicate via email through treatment helped and took the pressure off because the side effects of the treatment made Eliza feel very ill and exhausted. The therapist was a female and Eliza said she became internalized to her. The therapy was Cognitive Analytic Therapy (CAT) and the therapist was a CAT practitioner. The therapist didn’t have specific knowledge of cancer and the therapy did not take place at the cancer hospital.

**TM04 Mary:** Mary was offered counselling early on after diagnosis (November 2009) but didn’t take it up then. After treatment had finished in September 2010, Mary was struggling and in May/June 2011 she went to see her GP to get help. Mary saw a female therapist who she called both a psychologist and a counsellor in her interview. Mary saw her at her GP surgery, quite quickly after asking for help, because she was prioritized following the psychological referrals being triaged. She was supposed to have six sessions but this was cut to three because of funding cuts. Mary had been referred to an art therapy group before the face-to-face therapy via a local cancer hospital, but she hadn’t found this very helpful and she said 6 months later she slid down into the depths and that is when she had the one-to-one therapy at her GP surgery. The therapist didn’t have any specific knowledge of cancer. Mary didn’t talk specifically about the therapeutic approach taken but she did say that before she left each session they always did a relaxation exercise, which helped.

**TS05 Sophie:** Sophie had therapy with a specific cancer counsellor at her hospital. The therapist was female. The therapy involved mindfulness as well as talking therapy. Sophie asked for psychological therapy at her third hospital appointment, three weeks after diagnosis, she wasn’t offered it automatically. Sophie saw her therapist for nine months from this point, starting off seeing her weekly and then reducing this to monthly. The therapy contract was left open at the end so Sophie could return to therapy if she needed it.

**TV06 Vinnie:** Vinnie was diagnosed in 2004. Her oncologist suggested she called her local hospice for help after diagnosis. She did and she had one-to-one talking therapy with a female therapist, which incorporated relaxation. Vinnie called her therapist a specialist psychologist. She was experienced at working with people with terminal illnesses at the hospice. Vinnie starting seeing her a month after her chemotherapy started. Vinnie had therapy for three and a half months, it started off with six weekly sessions and then she had two final sessions, one a month.
***TL07 Lola***: Lola talked about her daughter having therapy to try and help her cope with her mother’s cancer, at the cancer hospital. However this experience was not helpful to Lola and her daughter. Lola spoke about having to go in too, with her daughter, for two of the four sessions and the therapist concentrating on Lola’s childhood, which did not seem relevant to Lola. When Lola talked about this it sounded like a psychoanalytic approach and the therapist was a female. After this Lola had therapy on her own, for eight to ten sessions, having one every two weeks. She saw a male therapist and it was after she had completed her treatment. This felt really helpful and focused on the present. Lola called the two people she saw for therapy therapists, she didn’t call them psychologists or counsellors. However she did describe the first one as more like a psychiatrist. She did not specifically talk about the approach the second therapist took using a named approach, from what she described the therapist sounded like they were from an integrative background. The first therapist was seen at the hospital and the second one was not at the hospital. She didn’t talk about the second therapist having any specific cancer knowledge.

***TE08 Elizabeth***: Elizabeth had three different therapies. The first was with Macmillan and this can be described more as psychological support via listening from a female support worker; this was just after her surgery. The second was with a private female counsellor, not at the hospital, which her employer funded, this was Cognitive Behavioural Therapy (CBT) with mindfulness and the therapist didn’t have specific cancer knowledge. This was just at the end of radiotherapy, coming to the end of active treatment. Then eight months after this Elizabeth had some more therapy post cancer treatment, accessing the NHS service Talking Change service in her area via her GP. This service is a general stepped NHS service for mental health referrals and the female therapist did not have specific cancer knowledge. Elizabeth said she had CBT again which would suggest the therapy was carried out by a step three NHS CBT therapist. Elizabeth felt that the two latter therapy treatments were better than the psychological support from Macmillan as she found the first intervention too limited.

***TL09 Lucyna***: Lucyna had therapy with a female counsellor at a local hospice for about six months. She described taking part in group therapy and one-to-one therapy at the hospice after her diagnosis. Alongside this Lucyna had Reiki and massage treatments at the hospice, which were also helpful to her. Following her return to work she saw a female counsellor via her GP as she was struggling. Lucyna did not speak about a specific psychological approaches, it felt from her interview that the therapists were person centred.

***TS10 Shirley***: Shirley had therapy with a male Clinical Psychologist, who was also a CAT practitioner. The therapy took place at the general psychology department at the hospital, alongside the cancer treatment centre. The psychologist was specifically involved in seeing people with cancer in his role. Shirley say the psychologist five months after diagnosis, this was also after a bilateral mastectomy. She had four sessions weekly then a six week break and then three more sessions.
**TH11 Hannah:** Hannah had therapy after her treatment had finished, she called the first therapeutic intervention, counselling. She was assessed for the counselling over the phone and then met her female counsellor for two sessions. However Hannah was told she was too complicated and was then referred to a psychotherapist and after a second telephone interview she saw this therapist six times. The psychotherapist was also female, but unfortunately went off sick and then was made redundant so therapy stopped. Hannah then had a third and then a fourth telephone assessment and she was waiting for therapy when I spoke to her. Hannah talked about a waiting time of seven or eight months. Hannah found the therapeutic interventions were too short and the telephone interviews were impersonal. Hannah said all the therapy was via the NHS for people who had cancer and both therapists had cancer knowledge.

**3.5.4 Transcription**

The audio recordings of the eleven women’s interviews were all transcribed. The transcription was completed in part by myself and in part by a trusted transcription service because of the amount of data that had been generated and the time bound nature of the research project. The contact details of the transcription service came from The University of Manchester and the service signed a confidentiality agreement before they received any audio recordings (see appendix g for signed confidentiality form from transcription company). The transcripts are not included in the thesis as they contain confidential details about the participants (an extract of a transcript can be found in the appendix h). It is important to state that the research was aimed at giving voice to the women’s experiences, however the project doesn’t claim that the ‘authenticity of a person can be rendered through a faithful transcription of their voice’ (Back, 2012, p.12).

**3.6 Process of Data Analysis**

The method of analysis was GTA using a social constructionist approach (Strauss and Corbin, 1998; Charmaz, 2000). Within this section a description of what GTA is will be provided and why I chose to use it. A step-by-step guide will also be outlined as to how the data analysis process was applied to the eleven transcriptions. This will provide a clear and transparent view of the process of analysis.

**3.6.1 Analysing the Qualitative Data**

GTA is a method for systematically, yet flexibly, using guidelines to collect and analyse qualitative data ‘to construct theories ‘grounded’ in the data themselves’ (Charmaz, 2006a, p.2).
3.6.2 Grounded Theory Analysis (GTA)

"Throughout the journey we will climb up analytic levels and raise the theoretical impact of your ideas while we keep a taut rope tied to your solid data."

(Charmaz, 2006a, p.1)

The first statement of GTA was presented by Glazer and Strauss (1967) and over thirty years later Strauss and Corbin (1998) developed a specific detailed set of guidelines around the procedures and techniques in GTA. This analytical method aims to produce theories grounded in the ‘thick’ description of the patients’ experiences (Geertz, 1973). GTA is a systematic process with specific guidelines for gathering, synthesizing, analyzing and conceptualizing data leading to the construction of a theory (Charmaz, 2001). I chose this analytic framework because it offered an explicit, structured and logical approach, in this way it can be seen as both positivist and interpretative; the systematic techniques are consistent with positivism, whilst the data is focused on how people construct their world through meanings, intentions and actions (Charmaz, 2006b). The defining components of GTA practice were defined as follows by Glaser and Strauss (1967; Glaser, 1978):

- Involvement in collecting data and analysis at the same time
- Ensuring that constructed analytic codes and categories are from the data, not from preconceived hypotheses
- During each step of the analysis, using the method of constant comparison
- During each stage of data collection and analysis, advancing theory development
- Elaborating categories by memo-writing, specifying specific properties, defining relationships between categories and identifying any gaps
- Sampling not for population representativeness, but to aim for theory construction
- After developing the analysis, conducting a literature review

The eleven transcripts were analysed by following the steps set out in Strauss and Corbin (1998), these stages are outlined in section 3.6.4. I used GTA to gain an in depth understanding of the phenomenon without any pre-determined themes, the theory I devised was not preconceived (McLeod, 2011). However, it was important for me to recognise my role as the researcher in this research, in line with a constructivist GTA approach. From the start I actively constructed the data with the participants, although I did not review any specific literature on helpful moments in therapy for women with breast cancer, in advance of collecting the data. I am a Counselling Psychology Trainee and I have experience of practicing therapy at a cancer hospital in Manchester and I understand the theoretical underpinnings of psychological therapy. As a result it was difficult for me to completely bracket off my knowledge of the subject area. This is discussed in more detail in the reflexive analysis chapter 5. However many researchers have been in a similar position, of having knowledge of the processes involved in the research area, they are studying and therefore the key focus was to ensure the findings came directly from the data, in the transcripts (Rennie, 2002; Rennie, 2006).
3.6.3 Rationale

The rationale for this study was to understand the specific experiences of women, with breast cancer, in relation to psychological support, as opposed to a more general piece of research with men and women, who have different types of cancer. The emphasis was on finding how psychological therapy helped the women to find meaning in their individual experiences (James, 2011). I wanted to find this out from the views of the women, rather than from the views of psychology professionals. I wanted to find out which therapeutic aspects, the women specifically experienced as helpful and/or unhelpful. My approach to the research was that the women were not passive recipients of therapy and therefore this research was focused on bringing the voices, of the women with breast cancer, to the foreground and examining what they felt helped and did not help from a psychological support perspective (Bohart and Tallman, 1999; Elliott, 2008).

The rationale for using GTA, as the method of analysis, was in accordance with the two research questions being asked. I wanted to get rich data to ‘get beneath the surface of social and subjective life’ in answer to the research questions (Charmaz, 2006a, p.13). I also wanted to use a systematic, focused, analytic process with explicit guidelines, which is also flexible and that is why I chose to use GTA, from a social constructionist perspective. I was focused on examining the women’s data, whilst recognising that it was co-created, through our shared interactions in the interviews. I viewed the methods of GTA as a set of practices, which helped to guide the process of gathering the data and developing a theory. I was keen to examine the participants’ individual experiences, qualitatively, whilst constructing theories grounded in the data (Charmaz, 2006a). I don’t believe theory is discovered, emerging from the data as outlined by Glaser and Strauss (1967), I feel GTA is constructed through ‘past and present involvements and interactions with people, perspectives and research practices’ (Charmaz, 2006a, p.10).

A specific study by Elliott and Shapiro (1988) specifically encouraged me to examine helpful and unhelpful aspects of psychological support. In this study, the Helpful Aspects in Therapy (HAT) form was used to gain clients’ views of what the most helpful events in therapy were. The findings were then analysed using GTA. This research approach systematically helped to describe the change pathways, involved in particular significant events; it documented change processes and provided useful feedback for therapists about specific effective ingredients.

3.6.4 GTA within the context of the current research

The following section will set out the stages in the research process as proposed by Glaser and Strauss (1967), Strauss and Corbin (1998) and Charmaz (2006a) to illustrate the rigour, transparency and coherence of the research. The purpose of the GTA was to develop a theoretical analysis of the data, which fitted with the data, produced in the semi-structured interviews. The process was interactive, concentrated and active. I had already interacted with the participants in the interviews and subsequently, during the analysis, I interacted ‘with them again many times over through studying their statements and observed actions and re-envisioning the scenes’ in which I knew them (Charmaz, 2006a, p.47).
STAGE 1: Open coding
Each transcript was read and a reflexive log was written (see appendix i for an example). Then each transcript was closely examined and broken down into meaningful units, using action segment incident open coding, whilst being as open as possible to the data (Charmaz, 2006a); this involved breaking down the data through examination, comparison, conceptualisation and categorising. The open coding stage was completed at speed, this helped to spark my thinking and I was grabbed by segments of data, which I then labelled. These simple but precise labels, helped to depict what each segment was about, in terms of meanings and actions. The categories as this point were short, specific and active, which helped to define processes and actions in the data. The granularity of the open coding stage helped me to be critical of the data, rather than accepting it without question (Charmaz, 2006a). The aim of the open coding stage was to generate as many alternative categories from the data. Constant comparative methods were used at this stage to establish analytic distinctions, through comparisons and this process continued right through all the stages (Glaser and Strauss, 1967). Interview statements were compared within interviews and across interviews. The open coding generated the ‘bones’ of my analysis and was a ‘pivotal link between collecting data’, developing further levels of coding and developing the theory (Charmaz, 2006a, p.45-6).

STAGE 2: Focused coding
These line-by-line categories were then scanned for a second time to condense them, into active categories, which is called focused coding (Charmaz, 2006a). I related the categories to their sub categories at this point, linking the categories at the level of properties and dimensions to come up with 30 focused codes (Glaser and Strauss, 1967), (see appendix j). This process involved, rereading each category, and then reflecting within and between the individual transcripts, using post-it notes and flip charts. This moved the analysis forward, as the data was clarified into clear concepts and the relationships between them. I was careful not to put my motives, fears or unresolved personal issues into the data (Charmaz, 2006a). In addition at this early stage, the form and content of the analysis, started to become established, the data was categorized incisively. It was an emergent process, unexpected ideas developed and I could start to see what was happening in the data and what it meant. These two coding stages helped me to study the data explicitly, which provided new insights and rendered ‘hidden assumptions visible’ (Charmaz, 2006a, p.55). I felt during the GTA analysis that I was following the role of the researcher outlined by Thomas (1993), who stated that the role was to make the routine and familiar, new and unfamiliar.

STAGE 3: Memo writing
As the categories and concepts were clarified in stage 1 and 2, short memos were created by transcript and then 30 focused codes across all transcripts were devised (see appendix i and j). Memo writing provided analytic notes to explicate and fill out categories. The memos prompted me to elaborate processes, assumptions and actions covered by codes and categories (Glaser and Strauss, 1967). Any notes of hypotheses along the way were also captured in memos. The narrative form of memos helped to provide clarity and direction in the analysis process. The memos contained raw data to illustrate my ideas and this helped to identify patterns across the data rather than focusing on an individual case (Strauss and Glaser, 1970). The memos were further developed through the analysis process; they were helpful
exploratory tools, as they could be ‘partial, preliminary and correctable’ at the beginning (Charmaz, 2006, p.103). Writing the memos helped me to connect with the humanness of the women’s experiences, rather than just focusing on being a researcher.

**STAGE 4: Theoretical coding**
Theoretical coding is a sophisticated final stage of coding, which involved integrating and refining the theory to settle on one core concept, from ordering the focused codes into higher order categories; context, conditions, interactions, actions and consequence. Glaser (1978) defined this stage as conceptualizing ‘how the substantive codes may relate to each other as hypotheses to be integrated into a theory’ (p.72). At this point no new properties, dimensions or relationships were emerging from the data and the study had reached theoretical saturation, as defined by the time limit on the research project. Two diagrams were defined at this point in the analysis, through integrations and refinement. The diagrams illustrated the helpful and unhelpful aspects of psychological therapy for women with a primary breast cancer. These are detailed in the analysis section (see appendices k and l for diagram development).

**STAGE 5: One overall core category**
One overall core category was chosen, which summarised the research findings into an emerging theory (Strauss and Corbin, 1998). At this point no new properties, dimensions or relationships emerged from the analysis and the study reached theoretical saturation. At this final stage, I found it useful to check the analysis against Glaser and Strauss’s (1967) original criteria for assessing GTA studies: fit, workability, relevance and modifiability. Therefore it was useful to ask does the theory fit the world under study? Does it provide a workable explanation of this world? Does it address problems and processes? Does it allow for variation over time? Does it allow for refinements of the theory that would make it more enduring? (Charmaz, 2005). Reviewing these criteria helped me to check the quality of the theory. Theory has been defined as resolving a main concern, analytically and abstractly (Glaser, 2000; Charmaz, 2006a).

The strength of theorizing in grounded theory as defined by Charmaz (2006a) is that it can ‘start with sensitizing concepts that address such concepts as power, global reach and difference and end with inductive analysis that theorise connections between local worlds and larger social structures’ (p.133). Corbin and Strauss (2008) used the analogy of an umbrella to illustrate that concepts alone do not make a theory, they must be linked; ‘the spokes provide structure and give the umbrella form or shape. But it is not until the spokes are covered with some kind of material that the object becomes an umbrella and useful for keeping rain off the person (p.103).

**STAGE 6: Producing the report**
After defining the theoretical categories fully, with supporting evidence and ordering the memos, I started to produce the analysis section of this thesis. The focus of the GTA was conceptual looking at theoretical relationships, but it did not put the verbatim in a subordinate role, which was advocated by Glaser (1978). The quotes instead were used to bring the women to the forefront of the analysis, to make the research accessible to a wide audience and to keep the human story (Charmaz, 2006a). In GTA, the review of literature is delayed until
the data has been analysed in order ‘to avoid seeing the world through the lens of extant ideas’ (Charmaz, 2006a p.6). The aims of the completed GTA were, to have a fit with the data, for the analysis to be useful, to have conceptual density, having durability over time, being able to be modified and having explanatory power (Glaser, 1978; Glaser and Strauss, 1967). At the current time the durability of this research over time is unknown.

3.7 Qualitative research through a feminist lens and reflexivity

‘Feminist research is designed to seek social justice, to enhance women’s voice and influence in society, and to explore alternative ways of understanding the world through women’s experiences’


In this research, a qualitative method using semi-structured interviews was chosen to explore the rich diversity of the women’s experiences, rather than using a method that dissects data for statistics (Reinharz, 1992). Gergen (2012) described quantitative methods as a ‘corset’ that distorts ‘the body of inquiry’ with ‘much that is produced’ suffering ‘from the constraints of the methods used’ (p.282). Semi-structured interviews helped to achieve the active involvement of the women in the construction of data, about their lives (Graham, 1984). The research was designed to enhance openness to the experiences of the women, whilst having an awareness of structural factors that influenced their lives. Whilst using the method of interviews to bring the women’s voices into the thesis, I also recognised the important debates and limitations about representing voice, which I outline in section 3.4 Research design and the concept of voice.

The research aimed to explore the experience of women with breast cancer, in relation to psychological therapy, and gender was an important consideration. During the analysis phase, GTA helped to focus on the importance of the ‘actor’s’, the women’s ‘points of view’ (Gergen, 2012, p.183). In addition, taking a social constructionist position, to GTA, helped to explore the nature of reality, including breast cancer and gender, as both socially constructed.

In the reflexive analysis chapter 5, I also open up the researcher’s role, in constructing the findings. However it is worth considering that I am a woman and I was interviewing women. This women-to-women talk has been shown to have a different quality, than a man and women talking (Spender, 1990). It can be self-revealing and have a consciousness-raising potential (DeVault, 1987). A women listening to a women, with care and caution, can enable ideas to be developed and meaning to be constructed (Reinharz, 1992). Implicit in my research was my wish to focus the research on women with women which involved direct contact with women and gathering information directly from women (Kelly, Burton and Regan, 1995). I was keen to examine the effect of the structural forces of the masculine medical world on women with breast cancer. I wanted to understand pressures, constraints
and any oppression. My feeling through my work as a woman in a cancer hospital, which is largely dominated by male consultants, was that women who have been diagnosed with breast cancer may feel vulnerable and not empowered to ask all the questions they want to. The breast cancer is their embodied experience and yet a medical view can sometimes discount this important experience or women can feel under pressure to regain a traditional feminine appearance post treatment.

My goal of listening to the women’s experiences, whilst looking at gendered social constructions, with a feminist lens, encouraged me to think deeply during the analysis, reflexive analysis and discussion. Conducting the research in collaboration with the women was an intense, intimate experience for me. In addition, the degree of self-disclosure, by the women meant that the research had a strong relational component, not just in the interviews, but beyond into the analysis phase (Gergen, 2012). I also wanted desperately to share the findings with the women, because of the communal involvement in their construction and to see what they thought. At each point in the research process I ensured I received consent from the women and aimed to reduce the power dynamic between researcher and participant. I believe the line between feminist and non-feminist research is blurred and therefore I describe the approach I used as having a feminist lens (Gergen, 2012).

3.8 Trustworthiness, authenticity, adequacy and appropriateness of the research

‘Amongst the most knotty problems faced by investigators committed to interpretive practices in disciplines and fields … is deciding whether an interpretation is credible and truthful’

(Schwandt, 2007, p.11)

From a social constructivist perspective, validation is the process of evaluating ‘the ‘trustworthiness’ of reported observations, interpretations, and generalizations’ (Mishler, 1990, p.419). In qualitative research, we ask about the extent to which the researcher’s constructions are empirically grounded in those of the participants, who are the focus of study (Flick, 2002). Schwandt (2007) stressed that there can be ‘no appeal to some kind of evidence, experience, or meaning that is somehow outside of interpretation, independent of it, or more basic than it’ (p.11).

Guba and Lincoln (1986) outlined an argument for the way the creditability of interpretations could be demonstrated. They described two approaches, the first was employing trustworthiness criteria; they equated internal validity with credibility, external validity with transferability, reliability with dependability and objectivity with neutrality. The second way concentrates more on assumptions of interpretations and focuses on authenticity criteria; fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity (Schwandt, 2007). In this section of the methodology chapter I will look at both trustworthiness and authenticity criteria when reviewing the research. I will also discuss adequacy, appropriateness, and validity for completeness.
3.8.1 Trustworthiness

The following procedures were employed to enhance the trustworthiness of the research:

For credibility this study used semi-structured interviews, with the women, in order to examine their experience using an in-depth contact. In addition, the thoughts of one woman, with breast cancer, who had chosen not to have psychological therapy, were included in chapter 5, the reflexive analysis. This was a helpful negative case and the thoughts of this woman helped me to develop insights about why therapy would and would not be taken up by women with breast cancer. Within this research there was also a focus on both unhelpful and helpful aspects of psychological therapy. This aided my understanding of the importance of setting up therapy in the right way. Member checks were also used to engage the participants through the analysis phase of the research project; the women reviewed their transcripts and the analysis chapter, providing comments. These member checks helped me to informally test my interpretations and maintained contact with the women as co-researchers.

Transferability was achieved by focusing on thick descriptive data of the women’s experience, linked to this specific context. The reader is then able to make a judgement about the degree of fit in relation to all or part of the findings elsewhere (Guba and Lincoln, 1986).

Dependability was linked to keeping a detailed thesis diary, where each step of the project was noted down and this was then used to help outline the methodology clearly in this chapter. No external audit trail was conducted because of time and the limitation of only having one researcher. However evidence of how the data was reduced, analysed, and synthesized, as well as memos and process notes that reflected my on-going inner thoughts, hunches, and reactions were recorded. The information presented in the analysis, chapter 4, was also designed to provide an understanding of how the conclusions were arrived at. The critical self-reflection component of the study helped to illuminate my researcher potential biases and assumptions, looking at how they may have affected the research process. There is more detail on this in the reflexive analysis chapter 5.

3.8.2 Authenticity

I will now discuss the second approach outlined by Guba and Lincoln (1986), authenticity in relation to the research. I will review fairness, ontological authentication, educative authentication, catalytic authentication and tactical authenticity.

The study used a feminist lens to illustrate how breast cancer is socially constructed and this helped to expose conflicting constructions and value structures (Guba and Lincoln, 1986). Fairness was achieved by aiming to outline a balanced view of the constructions around breast cancer and the values that underpin them. In addition, fairness was achieved through constant collaboration with the women with breast cancer: There was a focus on informed consent, the availability of appellate mechanisms should a participant not be happy with any aspect of the research process, continuous open dialogue before and after interviews, ongoing communication of information about the study and as previously outlined member checking of transcripts and findings.
Ontological authentication was linked to the social constructionist philosophy adopted in the research. The study made clear and real the contextual shaping of breast cancer during the women’s experiences, this was a ‘found reality’ (Green, 2015, p.68). The research raised the consciousness around the social construction of breast cancer, achieving a richer understanding of the issues the women faced.

Educative authentication has been connected to promoting understanding of how psychological therapy can be helpful and/or unhelpful to women with breast cancer through different mediums: The findings have already been presented at a post graduate conference at The University of Manchester and at the Annual British Psychological Society Division of Counselling Psychology conference in Harrogate (both in 2015).

Catalytic authentication is about action and is an ongoing process in my current work at a cancer hospital in Manchester, The Christie Clinic at The Christie Hospital. I work with women with breast cancer providing psychological support on a daily basis and I am using the findings of this study to improve my work. In addition I work alongside many other health care professionals in Oncology and I am discussing the findings with many of them, in order to better care for women with breast cancer. The results have also been communicated back to the national charity, Breast Cancer Care and their Breast Cancer Voices, some of whom took part in the research to help gain action from other people in this arena.

Tactical authenticity in relation to this research is focused on empowering women with breast cancer. The socially constructed nature of breast cancer and the trauma of diagnosis and treatment can reduce the confidence of women. Cancer can shatter their beliefs in the world, in others and in themselves. This research is designed to put the empowerment of women centre stage in the care of those with breast cancer. This is essential to try to avoid women being manipulated, deceived or controlled during their medical care.

Reviewing the research in light of the authenticity criteria above helps to ensure the research is grounded, inductive and has utility.

3.8.3 Adequacy and appropriateness

Adequacy in this study related to the amount of data collected. This was achieved when I had obtained enough data, so that the previously collected data was confirmed and understood. However as the project was time bound, with only one researcher, I cannot guarantee saturation from a Grounded Theory Analysis (GTA) perspective. The appropriateness of the research focused on meeting the theoretical needs of this study to understand lived experience and pull together theoretical themes across the experiences of the women with breast cancer. Information was sampled and chosen purposefully, rather than randomly (Morse, 1998). In
addition, as the research progressed thoughts on findings were revised, as more data became available.

The study was grounded in interpretations within the women’s experiences, whilst understanding the inter-subjective aspect of interpretation and the situated position of myself as the researcher.

3.9 Validity in qualitative research

‘The validation of qualitative research becomes intrinsically linked to the development of a theory of social reality’
(Kvale, 1989, p.83)

Alongside discussions of trustworthiness, authenticity, adequacy and appropriateness for completeness I have looked at definitions of validity in qualitative research. Validity has been linked to two main areas in qualitative research: allowing ideas to emerge as the research progressed and self-reflexivity. The constructing of ideas in this thesis was focused on building understanding, in an effort to try and improve the care for women with breast cancer. Self-reflexivity, as a researcher, was captured in my thoughts in my research diary, as the research progressed. The latter was then summarised in the reflexive analysis chapter 5.

In addition Stiles (1993) summarised specific criteria on validity in qualitative research that is helpful to review at this point in the thesis. Stiles focused on the goal of understanding people in research, rather than achieving objective truth. I have considered these validity criteria in relation to the research, to ensure I have examined this area of the methodology extensively:

- The clarity and comprehensiveness of the description of research procedures employed; this research study had clear data collection and analysis methods, which are all detailed within this chapter.
- The sufficient contextualization of the study; this research has been openly discussed within the thesis as situated in Counselling Psychology, from a psycho-oncology tradition, in contrast to the medical model in relation to women with breast cancer.
- The adequacy of the conceptualization of data; during data collection and analysis I aimed to get to saturation of the data within the time frame of this study, with only one researcher, to ensure the core theme from the GTA had the recommended depth for this type of analysis, I felt that I did achieve some level of saturation, as the same themes started to reoccur with the completion of more interviews. However saturation cannot be guaranteed (Glaser and Strauss, 1967; Strauss and Corbin, 1998).
- The systematic consideration of competing explanations of the data; during the process of data analysis, I used memo writing to capture thoughts and hypotheses, around the data and I constantly compared the data captured through a systematic series of stages (Strauss and Corbin, 1998).
- The reflexivity of myself as a researcher; the theory came from the data and I took care to try to avoid my own thoughts influencing the coding process, although I accept that the findings are interpretations. I recognised my positioning within the research reflexively, in addition to setting out my approach epistemologically from a social constructionist philosophy.
• The experiential authenticity of the material; the methods were designed to gain an insight into what aspects of therapy were helpful and/or unhelpful to women with a primary breast cancer, from their viewpoint and in their own words.

• The use of triangulation; the time pressures of this research study meant that there wasn’t time to collect and analyse interview data from the psychological therapists, who conducted the sessions with the women, on what they thought were the helpful and unhelpful aspects of the psychological support. However, it is important to note that in line with a social constructionist approach, the psychological professionals would not necessarily have had similar interpretations of what was helpful and unhelpful. Therefore triangulation from my epistemological perspective is not a case of checking the correctness of the findings, but rather checking the differing views of women with breast cancer and their therapists.

• The catalytic validity of the research (the empowering nature of the research for the participants); the interviews were designed to bring out the detail of the feelings and thoughts of the women with breast cancer, in relation to the psychological support. The women were active and engaged in this research study, as detailed in the reflexive analysis chapter.

• The possible replication of the research; the data collection process was a semi-structured interviewing technique, with key questions which are detailed in this chapter and in the appendix. The data analysis was a social constructionist approach to Grounded Theory, using defined stages of analysis (Strauss and Corbin, 1998; Charmaz, 2006).

This research has been examined for trustworthiness, authenticity, adequacy, appropriateness and validity. However it is important for me to note that I do not want to anchor the research in a positivist legacy, focusing on the method above the understanding of the women’s experiences. I agree with Chamberlain (2000) who raised concerns about methodolatry in qualitative research the ‘privileging of methodological concerns over other considerations in qualitative health research’ (p.285). In addition because breast cancer is located within a medical context, the focus on methods can be influenced by this context, Spicer (1995) named this as a problem of being situated in occupied territory. This again links to a social constructionist perspective of noticing the influences and pressures to conform to medical context norms; detached researchers, objective reality, mind/ body separation and the separation of the physical body from the social context (Chamberlain, 2000). I wanted to demonstrate thoroughness, professionalism, interpretations that were informative and that provide insight and above all care for the women in how I approached the research. It is not just good methods that make good research, it is a focus on good interpretations, methods are tools rather than the end in themselves (Chamberlain, 2000).

3.10 Ethical Considerations

This study involved adult women, over the age of 18 years, who had primary breast cancer and had chosen to have psychological therapy. The interviews took the form of a conversation about what aspects they found helpful and/or unhelpful in psychological therapy. The research complied with the ethical research requirements of the Health and Care Professions Council and the British Psychological Society (HCPC, 2012; BPS, 2010). The University of
Manchester School of Environment, Education and Development approved the research (see appendix a). The participants were given an information sheet and had an opportunity to ask any questions they might have. The participant gave informed consent before the interview and had the opportunity to withdraw at any point in the study. Data has been anonymised and stored securely in encrypted files. (See appendix f for information sheet and example consent form from the client).

There is a further discussion of ethics in section 6.4.3. This examines ethics from the perspective of participant benefits of research participation as oppose to just focusing on risks.

3.11 Limitations of the research – methodological issues

One of the key limitations of a qualitative methodology is that the research findings cannot be generalized, because of a small sample size. The research findings are not objective and universal. However the research fulfilled its aim of generating rich in-depth data about the experiences of the 11 women. It provides important considerations and learning points for people who are psychologically supporting women with a primary breast cancer.

A delimitation imposed on the research, was that only women with primary breast cancer would be eligible to participate. I wanted to work to understand the specifics of women’s experiences of primary breast cancer, rather than examine men’s experience of primary breast cancer or women with secondary breast cancer. In addition, the population studied in the research was limited in terms of number, because of the time boundaries of the thesis as already discussed.

The participant recruitment was originally meant to be from a cancer hospital in Manchester, but again, because of the timings around ethical clearance in this setting I had to choose a different recruitment strategy. The participants were recruited from a national breast cancer charity in the main and therefore location of the interviews changed. The location of the interviews had to be split between face to face and over the phone, from a practical perspective, because of the location of some of the women.

GTA was used to analyse the data and is not without problems. Researcher bias means that the core category would not necessarily be the same one stated if another researcher did the research, as they would access different representations of the phenomena under study (Haraway, 1991). Within qualitative research, the effect of the researcher is acknowledged which means that a subjective element is introduced into the work. However, this aspect has been discussed in detail, in the reflexive analysis chapter 5 and therefore although bias cannot be eliminated it is accounted for
3.12 Chapter Summary

Within this chapter I have outlined the research design for the thesis. I stated my epistemological positioning, a social constructionist approach. My ontological stance is that there is no one objective truth to be discovered. There are many truths dependent on the positioning of the individual participants and researcher’s. I described the step-by-step guide of how I used GTA and the rationale for using this analysis method. In addition, I discussed the research process with reference to a feminist lens, which opened up the research to consider how breast cancer as a gendered issue, that is socially constructed. In conclusion, the chapter discussed the trustworthiness and validity of the research, alongside the ethical considerations and limitations.
4.

Analysis

4.1. Introduction

This chapter intends to outline the findings of the research. For reference, the research was designed to explore the helpful and unhelpful processes in psychological therapy for women with breast cancer:

- What are the helpful aspects of psychological therapy as identified by women with a primary breast cancer?
- What are the unhelpful aspects of psychological therapy as identified by women with a primary breast cancer?

Within this chapter, I describe the interpretative findings of the qualitative data, in which the semi-structured interview data was analysed using GTA (Charmaz, 2006a; Charmaz, 2006b; Strauss and Corbin, 1998; Corbin & Strauss, 2008).

4.2. Qualitative Findings

The data from the semi-structured interviews was analysed using GTA from a social constructionist perspective as outlined in the methodology (Charmaz, 2006a; Charmaz, 2006b; Corbin & Strauss, 2008). During the coding, the central name that refers to the phenomenon that was researched was “helpful and unhelpful aspects of psychological therapy as identified by primary breast cancer patients”.

4.3 Presentation of the findings

The findings will be presented first looking at the context of the women and then focusing on the helpful aspects of psychological therapy, before examining the unhelpful aspects.

A theory of helpful aspects of psychological therapy with breast cancer patients was understood through the shared thoughts and experiences of the study participants (figure 1 and table 1 detail the organizing scheme, the higher ordered focused codes and the original detailed focused codes). In this area there was a huge amount of rich material and as a result I decided to discuss focused codes in addition to the higher order focused codes, in the organizing scheme of context, conditions, interactions, actions and consequence. The detailed focused codes will also be discussed at a greater level of detail under the organizing scheme in three areas; interactions, actions and consequence.
Figure 1. A diagram depicting helpful aspects of psychological therapy
<table>
<thead>
<tr>
<th>Ordered higher order focused codes</th>
<th>Original detailed focused codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td></td>
</tr>
</tbody>
</table>
| BEING THROWN INTO THE BREAST CANCER WORLD | -Experiencing the pain of the treatment not the breast cancer  
-Experiencing cancer as like being in a different culture  
-Experiencing body losses as empowering or disempowering |
| **Conditions**                    |                                 |
| HAVING PSYCHOLOGICAL NEED RECOGNISED BY OTHERS | -Others often recognising the therapy need, not self |
| HAVING EASY ACCESS TO FLEXIBLE CONTINUING THERAPY | -Appreciating accessibility and flexibility  
-Having psychological support continuing after medical treatment stops |
| VALUING THE PERSONAL QUALITIES OF THE THERAPIST | -Experiencing male / female therapists as helpful  
-Valuing the personal qualities of the therapist |
| **Interactions**                  |                                 |
| BEING ENABLED TO EXPRESS SELF SAFELY | -Having protected safe space & time to offload / express real fears with no guilt.  
-Making sense of experience; navigating and processing  
-Normalising thoughts and feelings in therapy  
-Having a physical separation in location for therapy |
| BEING TREATED AS AN INDIVIDUAL WHOLE PERSON | -Valuing a whole person personal approach or not wanting just a medical approach |
| ACCESSING THERAPISTS INNER SELF | -Having access to a wiser head  
-Experiencing the therapist’s self- disclosure as increasing relational depth |
| **Actions**                       |                                 |
| BEING HELPED TO EMPOWER SELF      | -Putting self first  
-Being empowered to ask medical questions |
| BEING TAUGHT NEW COPING SKILLS    | -Reframing thoughts and focusing on helpful behaviours  
-Learning practical coping strategies  
-Being helped to adjust  
-Being helped to be compassionate to self |
| **Consequence**                   |                                 |
| BEING HELPED TO PUT ACTIVE SELF BACK TOGETHER AGAIN | -Putting life back together  
-Being helped to take some control again  
-Gaining post traumatic growth  
-Being enabled to look to the future again  
-Recommended therapy to others because of personal experience  
-Laughter helping to reduce anxiety and regain self |

Table 1. Full list of axial and focused codes for helpful aspects of psychological support
The context was: Being thrown into the breast cancer world. The three helpful conditions were: Having psychological need recognised by others, having easy access to ongoing flexible therapy and valuing the personal qualities of the therapist. The three helpful interactions were: Being enabled to express self safely, being treated as an individual whole woman and accessing the therapist’s inner self. The two helpful actions were: Being helped to empower self and being taught new coping skills. The perceptions of the participants highlighted the core variable of, being helped to put active self back together again, which illuminated the main helpful themes and was the consequence of the therapy process. The axial and focused coding is detailed in table 1. The analysis will talk briefly about the context before focusing in detail on the helpful conditions, interactions, actions and consequence.

4.3.1 Being thrown into the breast cancer world (context)

‘The fantasies inspired by…cancer now, are responses to a disease thought to be intractable and capricious – that is, a disease not understood – in an era in which medicine’s central premise is that all diseases can be cured. Such a disease is, by definition, mysterious… Cancer fills the role of an illness experienced as a ruthless, secret invasion. (Sontag, 1991, p.5)

The women described being thrown into the breast cancer world. This broke down into three areas; experiencing the pain of the treatment not the breast cancer, experiencing the cancer world as like being in a different culture and experiencing body losses as either empowering for some, but for others they were disempowering.

The women spoke about the harsh treatment, from feeling physically well when they were diagnosed with breast cancer, to being made ill because of the treatment, Vinnie said,

‘I was quite well, you know…erm…and then, all of a sudden it’s not the cancer that makes you feel ill. It’s the bloody treatment. You go from feeling quite well…. well, you go from feeling well and normal to…right down to the bottom.’ (TV06, p.6)

The treatment journey, was described by Lola and Lucyna as a tunnel to get through,

‘It’s like a tunnel, and it’s just getting to the other end of that tunnel and coming out and then going ‘oooh…what the hell happened there?’ (TL07, p.8)

‘It was a black tunnel…. A very long one... ’ (TL09, p.18)

Experiencing cancer was described as being like being in a different culture. Eliza said when she bought her family into the cancer hospital wig room,

‘I knew, as I brought them in…I thought…this is like…it’s like bringing them into a different culture and it’s going to be really uncomfortable for them. But this is my reality and I want them to see it because…this is my world at the moment’ (TE03, p.17)
Sophie also described the different, new culture she was now part of,

‘You do get thrown into this whole new world, of like hospital terminology’ (TS05, p.2)

Women described the breast cancer world as experiencing body losses. Some described these losses as empowering. Vinnie described thinking about losing one of her breasts,

‘It was funny really...I wanted...I just thought ‘take it away’...it does not serve any purpose for me’ (TV06, p.2)

Vinnie also described losing her hair in an empowering way for her,

‘They just said ‘the probability is that you’ll lose your hair. So I shaved it off. I thought ‘well...sod it. I’ll do that... I’ll be in charge of my hair falling out...thank you.’ (TV06, p.9)

For Lucyna the body losses were scary and disempowering,

‘I just said ‘right do what you need to do’. So, it was a bit scary that I was going to be losing my breast.’ (TL09, p.3)

‘You’ve actually been faced with death...which was the biggest thing...obviously... that and losing my hair....those were the two hardest...’ (TL09, p.7)

4.3.2 Having psychological need recognised by others (condition 1 of 3)

There were three key conditions mentioned as main themes in the research data. The first one, having their psychological need recognised by others not self, describes how many of the women did not identify in themselves that they needed psychological support or that it may help. There was a hidden reliance on others, sometimes friends and family, but mainly the healthcare team they came into contact with, to recommend therapy to them. This personal recommendation by someone they trusted was a crucial condition. Jane, Vanessa and Lola talked about others recommending psychological therapy to them,

‘It was a friend of a friend who told me about it initially’ (TJ01, p.13)

‘It was through someone who worked in the GP practice who told me about her’ (TV02, p.4)

‘Erm...went and saw my surgeon, because I was worrying about lumps and bumps and everything. And he said to me ‘your body is fine, it’s your head that needs sorting out. You need to get into therapy’ and he told me how to do it. So I then started with a therapist’ (TL07, p.1)
4.3.3 Having easy access to flexible continuing therapy (condition 2 out of 3)

It was very important that the psychological therapy was easy to access and flexible as the treatment caused people to feel unwell and fatigued. The women were often ground down by the treatment journey and therefore the therapy needed to be easy to obtain and sessions needed to move around depending on how the person was feeling physically or emotionally with no penalty. Eliza described the psychological support as,

‘It wasn’t like we had to sit through that structure. So there was a …there was flexibility…’
(TE03, p.4)

There was also a need for the therapy to be open ended in some cases, continuing after the medical treatment had stopped, Jane said,

‘I could pick up the phone if I needed to it was possible to pick up the phone and make an appointment to see someone so I knew’ (TJ01, p.12)

Sophie described the ending of therapy as a gradual process, which still left the door open for Sophie,

‘We kind of came to the decision together…that rather than me be discharged from her…her list if you like…that it’s left open to say that I can see her…And I am thinking about going to see her at the moment’ (TS05, p.4)

4.3.4 Valuing the personal qualities of the therapist (condition 3 out of 3)

The third condition was valuing the personal qualities of the therapist. Nine women had female therapists and two had male therapists. There were women who preferred working with someone of the same sex, because they felt they could relate better, Vanessa talked about similarities of sex and age and Jane said she could open up more,

‘She is probably the same age as me so…she felt familiar’ (TV02, p.5)

‘I think because of what I was going through I don’t think I could have discussed things with a man’ (TJ01, p.5)

Others found male therapists helpful as they offered a different perspective and didn’t inject any of their personal experience into the therapeutic space, Lola said,

‘I mean, it’s from a different…he comes from a completely different angle. And…the first time I was told it was a man I was having…I was thinking ‘oh…how is he going to understand?’ You know. But actually he was…it was probably more beneficial having a man, who…you know…a proper sounding board, you know…And there was no personal experience for him…for him to inject into the…the meetings’ (TL07, p.2)

The personal qualities of the therapist were mentioned many times; they were described as having emotional warmth, being open, approachable and trustworthy. Another therapist was
described as charming and funny. The therapists provided ongoing support, reassurance and comfort. They were real and human. Shirley said,

‘He was very up front...he was surprisingly open’ (TS10, p.8)

The therapists were also described a calm, patient and objective. They were caring, gentle, and kind and they helped the person relax. They were also non-judgmental, non-conditional and not patronizing. Vanessa talked about the caring aspect,

‘I felt that she cared and that felt really important..Yeh that I mattered to her and she wanted the best for me really’ (TV02, p.3)

4.3.5 Being enabled to express self safely (Interaction 1 of 3)

This interaction broke down into four detailed focused coding areas; having protected safe space to express real fears, making sense of the experience, normalising thoughts and feelings and the location of the therapy. Each of these will be discussed using the words of the women.

4.3.5a Protected safe space to express real fears

‘Whatever you do, don’t say ‘cancer’. The unspoken word, written on everyone’s lips, must not be voiced. Frozen in its previous associations with inevitable death, cancer is still an illness, which even hospital staff endeavour to avoid. Even after diagnosis no one on the surgical ward says the word cancer to me’

(Stacey, 1997, p.65)

Sontag (1991) noted that many people with cancer are shunned by friends and family and this can mean that they struggle to voice their thoughts and emotions. It was important to the women, in this research, to have an interaction with the therapist that was just for them, a safe and protected space. They were able to offload and express their real fears, with no guilt or concern for the other. They didn’t have to worry about the therapist’s feelings or thoughts, they were free to voice their fears and the therapist would not shun them, Lola and Sophie said,

‘I think just talking to somebody that...he didn’t know me...so...and everything obviously was confidential. So I just I could just like...spill my guts basically’ (TL07, p.2)

‘And, you know...you can have all the friends and family in the world, but I think...sometimes...to really be able to open it up...it needs to be a stranger... and a professional person that knows how to deal with fears and despair and things like that’

(TS05, p.10)
4.3.5b Making sense of the experience

The psychological support helped many of the women to make some sense of their experience of breast cancer. They were helped to navigate and process what was happening to them. The therapist was there to bounce things off, to help a person make sense of their experiences. They were helped to understand, Jane said,

‘It’s just that bouncing it off somebody else so you know you have somebody there that you can say things to about your concerns’ (TJ01, p.3)

Vinnie described how her therapist helped her to make sense of the chemotherapy when she ended up going to hospital because she was neutropenic,

‘She said...what she said was ‘just imagine if that’s making you feel so ill...just think what it’s doing to the cancer cells’ (TV06, p.5)

A person could also be helped to make sense of existential areas like dark thoughts about their own mortality, Elizabeth said,

‘Making me feel equipped to deal with the darker thoughts...it was kind of identifying patterns of thoughts that I was letting myself get into...’ (TE08, p.8)

The cancer journey was smoothed as a result of psychological support Shirley described it by using the metaphor of smoothing icing on a cake,

‘I think I was surprised how useful and valuable and comfortable it made me feel...it’s it’s almost...it was almost...I was going to say...like smoothing icing...laughs... the icing on the cake. A really bad cake. But, it was...it made...yeah...it sort of smoothed off the edges about...you know the diagnosis and this, and operations and drains’ (TS10, p.14)

4.3.5c Normalising thoughts and feelings

The therapy encouraged people to feel comfortable to admit their vulnerabilities. It helped to normalize what was happening to them both physically and psychologically. Specifically thoughts and feelings were discussed as being ‘okay’, being ‘normal’, Vinnie and Lucyna said,

‘And it’s completely normal, and there would be something very wrong with you if you weren’t thinking like that, you know... Yes I think being able to...being able to say it out loud and say ‘well you know what...this is this and this is how it is’, but it’s okay’ (TV06, p.14).

‘And it is somebody saying ‘it’s okay. It’s alright to feel like that. It’s okay to be angry’’ (TL09, p.12)
4.3.5d Location of therapy

A couple of people specifically described that it was helpful to have the therapy in a location outside the hospital environment. They found that they didn’t have to re-experience the anxiety of going back to the hospital they were diagnosed at, which made them ill through the treatment or where they went for worrying medical tests, Jane said,

‘That worked well really because you just associate the hospital with your treatment so ermm I think obviously you go in there and you want your treatment over with and just come straight back home that’s how I used to look at it…I probably may not have accessed anything at the hospital’ (TJ01, p.6)

For others, location was not mentioned as helpful or unhelpful, some women were seen at the hospital they were treated at for psychological support.

4.3.6 Being treated as an individual whole person (Interaction 2 of 3)

There were many comments about how it helped to be treated and cared for both medically and psychologically at the same time. The therapy helped people find the strength to continue with the necessary harsh medical treatment. For some the therapy was a comforting common thread throughout their treatment, Shirley said,

‘There’s such a lot of different experiences and appointments and people to talk to and things to think about and medical things that have done right and medical things that have gone wrong…and…it’s…there’s different….there’s just such a lot of different bits and he could put links between them, or…or sort of…smoosh them together and make it more of an overall experience apart from a collection of things that took up every day…That connecting thread’ (TS10, p.14)

Being directed to the right individualized information also helped. This signposting was important and it was more helpful when it was not generic information, Jane mentions it,

‘Nutrition particular you know she was able to help me find the right books I needed things like that… that was useful’ (TJ01, p.7)

4.3.7 Accessing the therapist’s inner self (Interaction 3 of 3)

This interaction broke down into two detailed focused coding areas, which will each be discussed; having access to a wiser head and experiencing the therapist’s self-disclosure as increasing depth of the relationship.
4.3.7a Having access to a wiser head

The therapists had helpful skills and knowledge; listening skills were mentioned and some women talked about the therapist’s specific cancer knowledge as being helpful. This helped to provide reassurance to the person, giving information about what was happening to them physically and psychologically. Sophie described how there was a common understanding straight away because her therapist specialized in working with cancer patients that did not need any explanation,

‘You don’t have to explain. You can just...you can just talk. You don’t have to stop and explain why...or what this word means...or anything like that’ (TS05, p.2)

Vanessa talked about having access to a wider head at a time when you were vulnerable and less confident than she usually was,

‘Yeh and also to help you to think about other ways around it so she would sort of think about can you look at it another way or perhaps you could do this or perhaps help me if it was difficult exchanges with someone else...space to stop and think about who that person is and what your exchanges...what is happening in that exchange and a more constructive way to go about it, it is just like having a wiser head’ (TV02, p.13)

4.3.7b Experiencing the therapist’s self-disclosure as increasing relational depth

There were three women who mentioned their therapist self-disclosing in a limited way and in each case this was helpful. The therapists showed their vulnerability and this helped people open up, Eliza said,

‘There was always this quite human bit of her that wasn’t concerned about being too boundaried or even maybe if she hadn’t had that particular health problem, she might not have chosen to be so open. But she kind of...it kind of forced her to be...but for me that’s helpful, you know. That was fine and okay and it set the tone’ (TE03, p.6)

The therapist’s self-disclosure also helped people to develop a stronger therapeutic alliance, Shirley said,

‘Dropped me in a couple of little personal stories...which...but you know...it was probably deliberate...but it sort of made me feel a bit ... a bit more connected’ (TS10, p.9)

4.3.8 Being helped to empower self (Action 1 of 2)

The women talked about how the psychological support helped to empower them. Two specific areas came to light as detailed focused codes, firstly in gave them permission to put themselves first and secondly being enabled to ask questions of the medical team about their treatment.
Lucyna said it made it okay to be more conscious of her own needs and putting them first,

‘It just made me start to think that actually you can do things for yourself and it’s okay...and it’s not being selfish...that took me a long time to learn that...allowing myself to be put first’ (TL09, p.10)

Shirley talked about the guilt she felt in contemplating a second reconstruction operation as the first one had not turned out as well as expected. The psychological support helped her to put herself first and relieve her guilt,

‘The weird guilt that I was feeling about...I dunno taking up hospital time, taking somebody else’s operation slot you know. Because what...because I’m not happy with this amazing ten grand worth of operation that I’ve already had...and I’m... ‘Mmm...it’s not quite good enough’. And I felt...a bit selfish...He made it...he made it alright for me to...to want...to want something better.... that I could still be grateful and still want something better’ (TS10, p.5)

Shirley also talked about being empowered to ask medical questions of her surgeon about the second reconstruction in order to reduce her anxiety,

‘He said ‘ask him what his vision of better is, because if it doesn’t match your vision of better or it’s only five percent better than what you’ve got now, that may make’... because he was helping me decide...so I went back to the consultant and I had thirty-six questions on an excel spreadsheet’ (TS10, p.6)

4.3.9 Being taught new coping skills (Action 2 of 2)

All of the women talked about being helped to gain new ways to help them cope. In this category there were four detailed focused codes; reframing thoughts and focusing on helpful behaviours, learning practical coping strategies, being helped to be more flexible and being supported to be compassionate to self.

4.3.9a Reframing thoughts and focusing on helpful behaviours

The women described how it was helpful to be encouraged to recognise and notice the negative thoughts they were having and how they were directly affecting their mood. They learnt to reframe their thoughts, restructuring them to be more helpful, Elizabeth said,

‘Trying to identify sort of patterns of behaviour where I was allowing myself to feel very negative...so we worked on...thoughts. Just triggers and things that would make me think...you know...it’s not worth going on because I’mm gonna get cancer and die...and things like that. So...it was just stopping myself going down into that sort of hole again’ (TE08, p.4)

‘It was kind of identifying patterns of thoughts that I was letting myself get into...and how I could stop those happening, and if they happen again in the future. How I can nip them in the
bud before they get me into a kind of depression spiral’ (TE08, p.8)

Shirley described how the therapist enabled her to reflect on her own thoughts to problem solve,

‘And he’d probably say ‘Oh it’s not what I think is it? What do you think?’ laughs...’which one makes you happy?’ ... and ‘Oh...okay ...that’s a good way of looking at it’...laughs. Just a bit of guidance really’ (TS10, p.15)

4.3.9b Learning practical coping strategies

The women talked about being taught practical coping skills, strategies and tools. Relaxation, mindfulness and visualisation helped them to relax and cope. Mary said she was surprised how helpful relaxation was,

‘We always did a relaxation before I left.... It’s a really good strategy and I think if anybody had said that to me beforehand it was like...oh.... it’s a bit...erm...erm...It wouldn’t have been for me, put it that way.... it helped enormously’ (TM04, p.6)

In one case visualisation helped Vinnie to be able to have blood taken as her veins kept collapsing,

‘And...I was...she taught me how to put myself into rooms...so if I was feeling sick I could go into this room.... And erm...and the nausea would go....a sleep room...and a getting blood out of your arm room’ (TV06, p.4)

4.3.9c Being helped to be adjust

There was a sub category described about how the psychological support helped the women to start to be a little more flexible in their outlook and beliefs, to adjust. One woman related this to attachment theory and how rigid beliefs can develop about self, others and the world as we grow up and something like the trauma of a breast cancer diagnosis challenges these beliefs and threatens our core being. Being helped to look at these beliefs and alter coping mechanisms can help, Vanessa said,

‘This crisis, you know it is like all that theory about crisis just when people are in crisis so much can shift and move and I was in this big crisis and I had support around that time so you can adjust coping mechanisms because everything has loosened up’ (TV02, p.11)
4.3.9d Being supported to be compassionate to self

There was a sub category about being more compassionate to self and less judgmental. They were being harsh to themselves and through the therapy they were helped to be kinder to self, Vanessa said,

‘Oh yeh yes absolutely, giving you that space because there was always me saying what’s wrong with you that very judgmental part of myself I was much harsher on myself…I couldn’t boundary things, I couldn’t look after myself you should be able to do this there is something wrong with you…And she would say if you are doing that how can you, it was an outside perspective who could see what you are faced with and say ‘of course it is going to feel like this’…So helping me to put some sort of perspective on it helping me to be a bit kinder’

(TV02, p.12-13).

4.3.10 Being helped to put active self back together again (Consequence)

Being helped to put active self back together again and gain agency, individual volition was found to be the core category and the consequence of the psychological support for all the women with breast cancer. There were six detailed focused codes underpinning this; putting life back together, being helped to take some control again, gaining post traumatic growth, being enabled to look to the future again, recommending therapy to others because of personal experience and be able to laugh again which helped to reduce anxiety:

4.3.10a Putting life back together

The process of putting their life back together with the help of psychological support was described by many of the women. Sophie discussed the metaphor her therapist used of a stained glass window to talk about how her life was being put back together slowly through therapy and that it could be more beautiful than before, Sophie said,

‘She talks about life at the minute…you know immediately when you have something that disrupts…It’s like…imagine a lovely stained glass window that…you know…. that’s broken and you just kind of look…you’re looking at all the pieces on the floor and you don’t know how they fit back together again. But …over a period of time you’ll be able to see the opportunity to take the pieces of your old window…or your old life…if you like…And put them together to make something new…so it’s that kind of…went along the lines with coming to…really the understanding that I’’’ never be able to get my old life back but it doesn’t mean that that’s necessarily a bad thing. I can take the good parts and turn it into something…you know…better’ (TS05, p. 4)

Lola described the experience using the metaphor of a jigsaw. She was shocked that she fell to pieces because she had always been so confident and organized before the breast cancer, but her therapist was able to help her make sense of the experience and help her put things back together again,
'And he was very...erm... I dunno, he was very... he was just a very good listener and I was able to really just...you know...explain everything...how I was feeling, and it kind of started to make sense in my own head. The more I spoke, the more it made sense to me, and it was kind of like a jigsaw puzzle really, and he was ....erm... yeah, he was very good. He was...I can’t think of the word. He didn’t...erm.... patronize me.’ (TL07, p.2)

Lola continued to use the jigsaw metaphor throughout the interview to help explain what happened in therapy,

‘I mean..like I had to find..but you couldn’t rush it. It had to be put back together the right way you know...Maybe start at the outside and then the inside...and that’s a strange way to say it...but that’s how it feels. I had to put everything around me back in place before then me’ (TL07, p.7)

4.3.10b Being helped to take some control again

The breast cancer threw the women into an uncertain situation where they often suddenly realised they could not control what was happening with the cancer and the treatment. Through having the psychological support the women were helped to gain some control over their life again, they were encouraged to take back control over what they could control. This process was completed slowly by taking small steps. Vanessa described,

‘Yes cause it has shifted my relationship with my husband, helped me boundary work...More on top of life...Become a better practitioner really’ (TV02, p.10-11)

4.3.10c Gaining post-traumatic growth

The women talked about experiencing a positive shift because they had experienced a crisis in being diagnosed with breast cancer and they were helped psychologically to process this in therapy. They talked about relationships changing, altering their working lives, not avoiding things and being more boundaried, Vanessa remarked,

‘Yeh yes I just avoid things and now I suppose I don’t...if there is a difficult time I go in there and deal with it so I feel more in control because you are not avoiding things all the time’ (TV02, p.12)

Vinnie said her confidence had risen. She had more psychological strength and resilience now and this enabled her to take part in this research project,

‘I think (therapy is) an important thing. I honestly...I honestly believe I wouldn’t be...I wouldn’t be at the place that I’m at now without that...Because I don’t think...like I say, I wasn’t confident before all this...And... like ....I mean...if I go back...if I take myself back ten years...there would be no way on this earth I would talk to a...I wouldn’t have been able to do it. I just wouldn’t have done it’ (TV06, p.17)
4.3.10d Being enabled to look to the future again

The breast cancer stopped people in life. Life was described as being on hold. They did not feel they could look to the future as they felt this was uncertain. They seemed not to be able to move forward in their life, the psychological support helped to unblock this, Elizabeth talked about being able to move forward again with the second set of Cognitive Behavioural Therapy sessions,

‘But then the second lot I had, it was going forward...with life...Like how do you kind of get past...the fact that you might die one day. That kind of mortality thing’ (TE08, p.4)

Lola talked about starting to arrange an important family celebration that she had put on hold when she was diagnosed,

‘I’m married twenty-five years next year and we’re having a...you know...a renewal of vows and everything...and I was talking about it a few years ago...about maybe doing something on our twenty-fifth, and when I was diagnosed...just every time my husband brought it up, I just said ‘I don’t want to talk about it’. So...that’s changed. I’ve now started planning it again.... I think just being able to go and chat about how I’d been feeling...generally just having someone that didn’t know me’ (TL07, p.5)

4.3.10e Recommending therapy to others because of personal experience

Many of the women wanted psychological support to be available to all women who are diagnosed with breast cancer. They did not want people to go on the journey without this. Lola talked about how she had recommended therapy to others,

‘I’ve spoken to a few of them about therapy and said ‘look, it may not be for you, but it’s something that you could think about...not just now...but when you’re ready to start facing it and dealing with it’ (TL07, p.8).

The women spoke about how they didn’t know how much it could help before they had the psychological support and how some of them thought they were not the type of people to need therapy even at this traumatic time. Therefore in their recommendation to others they speak about the need for people to be offered the support and be encouraged to try it at the right time for them, Shirley said she would recommend it to,

‘Every single one of them. Whether or not you think you need it. Go and have a session. Because... I think I was surprised how useful and valuable and comfortable it made me feel’ (TS10, p.14)

Elizabeth when I asked about psychological support for others was absolutely convinced women should have this,

‘Yeah. Definitely. Definitely.... And how that’s really helped. Pretty much everybody has
accessed those kind of services and really, really sort of said...you know, everybody has very positive outcomes from them and said it really helped.’ (TE08, p.5)

Although there was a sense that some women would not think they needed psychological support, there was a sense for some that they had taken up therapy later in their journey after being offered it a few times. Early on some women spoke about how they just had the energy to get through the treatment and valued the therapy later on to process the emotions they had been holding at bay. For others it was valuable having therapy all the way through the treatment.

Some of the women were a little more cautious about the type of person, who would get value from therapy, Vanessa said,

‘I depends who it is I suppose... and how they would perceive it you know whether they could use it ermm I think it can be constructive for most people really I think’ (TV02, p.14)

Psychological support was seen as a necessary natural part of the breast cancer care and treatment, as important as the medical side. Mary talked how it should be offered routinely and the multidisciplinary team meetings at the hospital should also include a psychologist,

‘Because it would be like ‘well, you know...you’re going off for a scan...well you can see the therapist as a routine appointment...everybody has this scan and so everybody sees a psychologist’...I think it would be...I know the clinic that I attended has a multidisciplinary team meeting on a Tuesday morning, and the surgeons are there, the oncologists, the breast care nurses, the radiologists...all that sort of thing...and they look at who’s had erm...a scan, what the next bit of their treatment is going to be, etc., etc. I think if there was a psychologist as part of the team...you know...that would be good.’ (TM04, p.8)

4.3.10f Laughter helping to reduce anxiety and gain sense of self

Laughter was talked about in terms of relieving anxiety and helping to raise the women’s moods. It helped to keep them going, to keep fighting. Gaining their sense of humour was also a sign of their old self still being there, it was their active self, they had agency even though they were facing adversity, Vinnie said,

‘Well, your send of humour goes and I have to say...I am one for laughing...laughing at adversity as well...I have to say. I’ll never go to heaven, I’m afraid...because...there are things I find funny that I just should not but I do ’ (TV06, p.13)

Jane talked about being with other people with cancer and how they,

‘Didn’t really speak much about our personal ermm problems at all but ermm we probably laughed most of the time’ (TJ01, p.9)
4.3.11 Unhelpful aspects of psychological therapy for women with breast cancer

The majority of women interviewed could not think of anything unhelpful when I asked them about their psychological therapy. Jane, Sophie and Vinnie illustrated this when I asked them to consider unhelpful aspects,

‘I can’t bring anything to mind I know it was a long time ago I just saw it as a really positive experience’ (TJ01, p.18)

‘No. Absolutely not. All of it was helpful’ (TS05, p.6)

‘I cannot find any downside at all…I just had…. my experience was one of …a hundred percent positivity.’ (TV06, p.17)

However there were unhelpful aspects and a theoretical model is detailed in figure 2 and table 2. The same context emerged, being thrown into the breast cancer world. Two conditions of the therapy that made it unhelpful were not having easy to access therapy and the therapist’s personal qualities being cold and harsh. The two interactions that were unhelpful were unable to express self safely and not being treated as an individual whole person. The action that emerged that was unhelpful was that the therapy was too short. The consequence of when therapy was not set up in the right way was that the women were re-traumatised and remained shattered, after a breast cancer diagnosis and treatment.

As there was less data found in the unhelpful aspects area I have concentrated mainly on the high level organized focused codes. I have discussed the next level down, the original detailed focused codes but I have not broken these up into separate sections to discuss.
Figure 2. A diagram depicting unhelpful aspects of psychological therapy
<table>
<thead>
<tr>
<th>Ordered higher order focused codes</th>
<th>Original detailed focused codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context (same as in helpful aspects table 1)</strong></td>
<td>BEING THROWN INTO THE BREAST CANCER WORLD</td>
</tr>
<tr>
<td></td>
<td>- Experiencing the pain of the treatment not the breast cancer</td>
</tr>
<tr>
<td></td>
<td>- Experiencing cancer as like being in a different culture</td>
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<tr>
<td></td>
<td>- Experiencing body losses as empowering or disempowering</td>
</tr>
<tr>
<td><strong>Conditions</strong></td>
<td>THERAPY NOT EASY TO ACCESS</td>
</tr>
<tr>
<td></td>
<td>- Long waiting lists and inconsistent therapist support</td>
</tr>
<tr>
<td></td>
<td>THERAPIST’S PERSONAL QUALITIES BEING COLD AND HARSH</td>
</tr>
<tr>
<td></td>
<td>- Finding psychoanalytic therapist cold, harsh and punitive</td>
</tr>
<tr>
<td></td>
<td>- Psychoanalytic therapy too focused on the past rather than present issues</td>
</tr>
<tr>
<td><strong>Interactions</strong></td>
<td>BEING UNABLE TO EXPRESS SELF SAFELY</td>
</tr>
<tr>
<td></td>
<td>- Not feeling psychologically held</td>
</tr>
<tr>
<td></td>
<td>NOT BEING TREATED AS AN INDIVIDUAL WHOLE PERSON</td>
</tr>
<tr>
<td></td>
<td>- Not being treated as a person with feelings, underpinned by a lack of therapeutic alliance in assessment</td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td>THERAPY BEING TOO SHORT</td>
</tr>
<tr>
<td></td>
<td>- Therapy stopped abruptly and a long wait for another therapist</td>
</tr>
<tr>
<td><strong>Consequence</strong></td>
<td>BEING RETRAUMATISED AND REMAINING SHATTERED</td>
</tr>
<tr>
<td></td>
<td>- Therapy not helping to move someone forward and causing a person to experience more distress because the therapy is not set up in the right way</td>
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**Table 2. Full list of axial and focused codes for unhelpful aspects of psychological support**

**4.3.11a Therapy not easy to access (condition 1)**

Hannah had a particularly poor experience of accessing therapy. She talked about waiting months for therapy and then after a short therapeutic intervention her therapist unfortunately was not around due to illness and then the therapist was made redundant. There was no therapist for Hannah to be passed onto quickly and this was extremely traumatic,

‘Yeah. Months. I finished with…that other woman went off sick …erm. And then she was made redundant. So I’ve not actually seen anybody again for…. I don’t know…. a good few months anyway…. And that’s happened…. first woman…and she said she couldn’t see me again because I was too complicated…. and then I had a telephone interview and then they gave me Ros. A couple of months between that, and then I saw Ros for the assessment period…erm.. and then she went off.’ (TH11, p.4)
4.3.11b Therapist’s personal qualities being cold and harsh (condition 2)

A few of the women had experiences of psychotherapy from a psychoanalytic perspective, as well as other approaches like person-centred, CBT and integrative. These women found the psychoanalytic therapist’s approach and personal qualities at odds with what they needed as they felt extremely vulnerable. The psychotherapists were described as cold’, harsh, punitive, rigid and too focused on past experiences at the expense of looking at present issues. Vanessa had psychoanalytic therapy before she was diagnosed with breast cancer, she then went on to have person-centred therapy after the diagnosis, she said,

‘Because I was in therapy in the past... And that was very different... in the past it was Freudian... lying on a coach, completely different, quite persecutory really and this was different, warm she was attachment based... the relationship is just key’ (TV02, p.3)

Lola talked about her experience of psychoanalysis when she had been diagnosed with breast cancer and she was trying to get help for her daughter, who was struggling to cope with what was going on,  

‘It was basically we went to her for my daughter, because she was having trouble... ermm coping with it. But... ermm... she started turning it around and making my daughter sit outside and it was... became all about me... and all about... it was always about my childhood all the time... And I kept saying ‘But why? This is nothing to do with it’... I didn’t understand why talking about how my childhood and whether it was happy or unhappy... And was I the eldest child, the youngest child, the middle child... made any difference to how I was feeling about well... with dealing with cancer.... Trying to find something wrong in your past to blame really, you know’ (TL07, p.4)

4.3.11c Being unable to express self safely (interaction 1)

Hannah also spoke about the therapist’s handling of risk. From Hannah’s perspective she was being honest and insightful about how she felt, as she had been diagnosed with a life threatening illness as an adult, on top of suffering abuse as a child. However this led to Hannah being labelled as too complicated by the first therapist and Hannah had feelings that she could not express herself safely in the therapy, she did not feel psychologically held,

‘Not being treated as an individual. I mean, what they were saying to me... is do you ever feel... that’s why they said I was complicated... she said “Have you ever felt suicidal?” And I said, “Yes. I do. But I’m not going to commit suicide. But sometimes I feel like that because... I don’t know... probably the triggers to my past and also my life’s just changed so much”. And she panicked. But I know myself well. I know myself well because I’d had years and years of therapy in the past before... And all it is... I’m probably more insightful into myself than what some people are... and able to be honest... and from that she’s took it that
“Oh my God… I can’t work with you”. Well, I’m not at risk of committing suicide, but yes, sometimes I feel like that and I just think she needed more training… Because that… that to me is not… I’m not a risk to her… I’m not a risk of going out and committing suicide. If you want time out… and you’re, you know, you’re tired and you need time out… it’s not the same as wanting to die forever type of thing. And I just think…. I don’t think she was qualified enough… to… be doing what she was doing, to be honest.’ (TH11, p. 6-7)

4.3.11d Not being treated as a whole individual person (interaction 2)

Hannah had to wait a long time for therapy and then she was told she was too complicated because she talked about other issues that had been distressing in her past alongside coping with breast cancer, she became frustrated as this led to more delays in being seen by an appropriate therapist. She had to take part in assessments over the phone with people she had never met. This led to her being asked for personal details when there was no therapeutic alliance established, Hannah said,

‘And then I had another…..well somebody rang me up then and said can we have an assessment over the phone, and she said “What have you been talking about in your therapy?” And I said “Well I’m not telling you over the phone” what we have been talking about it’s private… It’s private. And so somebody else rang me up and I had another telephone interview and then she said she was going to ring me back when they’ve got somebody, but it’s a long waiting list.’ (TH11, p. 4)

4.3.11c Therapy being too short (action)

Hannah found her psychoanalytic psychotherapist cold, she said she was good at what she did, and the difficulty was the short-term nature of the intervention. The relationship ended unfortunately after six sessions as the therapist went off sick and then was made redundant; Hannah is still waiting for another therapist. The resulting short and abruptly ending therapeutic intervention was a traumatic experience, not one that was psychologically held, Hannah said,

‘I found her quite cold. But she was good at her job. Erm… she… and I found it quite hard… but like I would have worked with her… I don’t see how you can work to that time restriction myself. It’s quite off putting… to have sort of a life threatening illness like that and to be treated like I was… I just think it was not realistic… It was horrible. Over the last two years I’ve gone from… I mean I’ve survived all my life…. Myself… and had a lot of therapy, and got into a good place in my life and then to find out I’d got cancer… to be in treatment… I had three operations, chemo, radiotherapy… and then they offer you six weeks therapy…. You know… I lost my hair, eyebrows, most of my breasts and I used to think, “What are you going to do in six weeks’” (TH11, p. 3)

As well as Hannah, Lucyna also described therapy ending too soon for her,
‘Then at the end...towards the last session.... I felt as if she was.... err...she didn’t understand me anymore. Because I could see what I was getting at, and she was like... “Well, you’ve got everything in place now, haven’t you?”’. “Yeah. Yeah. I have.... thanks very much. Thank you. You’ve been really helpful. Thank you so much” ... and that was hard for me...because I actually had to recognize...that the professional...wasn’t right for me...I knew...I knew that I wasn’t fully settled...I knew there were still issues...But...it was like she said “Well, you’ve got everything in place now. You’re fine. You’ve got a job...you’ve got this...you’ve got sorted out”....’ (TL09, p.19)

4.3.11f Being re-traumatised and remaining psychologically shattered (consequence)

‘There is the ‘fight’ or ‘crusade against cancer; cancer is the ‘killer’ disease; people who have cancer are ‘cancer victims.’ Ostensibly, the illness is the culprit. But it is also the cancer patient who is made culpable... and conventions of treating cancer as no mere disease but a demonic enemy make cancer not just a lethal disease but a shameful one.’

(Sontag, 1991, p.59)

When the unhelpful aspects of therapy were present the women did not move forward and sometimes went backwards, they remained fragile psychologically. Lola describes her experience of taking her daughter to get help to cope with a psychoanalytic psychotherapist and how there was an absence of a therapeutic alliance. After four sessions Lola decided it was not right to continue,

‘So I just stopped going. I just said to her “I’m not coming back. No that’s it”. It wasn’t helping H. It wasn’t helping me. I didn’t see the point in it. I mean, I’ve since heard that that.... I mean, she’s quite.... I mean she’s very well known... and she’s like Marmite evidently.... you either love her or you hate.... I didn’t hate her. But you either get on with her or you didn’t...and I just didn’t get what the...I didn’t understand why talking about how my childhood and whether it was happy or unhappy.... And was I the eldest child, the youngest child, the middle child...made any difference to how I was feeling about well...with dealing with cancer.... H and I just came away, and Hannah was just in bits and.... I said,... “It’s just pointless. It isn’t helping either of us. I’m not going back”’ (laughs) ’ (TL07, p.4)

There was inconsistency in the therapy experience for Hannah and she spoke about how she wanted to be treated as a whole person, and it was re-traumatising that this did not happen in her therapy. The poor set up and experience of psychological support was traumatic and she remained in a distressed place when I spoke to her,
‘I’d worked with a charity with survivors of childhood sexual abuse and there’s loads of our women have cancer. They should know how to work with people with cancer anyway.... er...you know... as well...you are a whole person. You’re not just a person that’s got cancer. For me.... I’ve gone right back to surviving again. Which I did all my life.... You know what I mean? And it’s put me right back in that place....erm... and people don’t come...they’re not just people that have got cancer. They are individuals...They have...their own story...their own life...I know I’m not on my own with that and I do think... when you go to therapy you should be working with a person that’s in front of you’ (TH11, p.5)

4.3.12 Concluding remarks and reflexive thoughts on the analysis

The first striking finding for me, in this analysis, was just how thrown the women felt when diagnosed. They were thrown and they knew they had been thrown unlike a rock, a tree, a horse or an angel, as Willig (2009) said. The women had no choice but to deal with where they had landed, they had to take responsibility, hold themselves together and make meaning out of meaninglessness. For me the findings on helpful aspects of psychological therapy started to illuminate what could potentially help. The idea that like putting a stained glass window together, a women could be given the space and be helped to put her active life back together, came directly from the women’s experiences.

I was also struck about the importance of the right conditions: Just how important referrers to psychological therapy are for women with breast cancer. The huge difference a medical team can make, if they recognise the need in a woman for psychological therapy, was vital, it made me consider the multidisciplinary teams in hospitals and the important role they have in helping women get access to the psychological therapy where it is available. The women may not have even been aware of it or may not have thought it was designed for them. In recommending a psychological space, to women with breast cancer, the medical teams are giving a flexible space for open expression of thoughts, feelings and fears, if the therapy is set up correctly.

To me I was helped by the women to understand the need for whole person care for women with breast cancer, rather than treating the cancer as if it is on any women, generically. Individuals have different thoughts, feelings, fears, needs, pasts and social structures around them, which all influence how they experience the diagnosis of breast cancer and the treatment. The women talked many times of almost pulling out the therapist’s inner self, using this as a resource to help them make meaning and this struck me as a powerful process, a need for someone else to reflect with them, to help them to understand what was happening. Some of the women also wanted more than understanding and meaning making they wanted practical coping skills, they wanted to hold themselves together to get through the diagnosis and treatment. I felt a real sense of the women empowering themselves through learning what helped them and what didn’t, in this new strange world.

Unfortunately when the psychological therapy was not set up in the right way, in terms of the quick access, the personal qualities of the therapist or consistent therapy the women were caused more distress. This was hard for me to hear. I felt that re-traumatising the women with breast cancer, who spoke about the unhelpful aspects, was against every value I had as a
compassionate Counselling Psychologist. Maybe the problems were structural to do with how the services were set up, not thought through or not funded sufficiently, but it didn’t take away from the shame I felt that this had happened.
5.

Reflexive analysis

5.1. Introduction

‘The problem is not that we tailor but that so few qualitative researchers reveal that we do this work, much less how we do this work’

(Fine, 1994).

The presented thesis had two main research questions:

• What are the helpful aspects of psychological therapy as identified by patients with a primary breast cancer?
• What are the unhelpful aspects of psychological therapy as identified by patients with a primary breast cancer?

This chapter will provide reflections on the research process from my perspective as the researcher, at the specific time of the study, in line with post structuralism (Richardson and St.Pierre, 2005). Post structuralism links subjectivity, social organization, language and power; it has also provided me with the freedom not to have to write everything in this single thesis. Reflexivity has helped me to understand that the texts of the transcripts and of this thesis are representations of the women’s interviews, Derrida said that the text produced ‘a language of its own, in itself… a monstrous mutation’ (Derrida, 1984, p.123). It is important to hold in mind that the research interviews were specific social constructions, at a point in time, when the women were interviewed.

Reflexivity has been described as becoming conscious of areas that are preconscious or unconscious (Alvesson and Skoldberg, 2009). Alvesson and Skoldberg (2009) state that ‘reflection means thinking about the conditions for what one is doing, investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched… It is the very ability to break away from a frame of reference and to look at what it is not capable of saying’ (p.245-6). Thinking about these definitions, the reflexive process has helped me to focus on what was preconscious, in addition to enabling me to tell more of the whole story of the research. This has been a relief rather than having to try to erase the subjectivity, within the study (Burman, 2008).

There are a number of reflexive areas that emerged, for me, in this humanist research process, which I will now go on to discuss (Burman, 2006). Firstly the majority of participants were keen to be highly involved in the research. Secondly their willingness to participate deeply resulted in some of the women gaining indirect therapeutic benefits from taking part in the research. In addition, politically the participants became a virtual community of women, who were culturally different from me in that they were part of the breast cancer world. However they shared my desire to make the research a success in terms of getting to an understanding
of what was helpful and unhelpful to them, from a psychological therapy perspective. The women were both keen to participate and keen to know what the collective findings were. Fourthly when the participants chose, or decided not to choose, pseudonyms and write descriptions about themselves for the research, this provided a window on how they saw themselves. Their choice of names and descriptions could also not be divorced from their broader context. The decisions they made were imbued with emotions, which was also crucial to how the social was reproduced in the research (Holmes, 2010). In addition, I could not separate myself from the context of my professional work at The Christie Clinic at The Christie cancer hospital in Manchester, as a counselling psychologist in doctoral training. This work meant that while I was carrying out the research I had weekly psychological sessions with people affected by cancer. Finally I also wanted to consider gender dimensions in the research.

5.2 The reflexive themes

A theory of helpful and unhelpful aspects of psychological therapy with women with breast cancer was understood through the shared thoughts and experiences of the participants. The reflexive process enabled me to consider the research ‘in connection with interpretation’ (Alvesson and Skoldberg, 2008, p.238). It was useful to be forced into self-confrontation at this point in the research process (Holmes, 2010). The reflexive themes provided me with extra information about the research process and helped me to understand the structural positionings within this project (Burman, 2006).

5.3 Willingness to participate

It was important for me to hear the experiences of psychological therapy from the women who were directly affected by breast cancer. I wanted to get the women’s insights, rather than the thoughts of clinicians or practitioners who were not directly experiencing breast cancer. I first approached the Christie Clinic at the Christie Hospital, for participants but the ethics process was going to be too lengthy to complete within the timing of the thesis. I therefore approached the charitable organisation, Beechwood, a local cancer support centre in Manchester. Beechwood advertised a poster for me with details of the research project. I did not interview anyone as a result of this poster at Beechwood. I interviewed three participants to begin with, who were professional acquaintances. At this point my research recruitment slowed up.

In the summer of 2014, I approached Breast Cancer Care, a national breast cancer charity based in London who agreed to advertise the research to their ‘Breast Cancer Voices’. The ‘voices’ are made up of hundreds of people affected by breast cancer, who share their experience and expertise to inform the charity’s work. I immediately started to receive emails from willing participants after my proposal was advertised. In total I interviewed 9 women from Breast Cancer Care (note: one chose not to have psychological therapy therefore her data is not part of the analysis but is included in this chapter). I had to set an end date for recruitment of early September 2014 and I politely turned women down at this point.
The willingness of these women to talk about their experiences, to promote understanding and to want action was palpable. The conditions were right for this to happen; an engaged institution who were interested in the research topic and who had access to women who were motivated and able to talk about their experiences (Parker, 2005). The participants emailed me many times during the project; to set up interviews, to provide pseudonyms or not, to supply descriptions of themselves, with comments on their transcripts and with thoughts on the findings. I seemed to have tapped into a rich vein of women who wanted to tell their story to help other women who were already or would be diagnosed with breast cancer in the future.

5.4 In-direct therapeutic benefits

As the women took part in the interviews and reflected on their experience of taking part in the research indirect therapeutic benefits began to emerge for them. As I was a researcher in the research, not a therapist, I had not expected this to happen. A few of the women found reading the transcript emotional; they said they were processing the experience in some way again. One of the participants, Shirley, asked for the audio recording of her interview to listen to after I had sent her the transcript,

‘It was a pleasure to meet you and reading my 22 pages (blabbermouth!!) it has been a tearful but uplifting experience. I had forgotten how raw things are when they are poked. Please do not hesitate to contact me if you need any further input on any level. And, if I could get a copy of the audio that would be amazing. My friend C. would love to hear it... I probably don't say everything I said to you, to my friends. And, as it turns out, they want to hear it. Good luck with everything - just for the record you were very sweet and welcoming when I met you and I felt very comfortable and that it was ok I was a cranky bitch on the phone (I couldn't find the building and had to call you?). So, I liked you before I met you, you handled me really well.’

(TS10, email dated 6th November 2014)

In addition Lucyna described the pain of reading the transcript together with her desire for the research to happen,

‘I read your transcript yesterday. I must admit-it was quite hard reading it, in that

a) there was a lot of information
b) it triggered off some of the painful memories again.

However, I think it’s great what you are doing.’

(TL09, email dated 25th October 2015)
Mary added that reading the transcript was powerful in terms of reliving the experience of having breast cancer, but she was also very keen to see the collective findings. Here the willingness to engage despite the process being painful was again evident.

‘There is nothing I would like taken out of the transcript. It was very interesting to read it, oddly it actually brought back the experience more than the interview did. I would like to see the findings section if possible.’

(TM04, email dated 24th October 2014)

The high level of engagement by the women to express themselves and to want to process what they and others had experienced was an unexpected part of the research process. This provided a momentum to continue and complete the write up of the research that was outside the original scope of the research. The women created this momentum.

5.5 Virtual community of women

The analysis involved eleven participants who were women with breast cancer and had experienced psychological therapy after diagnosis. In addition as mentioned earlier one woman from the Breast Cancer Voices network wanted to feedback from outside the participant criteria; she had breast cancer, but had not had psychological therapy. She wanted to give me her views so I could understand them, I will talk about her views at the end of this chapter.

It became apparent to me that the women knew they were part of a community helping me to understand their world. I felt privileged to be able to enter this world and the women seemed to feel the sense of the virtual community, that we had created. They knew I was interviewing others and they were keen to see the findings, to know what other women had experienced, had thought, had felt and had said. When the participants looked at the draft analysis section of my thesis, which I sent them via email on 5th February 2015, many replied back quickly. The project had a feeling of being alive, still happening because of the community of women’s responsiveness, Lola said,

‘Thank you for sending me the link. It's very interesting a) reading my own words back (mental note: must stop using "Errm" and "Dunno" lol) and b) reading other the other ladies experiences. I can relate to the majority of what is written.

I must admit, I am not usually one for reading technical papers (it's a standing joke in our family that I NEVER read instruction manuals, I just muddle along), but I found your chapter so engrossing. I wish you all the very best with your thesis and your future!’ (TL07, email dated 7th February 2015)
Shirley said,

‘Hey lady! Loved reading it - got a bit emotional too... Good luck!’ (TS10, email dated 8th February 2015).

Jane said,

‘Read with interest the findings from your research. Thanks for sharing.
All the best. Love and regards’ (TJ01, email dated 8th February 2015).

Mary said,

‘Thank you for sending the findings of your research. It made interesting reading, it did take me a while but not because of the length rather because it made me tearful. The ladies comments and emotions were so familiar. I wish you well in drafting the rest of your thesis.’ (TM04 email dated 16th February 2015).

The community of women was constructed by the women, with the catalyst of the research remaining the central thread through 2013-5. The women knew there were others involved in the project and I wondered how the participants’ view of the others reflected the real and fantasised others (Burman, 2006). In addition I questioned how the research community affected me as researcher, rather than just those who were participating. I was affected by the power of the women in how they expressed their experiences, together with their measured determination to help me understand their world, which I was not part of (Burman, 2006). I became loyal to them. I wanted to ensure I communicated with them along the research journey, as well as represent them as thoughtfully and honestly as I could.

The majority of the participants (eight, plus the woman who had not had psychological therapy) were Breast Cancer Voices, from the national charity Breast Cancer Care. They were already part of a virtual community and their proactivity to act was a constant throughout the research process. In addition the charity was proactive in communicating to all their members about the research, through their electronic bulletins. The conditions for action and community were present in this research and this led to a high level of agency by the women, in terms of continued engagement in the research process (Parker, 2005).

5.6. Pseudonyms and descriptions of self

5.6.1 Pseudonyms

I asked all the women to choose pseudonyms in order that there could be names used with the quotes but that kept anonymity. It was important to me that the participants decided on their own pseudonyms rather than me making this choice for them. It is important to note that a few of the participants wanted to use their own name in the research because they wanted the
quotes attributed directly to them. Pseudonyms were chosen for many different reasons; Sophie wanted to choose a young woman’s name to represent those women, who are diagnosed with breast cancer in their twenties,

‘I suppose something…..erm….something that kind of reflects my age a little bit, I think. Like a younger person’s name rather than…..Erm… Sophie?’ (TS05, p.8)

Shirley chose her Mom’s name for her pseudonym. Her Mom had died from breast cancer and this was an emotional choice. Shirley had previously described, in her interview, how breast cancer was part of her family history,

‘I had mammograms because of my family history…grandma died of it, Mum died of it, sisters in remission. I am the only other female…so I’ve been having mammograms since I was thirty-five. (TS10, p.3).

Elizabeth chose her pseudonym as a symbol of getting through the treatment for her breast cancer; it was a post-cancer symbol,

‘I think probably Elizabeth…..Yeah. Because…erm…my partner and I were…well I’m pregnant at the moment and he wants to call the baby Elizabeth, but I don’t. So we’re having a massive argument about it. But, it’s kind of symbolic, because it’s …it was like the end goal was right I’m going to get this treatment and have this baby…so… ’ (TE08, p.11)

Lucyna also chose her pseudonym as a mark of a new life post breast cancer. It had a deeper meaning of her newly found purpose post breast cancer treatment,

‘I’ve deliberated over my new Polish name, and I’ve decided to go with Lucyna. It means ‘bringer of light’. I see myself as a bringer of opportunities to many Polish children…who knows?’

(TL09, email dated 25th October 2014)

5.6.2 Descriptions of self

I asked the participants to write their own descriptions of self to be included in the write up, in order that they had a choice about which words were used to them themselves. I was interested in the way the women constructed themselves socially, which involved both their constructing and constructed self, (Steier, 1991). The words chosen by the women, for their descriptions contained strong emotions of passion, defiance, struggle and hopefulness. Alongside these emotions they talked about the many socially constructed roles they held as
women and how they were supported. Vinnie said she was lucky, well supported and the experience has had positive effects on her life,

‘I’m a 53 year old gay woman who was diagnosed with breast cancer 9 years ago. It was a shock & it was scary but I was lucky because I had such fantastic support from my partner and friends. Most importantly I took positive things from the experience and didn't let it define me. Hope these few words are ok and what you are looking for. ps-I would be very interested to know the outcome!’

(TV06, email dated 24th October 2014).

Sophie who was in her twenties when she was diagnosed, described the devastation of a breast cancer diagnosis,

‘As for a few sentences about me... that’s been difficult to sit and write! Will this do?

"I was a normal twenty something when I was diagnosed with breast cancer; after graduating university I went travelling and had some amazing experiences then came home and started working hard in my chosen career. Breast cancer has devastated my life both personally and professionally."

(TS05, email dated 6th November 2014)

Mary described how her experience with breast cancer had changed her perspective and now helped her to live life to the full now, she said,

I was 58, working full- time as a senior nurse when I had a routine mammogram... I am now retired and have 2 adult children and 5 grandchildren. I am now living life to the full, and enjoying everyday.

(TM04, email dated 23rd October 2014)

Jane talked about the shock of the diagnosis and her socially constructed roles; as a mother and a working woman,

At the time of my cancer diagnosis I was a 43 year old, married mother of two young adults, and under the age bracket for breast cancer screening. I worked full time in the travel industry and held a managerial role. The prospect of having to take a long enforced break from work due to a serious illness therefore came as a complete and utter shock!

(TJ01, email dated 19th October 2014)
Elizabeth also described the shock of being diagnosed with breast cancer when as no history of it in her family, in addition to her roles as a mother and a working woman she said,

‘A level English teacher with three children and fourth due in December. Age 40 at diagnosis, with no family history or genetic link to breast cancer, so it was a bit of a surprise.’

(TE08, email dated 20th October 2014)

These pseudonyms and descriptions were extra, unexpected findings that enabled me see a fuller picture of the women, in terms of how they saw themselves in the world and how the breast cancer had affected them. Their individual selves were being described in their own words and reflected how they had changed quickly, adapting themselves to the ‘different demands and stringing together those changes on the threads of memory’ (Parker, 2005, p.29). The reflexive process was not just about considering relationally to the women for me, it was also about how the social was being reproduced by the women, in their descriptions and transcripts, and their emotions were key to this (Holmes, 2010).

5.7 Working in a cancer hospital, whilst conducting the research

I worked in a cancer hospital providing psychological support for those affected by cancer whilst I completed the research. Therefore I was not a neutral observer. Researcher involvement was an important area for me to openly consider, how subjectivity was present in the research. Although it is impossible to fully reflect on every aspect of this (Burman, 2006).

My interest in breast cancer and how psychological therapy could be helpful and/or unhelpful began in December 2012 when I applied to work with cancer patients on placement at The Christie Clinic cancer hospital in Manchester as a Counselling Psychologist in doctoral training. I started working with those affected by cancer psychologically in February 2012 and to September 2015 I have completed over 600 hours of psychological therapy with cancer patients and their relatives. During this time I was planning, carrying out and writing up my thesis. In addition in January 2015, I was appointed to the permanent post of Junior Counselling Psychologist at The Christie Clinic. This was the first permanent position in psychology at the clinic and I became responsible for two trainees in the Counselling Psychology Team.

My personal professional trajectory has helped me in my research, because I have practical experiences with women with breast cancer. However my professional role and my role as a researcher are so closely intertwined that I wanted to try and approach this research through the direct experiences of the woman affected with breast cancer, rather than seek the views of healthcare practitioners. I have attempted to counter this potential researcher bias by basing the analysis in the data generated by the women but researcher transparency is important for the reader to be aware of in order that they can decide for themselves to what extent, my personal assumptions and potential biases have impacted on this research (Morrow, 2007).
The research process has been a positive intense immersion into the breast cancer world and I have always been aware that I have a researcher position, alongside my institutional relationship with The Christie Clinic (Parker, 2005). I have become dedicated to working and researching within the cancer world and as such my capacity for reflection may have become reduced, (Alvesson and Skoldberg, 2009). However interviewing those directly affected using a flexible semi-structured interview methodology helped to gain a fresher perspective directly from the women. In addition I chose the GTA structured approach to try to help me examine the raw data from a bottom up perspective. Obviously I cannot divorce my position from the research and I was not striving for a ‘scientific positioning of the neutral observer’ (Burman, 2006, p.316). I empathised with the participants during the research process, but I could not completely put myself in their world. I was also keen to find where aspects of psychological therapy were both helpful and not helpful rather than assume it is always helpful (Parker, 2005).

5.8 Gender dimensions

In a number of ways I was an insider in this research, I was a British woman like the other participants. However I only knew breast cancer from a clinician’s perspective not an embodied one, which also made me an outsider (Parker, 2005). In the consideration of being a woman interviewing women with breast cancer, I felt it was important to reflect on the research in gender terms. I wanted to consider how asymmetrical gender relations and the conservation of traditional conceptions of gender had emerged from what the women had described (Alvesson and Skoldberg, 2009). I remained open in the research process and examined when gender conditions and perspectives appeared.

Firstly there was a theme that was concerned with the experience of having body losses, in relation to hair and breasts as empowering or disempowering. This seemed to link directly to the expected body image of a women in spite of the women suffering tremendous physical and emotional distress. Jo Spence, the feminist photographer, who died of breast cancer felt totally vulnerable and terrorised (Spence, 1986). Spence went on to say ‘given that women are expected to be the object of the male gaze, are expected to beautify themselves in order to become loveable, are still fighting for basic rights over their bodies, it seemed to me that the breast could be seen as a metaphor for our struggles’ (Spence, 1986, p.155). The interviews illustrated how some women’s own sense of their bodily imperfections affected them deeply. There was a focus to recover and to look feminine again, in line with social expectation (Wilkinson and Kitzinger, 2013). For others the loss of hair or a breast made them more confident and empowered, as if they were keen to challenge the status quo of femininity.

Secondly, there was a theme where the women talked about how they valued being treated as a whole person, with an individualized psychological and medical care plan, rather than just being treated medically, which seemed to link to more ‘masculine’ principles of cancer care. In addition, this linked to the theme of how psychological therapy can contribute to the women becoming empowered to ask questions of their medical doctors, who were mainly men. This gender aspect linked to a power imbalance that some of the women alluded to with their medical doctors. The power imbalance was acted out in the consultations with their
doctors, who had the medical knowledge and expertise. The women felt a loss of control and powerlessness (Foucault, 1980; Wilkinson and Kitzinger, 2013). Women can avoid confronting or contradicting doctors and female patients’ concerns have been found to be less recognised by male doctors, (Todd, 1989). Through the psychological therapy however the women were able to express their knowledge and expertise of actually experiencing breast cancer and it was interesting to me that they felt a greater level of empowerment, through the psychological therapeutic sessions, rather than the medical consultations. The women were able to express themselves within the therapeutic space and in turn the therapist sometimes helped them to ask the medical treatment questions, from their doctors, in order that they could get the answers they needed, to help them psychologically, as well as physically.

The final area that I was struck by was the way the descriptions of self that the women used, incorporated multiple socially constructed gender roles. This point is illustrated by the descriptions I received from Mary and Jane. Mary talked about her children and grandchildren when she described herself, alongside her identity as a retired nurse, the words Mary used were very much linked to the socially expected role of women as caring for others. The social order ‘constructs individuals to strongly gendered norms and expectations’ and this was evident in this description (Lorber, 1995, p.25).

‘Working full-time as a senior nurse…. I am now retired and have 2 adult children and 5 grandchildren. (TM04, email dated 23rd October 2014)

Similarly Jane described herself firstly as married and a mother before talking about her work. Socially gender statuses are therefore evident and are understandably hard to traverse (Kando, 1973).

‘I was a 43 year old, married mother of two young adults…. I worked full time in the travel industry and held a managerial role.’ (TJ01, email dated 19th October 2014)

5.9 Thoughts of a woman with breast cancer, who had chosen not to have psychological therapy

Jane wanted to talk to me about her experience even though she did not meet the criteria for the research, as she had not had psychological therapy. Jane had surgery for breast cancer and radiotherapy and Jane said psychological support was ‘not offered’ but she knew it was on offer, through leaflets. This was an interesting distinction to discover which could highlight the importance of active referral, rather than passive leaflet giving.

Jane also described being in shock and overwhelmed by the medical world at the beginning and she was worried that talking to a stranger might not help her. One of her consultants was very matter of fact about her breast cancer and wasn’t sympathetic, she described her second consultant as a little better. However Jane said she had a number of friends who were medical doctors and they helped her as to cope, as she wanted to know about the medical details of her cancer. They lived away from her therefore email and mobile was very important to keep the
channels of communication open. In this way she was empowered to ask the medical questions she needed to get answers to, by virtue of her existing social network. Her medical friends spoke to her about the medical side and she said they could see she was scared, they also talked about the emotional side, and her friends treated her as a whole person.

Jane said she felt disfigured after the surgery and wasn’t aware that she would feel this way before she had the surgery, to remove the breast cancer. Jane said she didn’t want a therapist ‘to tell me how to feel about it’. Jane had never had psychological support in the past. This highlights the importance of the key processes in Counselling Psychology; a strong therapeutic relationship, key relational skills, and particularly focusing on the individual needs of the person and tailoring therapeutic interventions (Cooper and McLeod, 2007; Hubble, Duncan and Miller, 1999). Jane said she felt that there is a place for psychological therapy, as different types of people get different types of breast cancer, this is a ‘very very personal decision’ she said. Jane felt her breast cancer was not as severe as other women’s and she had a strong support network around her. She described herself as always coping through doing a lot of work on her own and she hasn’t told a lot of people she has had breast cancer, as she didn’t know what to tell and who to tell it to. Jane sounded self-sufficient in her coping style in the main, but I did feel she didn’t really know what psychological support could look like. This encouraged me to be mindful about how women with breast cancer could get an insight into what psychological therapy was like, maybe all women diagnosed could have a routine discussion with a psychologist as part of their care.

5.10 Chapter summary

The reflexive analysis has helped me to reflect, to understand my position in the research and to indicate the areas that I had not expected. The women were dedicated to the research, there were indirect therapeutic benefits for some of the women in taking part, a virtual community of women was created and the socially constructed descriptions the women chose, as well as the pseudonyms, gave extra rich detail about the women. In addition it was important to reflect on the work I was undertaking at the time of the thesis, working in a cancer hospital offering psychological support to patients and their family. I also considered gender dimensions that were present in the research, in terms of the effect of specifically feminine body losses, the power imbalance within the ‘masculine’ medical model and how women defined themselves by socially constructed gendered roles. Finally, I reflected on a woman’s thoughts who had not had psychological therapy after her diagnosis with breast cancer.
6. Discussion

6.1. Introduction

The presented thesis had two main research questions, which shall be reiterated again for continuity.

- What are the helpful aspects of psychological therapy as identified by women with a primary breast cancer?
- What are the unhelpful aspects of psychological therapy as identified by women with a primary breast cancer?

This chapter will provide interpretations and implications of the results, which will be discussed in relation to previous literature, in an attempt to embed the current research findings within the psychological field. Implications will be outlined in three areas theoretical, methodological and practical. The chapter will conclude with reflexivity and final remarks.

To reiterate, the aim of the thesis, was to research helpful aspects of psychological therapy as identified by women with breast cancer, using a qualitative social constructionist framework. This links to my position as a Counselling Psychologist, with a focus on individual experience, in a social context. Social constructionism is a research paradigm that denies the existence of an objective reality, ‘asserting instead that realities are social constructions of the mind, and that there exist as many such constructions, as there are individuals (although clearly many constructions will be shared)’ (Guba & Lincoln, 1989, p. 43).

6.2 Summary of findings and how these relate specifically to breast cancer

A theory of helpful aspects of psychological therapy, from the perspective of women with breast cancer, was understood through their shared thoughts and experiences. In reviewing the findings it is useful to examine which ones are specific to female breast cancer, transferable to other female cancers (e.g. ovarian cancer) or more generic (e.g., to all cancers). I will go on to consider this after a brief return to the literature on helpful aspects of psychological therapy.

The research analysis links to the broader literature around helpful processes of therapy that illustrated that many factors are involved: Elliott (1985) found eight generic helpful events in therapy; new perspective, problem solution, clarification of the problem, focus attention, understanding, client involvement, reassurance and personal contact. More recently Paulson, Truscott and Stuart (1999) studied helpful aspects of therapy and reported nine thematic clusters; the facilitative style of the therapist, the therapist’s specific interventions, how the client is helped to realise their own resources, gaining new perspectives, the level of self-disclosure by the client, the client’s level of emotional relief, the knowledge acquired, accessibility of the therapist and the client reaching resolutions.
Narrowing down to people with cancer, therapy has been shown to be effective in helping people get information about the disease, diagnosis and treatment, (Anderson, 1992; Houts et al., 1986), providing them with a safe place to get emotional support to address anxieties about cancer (Cain, Kohorn, Quinlan, Latimer, & Schwartz, 1986), facilitating behavioural and/or cognitive coping strategies (Davis, 1986; Redd and Andrykowski, 1982), and aiding relaxation (Edgar, Rosberger, & Nowlis, 1992).

Certain issues faced by women with breast cancer, are more specific to this group (identity, body image, sexual and relationship issues). Therefore this research explored the views women with breast cancer and how their experiences differed to the broader cancer population (Shimozuma, Ganz, Petersen and Hirji, 1999; Ferrell, Grant, Funk, Garcia, Otis-Green and Schaffner, 1996; Hopwood, Keeling, Long, Pool, Evans and Howell, 1998; Pistrang and Barker 1995).

The research found that the women had the needs that other people with cancer have, but they also talked about their socially constructed female sense of self, being treated as a whole and individual woman, being helped to be empowered in the face of the masculine medical world and being helped to put their active self concept back together again.

Specifically, the context was: Being thrown into the breast cancer world. The breast cancer world seemed quite specific and different. Women went from not feeling ill, with breast cancer to post treatment where they did not have cancer, but looked and felt ill. Their body image was affected; they often lose their hair and had their breasts removed and in some cases had their breasts reconstructed, to achieve an idealised female form again. These bodily changes were powerful and often made a woman question her female identity; a woman could feel lost in the world, what was her place in it now? In the cancer world, generically, there are feelings of being thrown, but in the breast cancer world this was closely associated with changes to the female body image, which is socially constructed.

The three helpful conditions were: Having the psychological need recognised by others, having easy access to ongoing flexible therapy and valuing the personal qualities of the therapist. These conditions made me consider whether they were generic to all cancers. However the distinct masculine medical world can mean that women with female cancers don’t necessarily feel empowered to ask questions and to ask for psychologically help. They can feel vulnerable and can feel silenced by the power of the medical model. The importance of flexible therapy and the personal characteristics of the therapist were applicable to all cancers generically because of the harsh treatment involved in battling cancer and the need for containment by the therapist when cancer takes control away from the person.

The three helpful interactions were: Being enabled to express self safely, being treated as an individual whole person and accessing the therapist’s inner self. The first interaction of being helped to express self safely links to the empowerment of women with female cancers. This connects to the need for safe expression for women with cancer. Female cancers challenge a woman’s role in society. A woman may ask what is my purpose if I haven’t got breasts, following a double mastectomy to get rid of breast cancer or if I can’t have children, following a hysterectomy for ovarian cancer? Being treated as a whole person and accessing the therapist’s inner self feel like they are more generic to all cancers, as all cancers involve
individuals, with physical and psychological needs.

The two helpful actions were: Being helped to empower self and being helped to learn new coping skills. The new coping skills felt more generic to cancer, whilst the need to empower self felt specific to breast cancer. Changes to a woman’s body threatened the sense of self; women have to endure hair loss, lumpectomies and mastectomies. In these situations the women questioned their femininity and their life; one woman likened losing her hair to death.

The perceptions of all the women highlighted the core variable of, being helped to put active self back together again, which illuminated the main helpful themes and was the consequence of the therapy process. This again felt specific to breast cancer, linking to empowerment, female identity, a woman’s role in society, body image and a woman’s role in relationships.

The unhelpful aspects of psychological therapy were understood as having the same context, being thrown into the breast cancer world. However the two conditions were that the therapy was not easy to access and secondly that the therapist’s personal qualities were cold and harsh. The two interactions, that were unhelpful, were being unable to express self safely and not being treated as an individual. The action that was expressed was that therapy was too short. The consequence of these unhelpful aspects was that the therapy was not set up in the right way and the women were re-traumatised, remaining shattered after a breast cancer diagnosis and the corresponding treatment. The unhelpful conditions, interactions, action and consequence felt more like they would apply generically to all cancers and indeed to other experiences of therapy ruptures.

I will now discuss the key theoretical, methodological and practical implications of the research findings. I encourage the reader to note that whilst the research does allow us to know something, it does not claim to know everything about the research questions, this is in line with postmodernist thinking (Richardson and St.Pierre, 2005).

6.3 Theoretical implications

6.3.1 Treating the women as whole individuals

‘Illness (is) the ultimate crisis of self-representation’

(Spence, 1995, p.146)

In the research the importance of being treated as an individual was paramount to the women with breast cancer and this finding links to the philosophy of Counselling Psychology. The core processes that are important for therapy, to be helpful to the client from a Counselling Psychology perspective are building a strong therapeutic alliance, incorporating key relational skills, focusing on the needs of the individual client and tailoring therapeutic interventions (Cooper and McLeod, 2007; Hubble, Duncan and Miller, 1999). All the women wanted to be understood and helped individually with their own personal distress related to their breast cancer. This links to the view of therapy from James (2011) that psychological support from a Counselling Psychology perspective should focus on ‘individual difference’ but accept that ‘there is consistency and constancy … in the fact that people are generally upset by real
and/or perceived threats to the self’ (p.378). In this research, the findings illustrated that the therapist needed to really understand the client and in turn, the client learnt to understand more about their own experience (Strawbridge and Woolfe, 2011).

The roots of Counselling Psychology are based on humanistic values. The main assumptions of Maslow (1943) were that people’s motivations related to achieving certain needs related to the fulfillment of these needs. He represented the needs in a five layered pyramid model, starting with the bottom basic level of physiology, then moving up to safety, then to social needs, then to esteem and finally to self-actualisation. The deficiency of a basic need was seen by Maslow to motivate people to fulfil their needs and lower layer needs needed to be satisfied before moving to a higher level growth need.

Rogers (1951) agreed with Maslow’s hierarchy of needs, but also added that for a person to grow they also need an environment that provides genuineness, acceptance and empathy. Rogers (1957) determined that there were six conditions that needed to be ‘necessary and sufficient’ to enable ‘therapeutic change: Two people in psychological contact; the first, whom we shall term the client, is in a state of incongruence, being vulnerable and anxious; the second person, whom we shall term the therapist, is congruent or integrated in the relationship; the therapist experiences unconditional positive regard for the client; the therapist experiences an empathetic understanding of the client’s internal frame of reference, and endeavours to communicate this to the client; and the communication to the client of the therapist’s empathetic understanding and unconditional positive regard is to a minimal extent achieved’ (p.95). Rogers acknowledged clearly that clients often come to therapy not feeling empowered, they are often vulnerable and the aim is to empower the client through unconditional positive regard. This approach is based on ‘acceptance towards the Other...in a highly transparent way’ (Mearns & Cooper, 2007, p.36).

From a humanistic perspective, May (1961) also focused on people at a human level and existential psychology. He was interested in an actual immediate person to whom things happened to, rather than the theoretical view of a person. He was concerned with the idea of ‘being’ and that anxiety arose from our own personal needs to survive and assert our being. Therefore the roots of humanism in therapy were based on the individual’s subjective experience, eliminating power in the therapeutic relationship and focusing on the needs of the individual in terms of their being. The therapist and client need to work together to gain an understanding of a person’s situation and what specifically is contributing to their distress.

Cooper (2009) eloquently summarised the focus of Counselling Psychology as being about the client’s subjective and inter-subjective experience, focusing on facilitating growth in the client, empowering clients, a commitment to a non-hierarchical client-therapist relationship, an appreciation of the client as a unique being and an understanding of the client as a socially- and relationally-embedded being. The women with breast cancer, in this research, wanted to be understood as individual, unique and whole women, not treated from just a medical perspective as a patient with a certain type of cancer. Spence (1986), a women who died of breast cancer, commented insightfully that unfortunately ‘there are no departments of ‘whole body’ medicine in hospitals…the concept is quite alien at an institutional level’ (p.155).

The need of the women, I interviewed, to be truly seen as a whole individual links to the growth in psycho-oncology, which examines the psychological aspects of cancer, as oppose to the medical side (Barraclough, 2000). This thesis contributes to a growing body of work around the place of talking therapies, in a very medical forum. There is still a long way to
move forward in this area, but the psychological side of breast cancer care is growing in importance.

6.3.2 Being helped to learn individual coping skills

In this research the women with breast cancer described a number of coping strategies that they had experienced as helpful in therapy. The interventions, as described by the women, were not from a singular therapeutic model. Multiple interventions were described from different theoretical approaches, over the course of the therapy. Therefore it seems that many therapeutic approaches can be helpful, I will firstly discuss a pluralistic approach to therapy and then go on to talk about individual approaches in turn.

The helpful nature of varied interventions, at different times, for different women fits well with a pluralistic approach to Counselling Psychology. A multitude of therapeutic methods can ‘be most helpful for different clients in different instances’ (Cooper and McLeod, 2007, p.6). This research therefore supported a pluralistic philosophical stance where one therapeutic approach does not suit everyone and one size does not fit all clients (Cooper & McLeod, 2011). Pluralism is an approach to counselling and psychotherapy, which begins with the assumption that many different things are likely to be of help to clients, and that therapy works best when therapists and clients collaborate together on working out what is most helpful to each individual client (Omlinska-Thurston and Cooper, 2014).

Adjusting the approach therapeutically made sense to the women with breast cancer, as the psychological and medical problems they encountered were both numerous and unique. Fawry, Fawry, Arndt and Pasnau (1995) found that people with cancer benefit from a wide range of psychological interventions, from psycho-education, distress management, behavioural training, and problem-solving techniques to psychosocial support. In addition, varying the intensity of psychological technique has recently been found to be beneficial in psychotherapy, within a client’s therapy journey, because of the impact of unexpected environmental factors, client’s varying motivation or the differing therapeutic goals of individuals (Owen and Hilsenroth, 2014). This links directly to the research findings, in that the women were affected by many different pushes and pulls, while they were having psychological support, for example how their medical treatment was affecting them, the course of their specific breast cancer, the level of social support they had and how their own individual identity was being affected. The psychological support for the women needed to have both consistency of frame and flexibility in its approach, to allow for individual circumstances. A rigid therapeutic intervention, based on one therapeutic model, may not have suited all the women interviewed. The women may have felt controlled by both the cancer and the therapy approach, rather than empowered by the psychological support.

The women valued the space to be listened to as an individual, which links to Person Centred Therapy (PCT). This links to a framework of empathetic understanding, which psychologically holds the client in the therapy sessions. PCT stems from Rogers’ (1957) six conditions of therapy, which were outlined in section 6.3.1. Timulak and Lietaer (2001) more recently found that in PCT, the most frequently reported positive client experiences were
associated with empowerment, safety and insight. Other significant themes emerging from Timilak and Lietaer’s (2001) analysis included: freedom in the relationship, assurance of the relationship, unfolding of the client's personal meaning and the importance of the counsellor's presence.

The women also described being helped by being encouraged to give themselves permission to put themselves first, to be self-compassionate. This links to the aims of Compassion Focused Therapy (CFT), the work of Gilbert (2000). Gilbert hypothesized that a client can find it difficult to be self-compassionate, because they are more focused on their threat system and as a result being self-critical. The women were reassured in therapy and encouraged to learn how to self-sooth themselves (Gilbert 2009). They were encouraged to be less harsh on themselves, less judgmental, which helped the women to be more focused on putting their own needs first, which was a new emphasis for some.

The women with breast cancer in this study also described how Cognitive Behavioural Therapy (CBT) tools helped them. This links to the research by Moorey, Frampton and Greer (2003). They examined coping with cancer in relation to the effectiveness of CBT and found four factors, general coping (e.g. breathing slowly to deal with anxiety), positive focus towards the future, planning and diversion (e.g. distracting self from worrying thoughts). The women, in this research, described being helped to reframe their thoughts, for example the process of normalisation helped the women to realize that often their thoughts were completely normal. In addition, the women were helped to focus on more helpful behaviours or in some cases behavioural activation, as they had become socially withdrawn and become isolated. The women also described therapeutic interventions that helped them to modify their beliefs, to make them less rigid and more flexible, which was helpful. In addition planning was mentioned as being helpful; the women were helped to look to the future again in therapy, when they were ready to, to begin to plan their future. Diversion in the form of relaxation, mindfulness and visualisation helped the women in this research, in terms of giving them a positive focus that they could use in and between therapy sessions.

The women wanted to be understood as individuals and it was important that the psychological support was flexible in terms of the balance between focusing on understanding and using different intervention techniques. Treatment flexibility was found to be helpful in this research and this links to previous work that called for therapists to be responsive to their client’s needs by adjusting their treatment approach (Wampold, 2001).

6.3.3 Helping to be put active self back together again

‘The language used to describe cancer evokes... catastrophe; that of unregulated, abnormal, incoherent growth. The tumour has energy, not the patient; it is out of control...With the patient’s body considered to be under attack (‘invasion’), the only treatment is counter-attack.’

(Sontag, 1991, p.64-5)

A woman with breast cancer often suffers a forced transformation of their identity because of
their diagnosis, the treatment they have, poor physical health, complex psychological health and changes in their role at work and at home (Mathieson and Stam, 1995). There is uncertainty with the illness and this is often felt quite continuously and is unremitting (Mages and Mendelsohn, 1979). There can be significant psychological distress either as an anxiety state or depressive illness, or both because there are many psychological hurdles, in a person’s cancer journey. Faulkner and Maguire (1994) highlighted six hurdles, uncertainty about the future, the search for meaning, loss of control, the need for openness, the need for emotional support and the need for medical support. They go on to outline key physical and psychological issues that can arise from cancer treatment; the loss of a body part, the loss of a bodily function, fatigue, skin soreness, nausea, vomiting, diarrhoea, body image problems, relationship issues and sexual problems.

There are also identity questions, the women with breast cancer in this research looked back, acknowledged the present and wondered about the future, as a result of their immersion into the breast cancer world (Charmaz, 1997). The psychological support helped the women to start to put their active self back together again; one person used the metaphor of re-crafting her own ‘stained glass window’ to describe this. This research was built upon literature about how clients have agency within therapy, when their agency is diminished elsewhere, in this way the women can be viewed psychologically, as active self-healers (Bohart and Tallman, 1999). Having taken time out to be treated for their breast cancer, the women wanted to return to the activities they associated with their preferred, real selves, however this was not easy and they talked about being helped through psychological therapy to create a new active self with parts of their old self and new parts. The implication of this core category was that the women with breast cancer valued help to enable them to recast their lives as their priorities had altered. Charmaz (1997) stated ‘illness and disability affront self. Beliefs that life would be perpetually positive, progressive and productive promise control over one’s self, one’s life and one’s fate…illness represents an unwarranted, illegitimate attack upon self’ (p.79).

In the face of breast cancer, the women were often not attacked physically by the cancer immediately, as they were often not ill when they are diagnosed. They become ill and in pain through the course of the treatment and this is a marked difference, from many other types of cancer. To cope they may pull back socially, to conserve their energy for the battle through the treatment, which repeatedly tests their self. The experience of psychological support can help the women to rebuild their lives and a key part of this is sometimes to reach out again socially in a safe, manageable and controlled way. This is part of putting their active self together following diagnosis and treatment.

The women also talked about being helped to put their active self together, in the face of a recurrence and uncertain survival. This has been called living with the sword of Damocles or Damocles syndrome (Koocher and O’Malley, 1981; Mauer, 1981; Wakefield et al. 2013). The sword of Damocles, from the story told by Cicero, described a metaphorical sword, hanging by a single horsehair over the head of cancer survivors, which can shadow their lives thereafter. Psychological support can be used to help women with breast cancer understand and process their own thoughts and feelings around this. They can work towards their life growing around the cancer experience, it doesn’t define them but it is part of their stained glass window; ‘although illness orders life, it does not entirely define or fill it’ (Charmaz, 1997, p.76).
There seemed to be an implicit desire to be back in control of their life, for the women in this research. This linked to the work of Spence (1986) who through her photography detailed confronting cancer and described the struggle to become well, to try and have more control. In addition, Charmaz (1997) described the realization that the individual has limits of individual control and the affect on self of ‘diminished control, in turn, diminishes a self’ (p.261). There is an attempt to take control of life again, the women started to focus on what they could control now, rather than worrying about what they could not control; they talked about building their new stained glass window with a simplified life, pacing themselves, living one day at a time and being focused on the present.

Post-traumatic growth was also a feature of some of the women’s experiences. They talked about a new approach to life, being more active, not avoiding things and growing in confidence after their breast cancer diagnosis and treatment. Positive changes, when struggling with adversity, have been referred to as adversarial growth, the individual is propelled to ‘a higher level of functioning, than that which existed prior to the event’ (Linley and Joseph, 2004, p.11). Horgan, Holcombe and Salmon (2011) found that women with breast cancer experienced several positive changes; their priorities in life altered for the better and their confidence increased, which both link to the findings in this research. Horgan, Holcome and Salmon (2011) also found that the women had increased empathy for others. In addition, Sherman, Rosendale and Haber (2012) developed a substantive theory of the process of breast cancer survivorship in women and discovered that the diagnosis led to a turning point in their life, which stimulated change in terms of positive growth, again this thesis mirrors their finding, as the women had a new approach to life, did more and avoided less after the diagnosis and treatment.

Linley and Joseph (2004) described several areas that were linked to adversarial growth; cognitive appraisal variables (threat, harm and controllability), problem-focused, acceptance and positive reinterpretation coping, optimism, religion, cognitive processing and positive affect. In this research the women cognitively appraised the threat as harmful, often life threatening and they understandably felt out of control. The psychological therapy was shown to be helpful as it supported the women to solve problems where they could, to have a level of acceptance of the diagnosis and treatment and to find individual coping mechanisms like compassion, mindfulness and cognitive restructuring. In fact Linley and Joseph (2002) advocated that facilitating adversarial growth may be considered a legitimate aim of therapy. From the perspective of this research, the findings have illustrated that post-traumatic growth can be an outcome post breast cancer diagnosis as a result of therapy. However the women did not talk about it as an explicit goal of therapy, therefore care should be taken at the start of and during therapy around positioning adversarial growth as an aim, when the women are in an extremely vulnerable state of mind. This therapeutic aim does not feel right and realistic in relation to the experiences of the women interviewed in this research.
6.3.4 Helping to empower women who find themselves vulnerable, a social justice agenda

‘But my daughter, when I told her of our topic and my difficulty with it, said, ‘Tell them about how you’re never really a whole person if you remain silent, because there’s always that one little piece inside of you that wants to be spoken out, and if you keep ignoring it, it gets madder and madder, and hotter and hotter and if you don’t speak it out, one day it will just up and punch you in the mouth.’’


Many of the women talked about disempowerment as they had been thrown into the breast cancer world, which was a largely unfamiliar medical world. The women sometimes found it difficult to speak out when being told their diagnosis and considering treatment. The women struggled to ask the questions they needed the answers to. They were also asked to come to decisions about their medical care at a time ‘when they are most anxious’ (Haber, 1997, p.4). Morton (1987) outlined a personal view that the medical system around cancer sometimes does not encourage communication, sensitivity and mutual respect, the women are often nervous and the system requires them to be stripped of some of their clothes.

Batt (1994), a feminist and journalist commented on her personal journey ‘I often felt disconnected from the medical proceedings…(the) medical treatment is being on a conveyor belt…. (I) don’t understand what the doctor is talking about (p.286-7). In addition Spence (1986) who died of breast cancer, described her experience as ‘passing through the hands of medical orthodoxy’ as ‘terrifying’ after her diagnosis, she felt she was being submitted to the medical machine (p.153).

The advancing medical world of cancer is often defined by masculine values, there seems to be a masculine ‘urge to fathom the secrets of nature’ in relation to cancer, to control and to fix, which in turn can disempower the women’s own experience (Keller, 1990, p.177). This poses a question, a paradox, about a largely female disease, being treated in predominantly a masculine way. Batt (1994) pointed out that the medical treatment for breast cancer is about ‘specialisation, hierarchical power structures, heroic intervention, rational and scientific thinking and high-tech methods of treatment and diagnosis’ (p.309). Batt (1994) then went on to say that although breast cancer is targeting a female organ, ownership of the struggle is male, in the main and this can control women, rather than control the disease. This is a tough arena for women with breast cancer to navigate, when they are at their most vulnerable, how they get real empowerment, rather than a veneer of empowerment is key (Dubriwny, 2013). The danger for the woman with breast cancer is that the doctor may take over and the woman can feel like an object, rather than being an expert on her embodied experience (Batt, 1994)

Body losses can also disempower and be traumatic to women with breast cancer. In this research facing the loss of hair was likened to facing death, an extremely painful experience to consider in the face of chemotherapy. The identity of women was often under threat from the medical treatment, rather than the breast cancer. Spence (1986) said ‘now, I could lose first one then another breast, terrified me beyond all reason’ (p.152). In addition, the recovery programs after breast cancer treatment can add more pressure, to a woman feeling disempowered. They are often focused on women looking normal again, feminine after their
treatment, attractive to men (Batt, 1994; Dubriwny, 2013).

The findings in this research illustrated that psychological support helped some of the women to put their own needs first, to be compassionate to themselves, to ask specific questions of their medical team and to have the right to expect better individualised care. These forms of empowerment helped some of the women to reduce a part of their anxiety or their guilt in relation to their experience. Empowerment for the women with breast cancer who had psychological therapy was a key finding and links to the study by Timulak and Lietaer (2011), who found that empowerment of client’s self was the most frequent positively experienced episode in brief person-centred counselling.

Counselling Psychology has a key aim of social justice, which is based on empowerment and equity (Cutts, 2013). Kagan et al (2011) defined social justice as being ‘serious about people’s rights to self-determination; to a fair allocation of resources; to live in peace, with freedom from constraints; and to be treated fairly and equitably’ (p.37). This research illustrated how important social justice is, in psychologically supporting women with breast cancer. The women were helped through psychological therapy to ask about the detail of their quality of care; they were supported to make real choices in their medical treatment and to be given time to make the important decisions affecting their bodies and minds.

Social justice is based on equity, this means that we need to ensure women with breast cancer are helped to get the resources, information and total care that they need, including psychological support (Crethar, Rivera & Nash, 2008). Counselling Psychology emphasises the goal and process of social justice, the need to empower, to reduce power imbalances and ensure fair allocation of resources. It ‘involves an emphasis on equity……in terms of access to a number of different resources and opportunities, the right to self-determination or autonomy and participation in decision-making, freedom from oppression, and a balancing of power across society (Cutts, 2013, p.9-10).

6.4 Methodological implications

6.4.1 Experiencing a therapeutic effect in taking part in the research

Participating in research interviews that explore an experience in depth has been found to have a therapeutic effect. Morecroft, Cantril and Tully (2004) stated that the effect may encompass not only changes in the interviewee's perceptions and behaviour, but in addition there is a possible development of a more meaningful appreciation and understanding of their condition. They go on to say that this depends on how the researcher communicated and listened to the person; ‘an empathetic and caring listener’ can elicit a positive and engaged interrelationship, while a ‘poor listener’ can leave the participant disengaged (Morecroft, Cantril and Tully, 2004, p.247). Rapport building right from the start of an interview puts a participant at ease, allays their anxiety and encourages them to be open and willing to tell their story (Mathieson, 1999; Murray, 2003). In this way, the interrelationship between the researcher and those being researched, in this research, was such that there was mutual cooperation in how the data was constructed. The women became more like co-researchers (Heron and Reason 1995). The research aimed to honour the women’s experience and explore
It from the inside (Mie’s, 1990; Olsen, 1994).

The women were the experts, because of their personal experience, unlike how they sometimes felt when they were in their medical consultations. The discussion of their experiences in detail, in their interviews, caused them to process the experiences again; they seemed to discover new patterns and relationships. A semi-structured or in-depth interview can have certain similarities to a therapeutic experience; the person is allowed to express their thoughts and emotions and there is time to do so, they are encouraged to set their agenda in the confines of the interview schedule and ‘by asking questions, summarizing and paraphrasing statements, the researcher is able to draw upon the meanings of the central themes that the interviewee holds and is able to empathise with the interviewee’ (Moorcroft, Cantrell and Tully, 2004, p.248). Rogers (1957) defined these features as key to enabling change in therapy (Rogers, 1957).

Humans are also interpretative beings and as result we are constantly reflecting on what happens to us. During a semi-structured research interview past events can take on new meanings and new cognitive models can be formed (Frank, 1995; Kleinman, 1988). Murray (1998, 2003) described the therapeutic benefit of taking part in qualitative research interviews with vulnerable participants, when discussing sensitive information, as related to when they are allowed to tell their stories in ‘a non-judgmental, non-blaming and non-threatening way’ using questions only to guide the interviews causes them to process their experiences again (Murray, 2003, p.233).

6.4.2 Valuing the women as willing, engaged and active co-researchers

As a researcher I was eager to discover and be helped to understand the women’s experiences. The women I interviewed were willing, engaged and active. I had a collaborative working relationship with the women. They were involved actively in approving the content of their transcripts, in choosing their pseudonyms or not, in writing the descriptions about themselves and in reviewing the analysis. The participants were not positioned passively in the research, there was care to reduce any power imbalance linking to participatory research designs (Docket, Kagan and Sixsmith, 2010; Reason and Bradbury, 2008). The women were involved during the active research and analysis processes.

The research aimed to highlight the women’s perspectives and focused on what they specifically experienced as helpful and unhelpful. The study was designed to help to bring their voices to the foreground (Bohart and Tallman, 2001; Elliott, 2008). This has a key implication for future research with women with breast cancer, in terms of how we work with this desire to be heard and to change things for the better, for other women. The women were empowered to talk about their experiences and open up about how psychological therapy helped and didn’t help them.

This research and future research with women with breast cancer could help to ‘create new relationships, better laws and improved institutions’ (Reinhard, 1992, p.175). There is a whole genre of feminist action research which has this as its specific aim, Lather (1988) stated that, she engaged in feminist efforts to help to empower by maximizing dialogue and encouraging participants to understand and change their situation. The women encouraged me to consider,
carefully, how this research could improve relationships and institutions, within the breast cancer care arena. I will go on to discuss this under section 6.5 practical implications.

6.4.3 Ethical – Participant benefits of research participation, alongside risks

Thinking about the therapeutic gains the women described from taking part in the semi-structured interviews as part of this qualitative research does raise an ethical question; should the benefits of research be considered alongside the risks of research? Often only the risks are considered in the ethics process (Richards and Schwartz, 2002). In addition the researcher-participant trusting relationship can contribute to therapeutic benefits for the participants and to the richness of the data for the researcher (Murray, 2003). Therefore although some researchers maybe discouraged from researching sensitive topics with a vulnerable population, there can be benefits for the participants and the researcher. It maybe that women with breast cancer, who are deemed vulnerable from an ethical perspective, are willing and want to tell their story, but they are not always asked because of the risk levels involved and the ethical sign off processes. It is important ethically that researchers consider both the risks and the potential benefits when researching with this population.

Women with breast cancer sometimes make sense of their experience through self-discovery. This can happen by having psychological therapy, taking part in a self help group, through expressing their experiences in a narrative or another outlet like phototherapy (Lorde, 1980; Batt, 1996; Spence, 1995). Taking part in research, like this thesis or being heard in other ways can also help women to process what they went through, where they are now and to generate new meanings, in relation to their breast cancer. The Breast Cancer Voices, set up by the national charity, Breast Cancer Care, is another way in which people help themselves to make sense of their breast cancer experiences and their lives now.

6.4.4 Grounded Theory Analysis (GTA)

Grounded theory Analysis ‘entails a process of purification, achieved by abandoning theoretical blinkers. Only then can diligent scholars see reality as it is, only then can they see the light’

(Alvesson and Skoldberg 2009, p.263)

My choice of GTA for the research was based on wanting to explore the idiographic and constructed reality of the women interviewed, in relation to what aspects they found helpful and unhelpful in psychological therapy, after a diagnosis of breast cancer. The roots of the specific GTA method chosen are in symbolic interactionism, from Strauss and Corbin (1990) and Charmaz (2006b) (Alvesson and Skoldberg, 2009).

The implications of the findings methodologically, in terms of GTA, were that although the research was focused on the interactive, the social and meaning making processes, there were questions in relation to the experience under investigation. Firstly, the process of analysis seemed bound by a process of purification and rigid rules as referenced by Alvesson and Skoldberg (2009). This jarred with the richness of the data and during the four months of analysis, between September and December 2014, I felt a total immersion into the interview
material. I became deeply involved in how the women had described their experiences, I could not separate the women, from their words or the themes and I could not separate myself from my psychological work, in a cancer hospital. This seemed at odds with the term ‘purification’ in relation to GTA, as this means literally ‘to remove contaminants from’. However, this did link to a social constructionist approach to GTA in terms of recognising the interpretive nature of experience and the role of the researcher (Charmaz, 2006a).

I also questioned whether the generation of the theories in this research was ever separate from the empirical data and whether the data was relatively theory-free (Alvesson and Skoldberg, 2009). The women’s experiences were diverse and the life in the research came from examining the interviews in detail. For me the core category of ‘being helped to put active self back together again’ came directly from the data, from the women, but I have to accept this was an interpretation by the researcher. The data from the women was not theory-free, from a positivist scientific perspective; it was constructed by the women and the researcher to some extent.

Finally we must consider ‘what can be known’ epistemologically not just how ‘we come to know it’ methodologically (Burman and Whelan, 2011). There is an important question here about whether texts can ever represent what they point toward? Were the texts, from the interviews, which were analysed using GTA, just an ironic representation of ‘neither the thing itself, nor a representation of the thing?’ (Lather, 2007, p.121). There was a question epistemologically about what was unknowable in the research, because the analysis was based on language and there is a rupture between language and the world (Quinby, 1991). There were ‘things that can’t be said’ within this research because of the ‘multiplicity of possible accounts of experience’ and the way ‘language systematically excludes some ‘abjected’ material’ (Frosh, 2007, p.635). Here again it helped me to focus on a GTA methodology that was based on social constructionism, with a feminist lens, rather than a positivist orientated approach (Charmaz, 2006b). The analysis was crafted to produce an integrity of the experiences of the women. To a large extent I had to assume that language, which is secondary, did represent the women’s realities, the primary. This enabled the research to explain the women’s experience using rich, thick, description (Lather and St.Pierre, 2013).

6.5 Practical implications

There are practical implications of this research that fit with the social justice philosophy of Counselling psychology, in terms of trying to improve equality for individuals through changes in practice (Cutts, 2013). Goodman et al. (2004) conceptualised the social justice work of Counselling Psychologists as ‘scholarship and professional action designed to change societal values, structures, policies and practices, such that disadvantaged or marginalized groups gain increased access to these tools of self-determination’ (p.795). Practically the research helped to examine where changes needed to be considered in the psychological care of women with breast cancer. In addition I wanted to utilize the findings from this project to make a difference to women with breast cancer, in my work and through working with the national charity, Breast Cancer Care. I agree with Richardson and St.Pierre (2005) who stated that ‘it seemed foolish at best, and narcissistic and wholly self-absorbed at worst, to spend
months or years doing research that ended up not being read and not making a difference to anything but the author’s career’ (p.960).

6.5.1 Being thrown into the breast cancer culture

‘Down, down, down. Would the fall never come to an end!’
(Lewis Carroll, Alice in Wonderland, 1865, p.4)

People who experience serious chronic illness experience an interruption in their life, it is intrusive and they become immersed in their illness although the trajectory of the illness can seem elusive, abstract and removed (Strauss 1984; Corbin and Strauss 1988, Charmaz, 1997). The women talked about becoming part of a new culture, a breast cancer culture even though they didn’t want to join it. The culture was described as often highly medicalised, fast paced and an assault on their bodies and mind. They used all their energy to get through the treatment. The terminology and medical treatments were foreign, as were the cancer hospital environments to many and the women were facing their own mortality, often thinking about this on their own, wanting to protect others. Batt (1994) described when she was in the process of being diagnosed with breast cancer by a male surgeon on duty, ‘the whole encounter had tilted, had spun us both out of control…. the more I read, the more astonished I was…in women 35 to 55, it’s the number one killer. I was 43’ (p5-6). She goes on to say ‘we are thrust (“no time to waste!”) into a medical system governed by undisclosed rules’ (Batt, 1994, p.287).

One of the practical implications to consider was how health care practitioners can help women with breast cancer, with their individual baptism into their new world. People with cancer often report psychological distress and impaired social functioning which, although adversely associated with quality of life and survival, often go unrecognized or undertreated (Armes, Crowe, Colbourne, and al., 2009; Fallowfield, L., Ratcliffe, Jenkins, and Saul, 2001; Werner A, Stenner and Schüz, 2012). Should every woman who is diagnosed with breast cancer, be offered psychological support along their individual journey? This would obviously have cost implications, but it could help to improve quality of life and in some cases the length of survivorship (Spiegel, Bloom, Kraemer and Gottheil, 1989; Fawry, Fawry, Arndt and Pasnau, 1995).

6.5.2 Guiding the women to psychological therapy, the importance of referrers

As part of the Department of Health’s Cancer Plan (2000) it is acknowledged that cancer patients commonly experience psychological problems and they need access to services that can help them. These services need to be integral to the cancer patient’s supportive care. In addition the National Institute of Health and Clinical Excellence (NICE, 2004), state that to enhance the quality of life and coping mechanisms for a cancer patient psychosocial interventions are important, which need to be tailored to their individual needs.

Although 1 in 3 people with cancer experience significant psychosocial distress not all of these are referred for psychosocial evaluation and psychological support, recent articles have suggested less than 10% are referred (Nekolaichuk, Cumming, Turner, Yushchysyn, and Sela, 2011; Holland, 2004). When narrowing down to breast cancer patients, research has
shown that as many as 25% to 30% experience clinically significant psychological problems (Glanz and Lerman, 1992).

In this research I found that a woman’s journey to get psychological therapy was often facilitated by others, often their medical team who had an awareness of the availability of psychological therapy and knew it may help. This is an important finding and the implication is clinicians need to be made more aware of the potential benefits of psychological support. Forsythe et al (2013) investigated the receipt of psychosocial care for adult cancer survivors in America and found that over 55% didn’t report discussions about, or use of professional counselling or support groups.

Fallowfield and Clark (1992) highlighted that many breast cancer surgeons were unaware of the symptoms of depression, while some felt it was an inevitable consequence of diagnosis and treatment, they also extended this to General Practitioners. This research illustrates how important referrers are. They could be the health care staff at the cancer hospital, the GP or charities who go further than sign posting with leaflets, but complete referrals for women with breast cancer who need psychological support. Often, the women interviewed did not recognise the need for psychological help and / or didn’t realize how it could help them.

The results are practically useful in relation to educating breast cancer clinicians, General Practitioners and feeding back to the source of most of the participants; the national breast cancer charity, Breast Cancer Care. The results can be used to help key potential referrers to understand the psychological side of breast cancer and how support in this way can help alongside medical and complementary therapy. In addition the discussion about psychological support may have to be repeated to women with breast cancer, as it has been shown that when people see a doctor in outpatients, for the first time, they can only recall 60% of what was said to them 80 minutes later (Ley and Spelman, 1965)

6.5.3 Being treated flexibly in the therapy contract

Flexibility, alongside accessibility, in therapy was important for the women. They needed to be able to flex the therapy contract, for example when their psychological sessions were and sometimes the length of sessions, because of the trajectory of their individual breast cancer, the level of treatment they required and the type and intensity of the side effects they suffered. The women’s individual approaches to understanding their personal breast cancer journey also required the therapist to have flexibility rather than a rigid formula. This is not to say that there are no boundaries, there must be to create safety and consistency, however the flex in terms of the frequency of sessions was found to be a supportive aspect. The implication of this is that counselling psychologists, who want to work with women with breast cancer, need to be made aware and to understand this central dynamic of flexibility in the therapy contract. This provides freedom and puts the women more in control, at a time when they are feeling out of control because of their breast cancer diagnosis and the harsh medical treatment.

Psychological therapy may also need to continue when the medical treatment stops, as this is often when the women interviewed felt most vulnerable, alone and struggled emotionally. They have used all their physical and mental energy to get through the treatment and they
have the expectation that everything will be fine and back to normal at the end of treatment. However their perspective of life has altered, they felt physically weaker and they had existential questions about what life is for. They can also feel isolated as everyone around them expects them to be happy. Psychological support at this time was helpful to some of those interviewed as they could take time to process what they had been through.

6.5.4 Ensuring a safe therapeutic space to enable the expression of real fears

A key implication of the research was that women with breast cancer often needed a safe therapeutic space and sufficient time to be able to talk and offload their real fears with no guilt. Often the women were trying to protect friends and family from their deepest fears. They didn’t want to hurt, frighten or worry the closest people around them, because they cared about them (Fallowfield and Clark, 1992). However, keeping these very real fears inside could isolate a woman with breast cancer, causing them to become more depressed and/ or more anxious.

The therapeutic relationship was found to be a secure base from which the women could explore from; there was mutual attunement, trust and respect. This gave the women safety, which encouraged confidence and a certain freedom to express their fears (Timulak and Lietaer, 2011). The therapeutic space was a containing experience, the therapist psychologically held the women. This links to Bion’s (1962) theoretical model of a container, in relation to the psychological space (Riesenberg-Malcolm, 2001). Most of the women in the research indicated that it was helpful to have a psychological therapist to hand over the anxiety to, in a designated space. The women often felt they could say anything to their therapist and not feel guilty for expressing their real fears. They were not judged and were often reassured that their fears were normal. ‘Normalising certain psychological responses for women in the post-treatment stage of

6.6. Reflexivity and concluding remarks

‘Reflexivity is a way of attending to the institutional location of historical and personal aspects of the research relationship’

(Parker, 2005, p.25)

As part of this thesis I have been keen to make my position as a researcher, within this research clear and reflexivity has been a constant theme throughout it. My activity in constructing the research process and this write up was an important part of the research. My research diaries, which included notes from supervision with my supervisor, helped me to maintain a personal and collective memory of the process. I felt certain things unfold in the research process; the creation of the virtual community of women, my growing loyalty and respect to the women, the need to do justice to the women’s experiences and my pragmatic desire to understand and know what helped and what did not.
Institutionally there were constraints, for example the time limit of the project, which meant I could not keep interviewing and I had to say no to some women who wanted to talk about their experiences. However, I tried to reduce the power imbalances where I could to try to fit in with the women, in terms of when and where they wanted to be interviewed, including scheduling the interviews around their ongoing treatment in some cases. I was also aware that I needed to recognise that what I found and the sense I made of it were ‘a function of what’ I thought I ‘would find and the position’ I tried ‘to make sense of it from’ (Parker, 2005, p.27). Therefore I consulted the women, as co-researchers, along the way to try to ensure I had it right in terms of what they wanted to say in their transcripts and the analysis.

In this discussion chapter the implications of the research have been examined under three headings; theoretical, methodological and practical. Theoretically I empathised with the women who wanted to be treated as whole individuals, rather than as a site of a cancer. Each woman had her own distinct identity, personal past experiences and other medical or psychological strengths and difficulties. This meant that each woman needed to be treated personally and their whole experience, needed to be acknowledged, in the psychological therapy. This fits completely with my values as a woman and a Counselling Psychologist and the humanistic philosophy of Counselling Psychology.

Theoretically a one size fits all approach to psychological therapy did not seem to meet the needs of the women interviewed. Tailoring the therapy to the women’s individual needs pluralistically was more helpful, than keeping to a strict single therapeutic approach. In addition, when some of the women were treated with a generic approach psychologically, for example when one woman had a series of telephone assessments, this was distressing and re-traumatising. When psychological therapy is set up with care, it can help a woman with breast cancer to put the self back together again, following the shattering of her self-concept, through a forced transformation. Suddenly a woman finds herself asking existential questions, about the meaning of her life and if she is encouraged to explore these, in psychological therapy, it can help her find meaning out of what is happening. Finally the social justice agenda of Counselling Psychology should be referenced again here. I felt a strong pull from the women in this area. The women wanted to be helped, to be empowered and to be more active in their care, in the face of the often masculine medical world and in this research psychological therapy often helped them to achieve this. The social justice agenda for Counselling Psychology needs to be paramount when helping women with breast cancer through psychological therapy.

Methodologically I had not expected the women to experience a further therapeutic benefit from taking part in the research. The process helped them to re-interpret their own experience of breast cancer and psychological therapy, they were processing it again. In this way I felt that being a research participant had similarities to being in a therapy. As the women were highly engaged in the research, I also became close to them, they were my co-researchers. The women carried the research, alongside me and this helped me to complete the thesis, their motivation carried me, they supported me and they encouraged me. It felt that we were all
taking part in the research process together, in order to help other women with breast cancer. In this way I strongly feel that the potential benefits, alongside the risks, of taking part in research should in future be highlighted at the initial ethics stage. This effect has also been found before when undertaking qualitative research with vulnerable populations, regarding a sensitive topic (Murray, 2003; Morecroft, Cantrill and Tully, 2004). A more meaningful appreciation of a situation can develop. This was facilitated by the women, in this research, being willing to tell their story and there was a redistribution of power, within the trusting participant-researcher relationship. The telling of their story may have contributed to the process of forming ‘a new self with a new perception of their past experiences’ (Murray, 2003, p.234). I felt the personal nature and intensity of the research process, whilst holding the space and boundaries as a researcher, rather than a therapist. This was an extremely valuable experience and I cared deeply for the women, taking time to really listen and hear them.

Practically I found that the medical world compounded the feeling the women had of being thrown and knowing they had been thrown (Willig, 2009). There was a strong felt sense of being out of control at diagnosis, which engulfed the women, often continuing through treatment and still being present at the end of the medical regime. The psychological therapy felt to me that it provided a breathing space, to help the women to make sense of what was going on, even though it was senseless. Active referring was an important practical implication, rather than passive leaflet provision. It made me consider the importance of the medical care team and how they need to understand how psychological therapy can help and what is available, in order that the chance to help women psychologically is not missed. In addition, unlike other contexts, the therapy contract needs to be more flexible, the therapist needs to take care not to add to a woman’s sense of being controlled. The women are already being controlled by the cancer and the medical treatment regime. There was also a strong sense of the women needing a protected space to be able to express themselves freely, without guilt or concern for other’s feelings. The therapist needed to be able to hold the space psychologically, to create an open space whilst also being able to contain it.

I will now finalise the thesis with concluding remarks about the contributions the research makes, alongside its limitations, whilst considering future research areas.
7.

Conclusion

7.1. Introduction

This research set out to explore the experiences of women with breast cancer in relation to helpful and unhelpful aspects of psychological therapy, post diagnosis. In this concluding chapter, I summarise the purpose of the thesis, discuss the findings in relation to the key issues arising, explore the limitations of the research and the contributions it makes to Counselling Psychology and psycho-oncology in the current economic context. Finally, I conclude with future research that could help to further develop the understanding in this research area and how this research impacted on me.

7.2. Purpose of Study

The research study was designed to answer the following two questions: ‘What are the helpful aspects of psychological therapy, as identified by women with a primary breast cancer? What are the unhelpful aspects of psychological therapy, as identified by women with a primary breast cancer?’

There have been many quantitative studies about the therapeutic benefits of psychological therapy to people with cancer, but there have been less in depth qualitative research papers looking at peoples’ experiences. Specifically this thesis set out to focus on the views and experiences of women with breast cancer. Coming from a humanist background of Counselling Psychology, I was interested in the unique individual experiences of the women, whilst examining any overarching themes that could be described across the data corpus.

I decided to look specifically at the experiences of people with cancer, because I was working in an oncology hospital supporting many people psychologically, with cancer and I wanted to listen to the views of people with cancer with regard to what they felt helped and didn’t help them. I chose to interview women with breast cancer because it is the most common cancer and I was interested in how women, specifically, are helped or not helped psychologically through therapy. I was also interested in how breast cancer is socially constructed in society.

I used semi-structured interviews to help the women talk in an open way about their personal experiences of psychological therapy. GTA, with a social constructionist perspective, was used to analyse the data. In the analysis I generated initial codes of action segments (Charmaz, 2006). Then I reviewed the initial codes in the focused coding stage, which was more conceptual. At this point memos were written for each of the 30 focused codes. Then I reviewed the focused codes and connected theoretical categories between them (Strauss & Corbin, 1998). I then applied an organizing scheme to make links between the categories visible 1) conditions/context, 2) actions/interactions and 3) consequences. The final stage was to identify the core category, the consequence, which linked and integrated all the other categories together.
A theory of helpful aspects of psychological therapy with women, with breast cancer, was understood through the shared thoughts and experiences of women. The context was: Being thrown into the breast cancer world. The three helpful conditions were: Psychological need recognised by others, easy access to ongoing flexible therapy and valuing the personal qualities of the therapist. The three helpful interactions were: Being enabled to express self safely, being treated as an individual whole woman and accessing the therapist’s inner self. The two helpful actions were: Being helped to empower self and being taught new coping skills. The perceptions of the participants highlighted the core variable of, being helped to put active self back together again, which illuminated the main helpful themes and was the consequence of the therapy process.

A theory of unhelpful aspects of psychological therapy with women with breast cancer was understood with the same context: Being thrown into the breast cancer world. However, the two unhelpful conditions then emerged as the therapy was not easy to access and the therapist’s personal qualities were cold and harsh. The two interactions that were unhelpful were being unable to express self safely and not being treated as an individual whole person. The action that emerged was that therapy was too short. The consequence of when therapy was not set up in the right way, was that the woman was re-traumatised and remained shattered after a breast cancer diagnosis and treatment.

7.3 Main Insights from Findings and Literature

In conclusion I will discuss the key insights from the findings and the literature. This research provides additional insight to the already existing body of research on psychological therapy with women with breast cancer. Specifically this research highlights the fact that breast cancer in women is unique; because of it is socially constructed around links to femininity. Women’s sense of self is heavily affected when they are diagnosed with and treated for breast cancer, because of how the breast is defined in their social and personal context.

This research also focuses on the voices of individual women with breast cancer; the findings are their words in relation to how psychological therapy has been helpful and/or unhelpful. This research is grounded in the experience and words of the women.

The important findings in terms of how this research adds to the body of work already in existence that I would like to highlight are the importance of being treated as an individual whole person, particularly in an often masculine medical environment and being helped to empower self when vulnerable.

In exploring the helpful aspects of psychological therapy, with women with breast cancer the context, conditions, interactions, actions and consequence structure was used to represent the coding (see figure 3).
7.3.1 Context: Being thrown into the breast cancer world

In exploring the helpful and unhelpful aspects of psychological therapy, with women with breast cancer, there was the common context of being thrown into the breast cancer world. As Batt (1994) described the experience spins women out of control. Willig (2009) described wrestling with meaningless. This immersion into a new, unknown, mysterious medical culture can be a frightening and confusing experience. Meaning is lost, the long road of harsh treatments make the women physically ill, not the breast cancer and they are faced with having to lose parts of their body to survive, their hair, their breasts. In this way being thrown is generic to all cancers, but being thrown into the specific breast cancer world, where a woman’s body image is mutilated and her self-identity is threatened is very different.
7.3.2 Helpful conditions: Psychological need recognised by others, easy access to ongoing psychological therapy and valuing the personal qualities of the therapist

The helpful conditions were the psychological need being recognised by others. Many of the women interviewed did not identify themselves as needing, or wanting psychological therapy. The women were often in a social role of putting others first and their feelings were usually bottom in line behind their families. This finding feels specific to female cancers, there can be a need to empower women, encourage them to speak when they are faced with the masculine medical world.

Simonton et al. (1978) described all cancer patients as ‘often people who have put everyone else’s needs first, they have obviously had difficulty permitting themselves the freedom without the illness’ (p.127). As a result this puts enormous importance of ensuring referrers aware of psychological services and the potential benefits that the support can provide alongside medical care. Referral pathways need to be clear and open to all.

Easy access to ongoing flexible therapy was vital to the women and feels vital for all people with cancer. A strict weekly therapy regime does not work when people are suffering the difficult side effects of treatment. The cancer often feels like it is controlling the person and the therapy needs to help to give control back to the person where it can be given back. The psychological support was also valued when it lasted longer than the medical treatment, as often at the end of the treatment; the women needed support to process what they had been through. They should be in the driving seat of their therapy rather than feeling they are being done to. The personal qualities of the therapist were valued, it did not matter if the therapist was a woman or a man, it mattered more that they were warm, compassionate and open, this feels like it would be appropriate generically for all cancers.

By contrast the unhelpful conditions found were linked to psychological therapy not being easy to access which would be a problem for all cancers; long waiting times for therapy added to a woman’s feeling of isolation and inconsistency in terms of who worked with a woman, through her breast cancer experience damaged feelings of safety and control. In addition, the therapist’s personal qualities were sometimes experienced as cold and harsh and this was particularly linked to when the therapist took a psychoanalytic approach. This therapeutic approach was felt to be too rigid, controlling, sometimes persecutory and rooted in the past rather than the present. It is difficult to say how this would relate to other cancers, this depends more on the needs of individuals.

7.3.3 Helpful interactions: Being enabled to express self safely, being treated as an individual whole person and accessing the therapist’s inner self as a resource

Being enabled to express self safely was key to the women with breast cancer and I feel this would be a key need for women with other female cancers, like ovarian cancer. The women in this research valued protected space just for them to offload. The space meant that they could
express their real fears, without feeling guilty and having to protect family or friends. The therapeutic space helped the women, to process and navigates their new environment, the medical world of breast cancer. The psychological therapy helped smooth the whole experience; it was a constant thread between the distinct time bound medical interventions. In addition the psychological space provided an environment where their inner thoughts and feelings could be normalized, by the psychological therapist. The women realised their vulnerabilities were normal, they were not alone, they could be open, free and it was okay to voice them. A few of the women valued that the therapy was taking place in a separate location to their medical treatment, whilst for others this was not mentioned at all.

It was important and helpful that the women were treated as individual whole women as already stated at the start section 7.3. This links directly to the philosophy of Counselling Psychology, in tailoring therapeutic interventions to the individual client’s experience (Cooper and McLeod, 2007; Hubble, Duncan and Miller, 1999). The therapist’s understanding of the individual woman is paramount (Strawbridge and Woolfe, 2011). Often medical care in cancer is focused on the specific type of cancer generically rather than the whole person with the cancer. A woman can feel processed and depersonalized. Psychological therapy from an integrative Counselling Psychology perspective can support the individual woman in the right way for her, at the specific time of the therapy (Cooper and McLeod, 2007). Being treated as an individual feels like this would apply to all cancers, as people have different psychological and physical needs.

Accessing the therapist’s inner self was helpful in terms of being able to have access to a wiser head, when a woman is feeling vulnerable, in the midst of a crisis of self. The therapist’s cancer knowledge, helped the women to be understood, in some cases, almost without having to explain the ‘what’s’ and the ‘why’s’. This access to another person to create meaning and understanding would apply to people with other cancers too. The women also talked about self-disclosure, by the therapist, helping to deepen the therapeutic alliance and strengthening the relationship based on trust. The therapists made themselves vulnerable, on occasion and showed that they were human too, which helped the women.

The unhelpful interactions seemed to be opposite of the helpful ones. The therapy experience was described as being unsafe and not personalized. The women were unable to express their thoughts and feelings freely as they did not feel safe and psychologically held. In addition they were not being treated as an individual, as a person, sometimes asked them very personal questions, over the phone, in assessment, who they had not built a relationship with.
7.3.4 Helpful actions: Being helped to empower self and being helped to learn new coping skills

The women were encouraged to empower themselves, put their own needs first rather than feeling selfish and guilty for doing this. This guilt, links to the societal expectation of a woman of always putting her family’s needs first, before her own. The women were also empowered to ask specific medical questions of their health care team, by the therapist, which helped them psychologically understand why certain medical treatments were happening in certain ways. This finding feels specific to women who have cancer.

New coping skills were discussed and encouraged, in line with the individual woman’s needs: Reframing thoughts, focusing on helpful behaviours, learning practical skills, being helped to adjust and being encouraged to be more compassionate to self. These coping skills link to Cognitive Behavioural Therapy, mindfulness and Compassion Focused Therapy. This again links to a pluralistic approach to Counselling Psychology interventions (Cooper and McLeod, 2007). Being helped to learn new coping strategies psychologically would benefit other people with other cancers.

The unhelpful action was that the psychological therapy was too short in length and did not help the women across the whole experience of breast cancer, which can be a long process. Chemotherapy and radiotherapy can take 6 months or more and then learning to be again after cancer treatment can be helped with psychological support.

7.3.5. Helpful core variable: Being helped to put active self back together again

The perceptions of the women highlighted the helpful core variable of, being helped to put active self back together again, which illuminated the main helpful themes and was the consequence of the therapy process. This was described quite potently as putting the stained glass window back together again, with pieces of your old life and new life coming together to create something better. The psychological therapy helped the women take some control back, from the cancer. This core variable felt specific to female breast cancer, linking to empowering women, female identity, a woman’s role in society, body image and a woman’s role in relationships.

Post-traumatic growth was also a benefit for some of the women and looking to the future, became a possibility again. Laughter helped and the women started to recommend psychologically therapy, to other women with breast cancer, as a result of their personal experience.

The unhelpful core variable was women being re-traumatised and remaining shattered as a consequence if the therapy was not set up in the right way. This emphasizes the importance of the therapeutic alliance, which is a vital foundation to a Counselling Psychology approach.
7.4 Summary of the key implications of the thesis

The key implications that I would pull out to conclude are firstly the opportunity to make more referrals to psychological therapy for people with cancer because they are being cared for by many health professionals. Secondly the flexibility needed by therapists to support people with cancer because of the nature of the harsh treatments. In addition theoretically this research shows the value of a pluralistic approach to therapy for women with breast cancer in terms of supporting individual experience. Methodologically the women were very involved in the research and gained therapeutic benefit, in some cases, from being able to express their views on the impact of psychological therapy to them. This points to a positive benefit focus of the research ethics process, as well as considering the risks.

The main points that emerged from this research were the following theoretical, methodological and practical implications:

Theoretical:

- Treating women, with breast cancer as whole individuals helps them psychologically cope with their experience.
- Being helped to learn individual coping skills from a pluralistic perspective can support individual women with breast cancer.
- Helping to put active self back together again, with psychological therapy and space, can be a consequence if the therapy conditions are set up, in the right way.
- Helping to empower women with breast cancer, who find themselves vulnerable, is as important as the medical care.

Methodological:

- Experiencing a therapeutic effect of taking part in the research is a possibility, when researching women’s experiences of breast cancer.
- Valuing the women as engaged and active co-researchers helps deepen involvement in a research project and makes it more of a communal, shared experience, together with the researcher.
- Ethics panels, alongside risks to participation, should consider participant research benefits, for example re-storytelling and processing an experience.
- Using GTA from a social constructionist philosophy helps to understand the individual experience of women, whilst looking for overarching themes and societal structural forces.

Practical:

- Being thrown into the breast cancer culture has an enormous impact on women who have been diagnosed and normalising this may help the women feel less isolated.
- Referrers and referral pathways are vital to ensure that all women with breast cancer have access to psychological therapy, as they may not recognise the need or possible benefits themselves.
- Being treated flexibly in the therapy contract helps to give some control back to women, with breast cancer, at a time when the cancer has taken away control.
- Ensuring a safe therapeutic space to enable the expression of real fears is a key part of
psychological support.

The research is qualitative in nature; therefore it is only appropriate to make tentative conclusions about the implications. This can only be inferred for this sample, at the time of the interviews. However the learnings can be incorporated practically when working therapeutically with individual women with primary breast cancer.

7.4.1. What does this mean for psychological therapy with women with breast cancer in the current economic context?

The present findings have several implications for psychological therapy with women with breast cancer. Being thrown into the breast cancer world, at diagnosis and through treatment, has an enormous impact on the women. Helping to normalise the thoughts and feelings, women with breast cancer may have, could help them feel less isolated, however it is also important to the women that they are treated as individuals. There may be overarching themes but care needs to be applied when working with each woman.

Psychological care should be available and easily accessible alongside medical care. As psychological therapy can help to empower women with breast cancer, in the face of the diagnosis, overwhelming treatment choices and decisions. The women often feel vulnerable, in the presence of expert medical consultants, which can lead to questions not being voiced, which in turn can lead to more psychological distress. It is also important that each woman is treated as an individual. Treating women, with breast cancer, as whole individuals, can help them psychologically cope with their experience. Women with breast cancer feel a loss of control in the face of cancer and the safe secure therapeutic space can give them some control back. Consistent psychological therapy, along the breast cancer experience, may help the women find meaning and help to put their self back together again. The therapeutic space needs to be set up in the right way to help this to happen; the therapist needs to be compassionate and resilient, whilst the therapy contract needs to flexible.

At this point it is worth outlining the context of psychological therapy provision in the UK as I did at the start of the literature review chapter. As despite the Department of Health (2000) acknowledging the psychological distress people with cancer suffer and the need for access to therapy, the provision is still patchy and so is screening (Carlson L et al., 2004; NICE, 2004). In this context ensuring women with breast cancer have access to psychological therapy is extremely hard. The provision is often limited and inconsistent and as a result many women may not have their emotional needs looked after.

Psychological therapy for people with cancer needs specialist pathways, as time is not always of a person’s side and the nature of adjusting to a physical illness, that is associated with death, is different to dealing with a mental health issue. Charities often fill the gap, but this is also hit and miss depending on where people live. People with cancer often feel abandoned psychologically by the health system, they are sometimes too distressed to seek help and their physical symptoms can mask the extent of the psychological distress (Carlson L et al., 2004; Mitchell, 2009).
The current climate of austerity in the UK, because of the economic crisis in Europe in 2008, means that the NHS has to make efficiency savings which are effecting the provision of psychological therapy services, in contrast to demand for these types of services rising when the economic climate worsens (McDaid, 2010). This is a very real problem for women with breast cancer as its incidence is on the increase whilst mortality is reducing, therefore helping women live with breast cancer psychologically as well as physically is a real priority for our society.

7.4.2. What does this mean for psycho-oncology?

Referrers and referral pathways are vital to ensure that women with breast cancer have access to psychological therapy, where it is provided. Often they may not recognise the need or possible benefits themselves. The Multidisciplinary Team (MDT) in any cancer setting needs to be aware of the psychological services available and how they these services can help women with breast cancer. The women with breast cancer can be helped to learn individual coping skills, from a pluralistic perspective. These skills can come from a multitude of therapeutic approaches like PCT, CBT, Compassion Focused Therapy and mindfulness for example.

7.4.3. What does this mean for Counselling Psychology?

In line with the philosophy of Counselling Psychology, the therapeutic relationship has been found to be a key foundation of the psychological therapy with women with breast cancer. The relationship heals rather than psychotherapy tool (Norcross and Lambert, 2011). It is not what the therapist does which is important, but how the therapist is (Wampold 2001). Ensuring a safe therapeutic relationship and space to enable the expression of real fears, is a key part of a counselling psychology approach.

The role of a Counselling Psychologist, alongside the medical team, in a cancer setting is important, in remembering the individual, the person, the woman. A woman with breast cancer, could be labelled as non-cooperative if she is unsure about treatment, but exploring her individual thoughts and feelings psychologically can help to understand her need to try and exert control at the hospital, whilst feeling controlled by the cancer (Stacey, 1997). Being treated flexibly, in terms of psychological therapy can give some control back to women, with breast cancer.

Working with people with cancer pas a Counselling Psychologist can have certain differences to working with people who have mental health issues. The relationship, with the person with cancer, may terminate prematurely. In addition, psychological improvement in coping with distress, maybe the goal, but deteriorating health can pose a challenge to this. Counselling Psychologists need to be led by the woman with breast cancer, in the therapeutic agenda, dependent on where the person is, in their individual experience.
7.5 Limitations

7.5.1 Methodological Issues within research

The methodological issues with the research are related to the role of the researcher, the analytic method of GTA and the use of semi-structured interviews.

Qualitative research cannot be objective, this is not the aim, it is nuanced and subjective. The context in which the qualitative data was obtained cannot be ignored and separated from the findings. Part of the context is the relationship between the research and the researcher and this is an important methodological limitation to consider. As I had worked and was still working at a cancer hospital at the time of the research, supporting people with cancer with psychological therapy, this has to be taken into account. In addition I approached the research as a Counselling Psychologist with a focus on the individual and the therapeutic alliance. As a researcher I cannot be completely objective and I did not aim to produce a 'privileged' account' (Snape & Spencer, 2003, p.13). A practical step to counter this limitation was the time spent discussing researcher effects in chapter 5, the reflexive analysis. This part of the thesis has helped me to be clear, about my practitioner role, but I also recognise that bias and skewedness cannot be eliminated (Haraway, 1991). The interpretations from the data may have resonated, with my interactions, with women with breast cancer, in my practice and in turn this could have influenced the findings. A different researcher could implement the research, using the same methods and come up with a different interpretation.

The analytical method, GTA is designed to find overall themes and therefore although individual accounts are utilized through semi-structured interviews, the individual account narrative is difficult to maintain unlike biographical approaches. However the advantage is that overarching theoretical themes can be drawn out of the rich description of individual experience. The GTA approach was purposely chosen to build a theory of helpful and unhelpful aspects of psychological therapy for women with breast cancer, out of the interview data.

Using semi-structured interviewing means that the data collected can be biased by what the researcher finds interesting at the time. The questions from interview to interview can vary and unintentional leading questions can place a value on what is explored and what isn’t. I therefore accept that there is a potential threat to reliability using the method of semi-structured interviews to collect data. In addition how the participants perceive the researcher can affect how they respond to the questions. The interviewer affect is linked primarily to the age, sex and ethnic origin of the interviewer for example (Denscombe, 2007). This is particularly prominent when the topic under discussion is emotional, as in this research study. However I endeavoured to create an open environment in order that the women would feel comfortable talking about their experiences in the research.
7.5.2 Research Limitations

The limitations in this research are the small sample size, the socio-cultural bias in the women who agreed to take part, the use of audio recording equipment and acknowledging the situated approach of the researcher as a counselling psychologist.

The limitations of this study are firstly that there was a small sample: There were 11 women interviewed who all had been diagnosed with a primary breast cancer and then had psychological therapy. However, although the sample size was small this approach was specifically chosen because of internal research factors and external limitations (Flick, 2012). The internal factors were that the research aim was purposely narrow and focused on an idiographic philosophy, looking at rich subjective experience, from a social constructionist perspective. This was in contrast to a nomothetic approach, for the generalisation of findings to a wider population. Externally the research interviews had to be manageable practically, in the time frame of the thesis and with only one researcher. In addition, it was important to me to analyse the data with care and dignity, which meant that the quality of the data collection and analyse was vital, rather than focusing on quantity of interviews. (Jenson, 2012). By doing this I could also process my own feelings as an interviewer, which helped to form the ideas and thoughts in the reflexive analysis, chapter 5.

I acknowledge that the findings can only be applied to these women, with primary breast cancer, at this time. However the objective of the thesis was still achieved, as the findings can help to understand from the women’s perspectives, what they experienced as helpful and unhelpful, in terms of psychological therapy. These findings in turn can influence practitioners in oncology settings, helping them to reflect on what helps and what does not, in terms of psychological therapy. The research can help staff in medical environments consider the psychological side of breast cancer and the need for this to be recognised as part of a woman’s care.

It is also important to state that the women were all culturally similar; they were all from the UK. In addition there was a socio-cultural bias in this study, to women who may be more inclined to take part in research; they may have been well-educated women. This links to key findings from previous research, that psychological therapy was often mainly taken up by, well-educated and urban women (Nekolaichuk, Cumming, Turner, Yushchynshyn, and Sela, 2011; Holland, 2004). Therefore I am not claiming that the women can be taken as a representative sample of women with a primary breast cancer.

The research also only interviewed women who were willing to take part. This may have attracted a certain type of person who was more engaged, motivated, reflective, well-functioning and used to taking part in research. Eight of the women were from the forum ‘breast cancer voices’, which is part of the national charity, Breast Cancer Care. These ‘voices’ are specifically recruited to openly discuss their experience, to help other people with
breast cancer. These women may have also been more predisposed and open to seeking psychological therapy, to help them cope with their diagnosis and treatment.

However the women who took part were vital not just as participants, but as co-researchers, during the research and analysis phase. This helped to keep the thesis grounded, in their experience and helped keep the pace of the research write up too. A further point I have now considered, on reflection, is that I could have used the women to help define the interview schedule. This could have been achieved through a pilot or through a focus group. This would have maybe uncovered more pertinent questions that could have revealed further insights into what aspects they found helpful or unhelpful during the interview phase.

A further limitation was the intrusiveness of the audio recorder for the participants and for the researcher. It may have influenced what the women said and how I, as the researcher, responded to the women. I tried used my skills as a researcher to limit this effect by creating an open environment, where the women felt at ease to speak. I also tried to remain attentive during all the interviews and I wrote reflective notes straight after each interview, to attempt to ensure the recorder did not limit my attentiveness (Back, 2010). Polsky (1998 [1967]) stated that ‘successful field research depends on the investigator’s trained abilities to look at people, listen to them, think and feel with them, talk to them rather than at them. It does not depend fundamentally on some impersonal apparatus such as a camera or tape-recorder’ (p.119). The recordings of the interviews may also have helped to strengthen the women’s conceptualisation, of what was helpful and not helpful in psychological therapy, as they knew they were being recorded (Rennie, 1990).

This thesis has been approached from the perspective of Counselling Psychology and this has been made clear. As a researcher I am situated within the discipline of Counselling Psychology and this has implications in terms of my focus as a researcher on the individual and their experience, the importance of the therapeutic relationship and a humanistic philosophy (Rogers, 1957). Theoretical, methodological and practical implications from the research for Counselling Psychologists, working in cancer settings, were described in the conclusion section (7.4). With reference to these implications I have already presented the results of this thesis at the annual British Psychological Society Division of Counselling Psychology Conference in Harrogate in July 2015, as part of a cancer symposium. In addition the research findings may have a wider impact in being helpful to other women with breast cancer and to those offering psychological support to women from a variety of health professional backgrounds including consultants, nurses, physiotherapists, dieticians, nurse specialists and health care assistants. It is therefore important to me that I disseminate the results to other women with breast cancer and other health professionals. I have given a written update of the findings to the national charity, Breast Cancer Care in July 2015 for the charity to distribute to their Breast Cancer Voices. Finally once the thesis is accepted as complete I will engage the wider health care team in the findings, at The Christie Hospital in Manchester where I work and I will look to present at a specific cancer conference.
7.6 Future Research

In the future there is a need to complete the research with women who have been diagnosed with a secondary breast cancer, where their experience could be different in terms of what aspects of the psychological therapy are more or less helpful. This would help to make a comparison to those women with primary breast cancer, in this research. In addition, women with primary breast cancer can go on to develop secondary cancer and there could be an examination of psychological therapy for women who have been supported through both types of cancer experience.

In addition doing the same research with women with breast cancer from other cultural backgrounds would be useful, as this research was limited to the UK. There could be a useful comparison of the societal structural factors around breast cancer in different cultures and how this affects women.

Finally, there would be an interesting research study in asking psychological practitioners who work with women, who have a primary breast cancer, what they think is helpful and unhelpful in psychological therapy for the clients they have supported. This would enable a limited level of triangulation of helpful and unhelpful aspects of psychological therapy for women with a primary breast cancer, examining the experiences both from the client’s perspective and the psychological practitioner’s viewpoint.

7.7 Impact upon the Researcher

It was humbling and inspiring to hear the women with breast cancer, talk about their experiences with psychological therapy. The women were open, honest and unique. Their enthusiasm for the research, gave me the extra motivation I needed to keep the project alive and write the thesis up. The women were my co-researchers, this was not intentional on my part at the start of the project, however the women were interested and active. Therefore their high level involvement was a natural part of the process as the research progressed. The women’s willingness to be heard and to be involved at the findings stage made me feel more interested in people with cancer as experts because of their experience, rather than the medical team as the only experts in a cancer setting.

It has made me consider the impact of being diagnosed with breast cancer and the effect of the harsh medical treatment, on women. Breast cancer did not make them ill, the treatment did. Normalising this process for the women is a small part, but it can have a huge effect. It helped me to see how isolating cancer is, how scary it is and that psychologically therapy should be available to all women with breast cancer, to help them find a way through the meaningfulness.

It has also helped me consider how breast cancer is a socially constructed disease, as well as a physical one. The diseased breast is neither attractive sexually or valued from a maternal perspective. Surgery and other treatments leave some women feeling inadequate and under
pressure to regain their femininity. It made me consider the programmes that are on offer at the hospital I work in, a complimentary beauty seminar with free make up samples and the wig room. It is interesting to now see more nuances around these areas, women sometimes want to get back to what we culturally have defined as normal, but sometimes they feel pressurised by those around them to do this, including those in the cancer setting. This made me stop, consider avoiding ideals around femininity or at least being cautious in this area when in the therapy room.

I have also considered, how I can ensure, that I work with the helpful aspects identified by the women with breast cancer in this research: Providing flexibility in the therapy contract, creating a safe space for people to express their real fears, the importance of referrers, providing and encouraging compassion, allowing free expression of emotions and thoughts, helping to empower women by finding their own individual resources and strengths, helping women to learn coping strategies that work for them, treating women as individuals always, working integratively to find the right therapeutic interventions for the individual from a pluralistic philosophy and the importance of building a strong and trusted therapeutic alliance.

The unhelpful aspects of psychological support that I have explored, as part of this research: The personal qualities of the therapist being unhelpful if they are harsh and cold, as this reinforces expertise, a power relationship and the women with breast cancer feeling controlled have also impacted on me. Control and power are now more important aspects for me to consider in my work, as the cancer often feels like it is controlling the women with breast cancer and the medical setting can disempower women. The social justice agenda of Counselling Psychology now has more meaning to me personally, in my practice. Enhancing women’s voices is becoming a larger part of my work in the cancer hospital I work in. This research has already impacted on my practice in talking with women about their embodied expert experience and how they can then use this to consult with their medical team, rather than them feeling they have to rely on other experts solely.

7.8 Chapter Summary

Section 7.3, the main insights from the findings and literature, and section 7.4, the summary of the key implications of the thesis provide an embedded view of the findings in previous research. These sections also bring the implications of the thesis, to the fore. In this final chapter, the theoretical codes found were explored in terms of what they meant, particularly in relation to women with breast cancer, psycho-oncology and Counselling Psychology. Limitations were outlined in relation to both methodological and research issues. To end the chapter, future research was suggested, proposing further research, with women with breast cancer and those who support them psychologically. Finally, I provided personal reflections about how the research has impacted me, with specific reference to my role as a Counselling Psychologist working with people with cancer, in a cancer hospital.

Finally I would like to conclude that this research points to practical considerations around referral and flexibility, treating the whole person pluralistically to help them to empower self and that research participation can be considered in light of its potential positive impact at the ethics stage.
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Appendix a: Ethics approval – The University of Manchester

From: Ethics Education <ethics.education@manchester.ac.uk>
Date: Thursday, 2 January 2014 09:36
To: Katherine Harrison <katherine.harrison-6@postgrad.manchester.ac.uk>
Cc: Terry Hanley <terry.hanley@manchester.ac.uk>, Deborah Kubiena <debbie.kubiena@manchester.ac.uk>
Subject: Ethics Approval Application - CONFIRMATION after Panel 2012-13

Dear Kate

Ref: PGR-8526846-A1

Project: What are the helpful and unhelpful processes in therapy that patients with a primary breast cancer identify?

I am pleased to confirm that your ethics application has now been approved by the School Research Integrity Committee (RIC) against a pre-approved UREC template.

If anything untoward happens during your research then please ensure you make your supervisor aware who can then raise it with the RIC on your behalf

Regards Gail

Gail Divall | Senior Programmes Administrator
School of Environment, Education and Development | The University of Manchester | Arthur Lewis Building 2.020 | Oxford Road | Manchester M13 9PL | UK

Tel: +44(0)161 275 0317
Appendix b: Original interview schedule – used for the first interview TJ01

Thank-you for agreeing to take part in this research, the interview will last for approximately 1 hour and you have the right to withdraw at any time.

Please can you check you have read the information sheet and then sign the consent form. If there are any questions around this please ask. Thank-you.

Are you ok to begin?

I will ask you questions about your experience of therapy and I am interested in your personal detailed view. Is that ok?

1. Of the events that occurred in your Counselling Psychology therapy sessions, describe the ones that you feel were most helpful or important for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)
2. Please describe what made the events helpful/important and what you got out of it.
3. How helpful were these particular events?
4. Did anything else particularly helpful happen during your therapy sessions?
5. What events happened that were unhelpful?
6. What made these events unhelpful?
7. How unhelpful were these particular events?
8. Did anything else particularly unhelpful happen during your therapy sessions?
Appendix c: Updated interview schedule used from the interview with TV02 onwards.

Interview Guide

Thank-you for agreeing to take part in this research, the interview will last for approximately 1 hour and you have the right to withdraw at any time.

Please can you check you have read the information sheet and then sign the consent form. If there are any questions around this please ask. Thank-you.

Are you ok to begin?

I will ask you questions about your experience of therapy and I am interested in your personal detailed view. Is that ok?

- Of the events that occurred in your Counselling Psychology therapy sessions, describe the ones that you feel were most helpful or important for you personally? (By "event" we mean something that happened in the session. It might be something you said or did, or something your therapist said or did.)
- Please describe what made the events helpful/important and what you got out of it.
- How helpful were these particular events?
- Did anything else particularly helpful happen during your therapy sessions?
- What events happened that were unhelpful?
- What made these events unhelpful?
- How unhelpful were these particular events?
- Did anything else particularly unhelpful happen during your therapy sessions?
- Would you recommend therapy to someone else who had breast cancer, if yes/no why?
- How did seeing someone for therapy add or take away from the medical treatment you received?
- What characteristics did you feel your therapist had?
- Was your therapist a woman or a man?
- How many sessions of therapy did you have?
- How close to your diagnosis/treatment was the therapy?
Appendix d: Poster used to advertise for participants at Beechwood Cancer Support Centre in Stockport, Manchester

My name is Kate Harrison and I am a Counselling Psychology Doctorate Trainee at The University of Manchester.

I am currently researching how Counselling Therapy can be helpful to women who have had primary breast cancer. This research is designed to learn what works in order to help other people affected by cancer and guide healthcare professionals to refer those who might benefit from this support.

I am looking to conduct interviews with a small number of people who have had counselling therapy.

I would be most grateful if you could contact me if you are interested in taking part and I will be very happy to arrange to meet you at Beechwood.

Thank-you

Katherine.harrison-6@postgrad.manchester.ac.uk

MOBILE: 07836 240 851
Appendix e: Breast Cancer Care national charity correspondence: Completed research application form, feedback from the Research committee, my feedback back to the committee members, one page research summary and approval for the research from Breast Cancer Care.

Original research application completed form to Breast Cancer Care 27/2/14

Information sheet for external researchers

Our policy
Breast Cancer Care often receives requests from researchers asking for help with finding people to take part in their research. We are always willing to help with these requests as long as they meet with our organisation’s aims and objectives.

Breast Cancer Care needs to be certain that research projects are of good quality and will deliver genuine benefits for service users and carers with whom we work. Before agreeing to help with recruitment to research, we therefore carefully assess each proposal to check it meets our required standards.

Researchers who would like Breast Cancer Care to help with recruitment to their projects are asked to provide further details of their project using the enclosed application form.

How we can help you
Breast Cancer Care has access to service users and carers, including people with direct experience of breast cancer and their carers. We also run a number of support groups and provide services for people affected by or concerned about breast cancer.

Contact with our clients, service users or staff members must be conducted via Breast Cancer Care as we do not release peoples’ details without their permission. We will contact our members to let them know about research projects via our website, publications and membership database if the research project is approved by our Research and Evaluation Team and Research Committee.

How decisions are made
Completed application forms are reviewed by our Research and Evaluation Team and our Research Committee which includes a number of service users together with academics, local clinicians and staff members of Breast Cancer Care. Decisions about whether to help with your request will be made within 6 weeks of receiving your completed application form.
Researchers will also receive feedback from the review panel. We hope that you find this process helpful and would welcome your comments on its usefulness.

A key factor in making decisions about the research is whether there is capacity within the current resources of the organisation to provide the support and help that is required. Breast Cancer Care will reserve the right to charge researchers for the support provided where this is appropriate and justifiable, although we will not normally charge students for supporting recruitment to small scale research projects undertaken for educational purposes.

**What we ask of you**

All researchers who receive support from Breast Cancer Care are asked to:

- acknowledge Breast Cancer Care in any subsequent publications/reports
- provide feedback to all participants about the findings of the study
- provide a ‘simple English’ summary of the research for dissemination to service users and carers
- advise Breast Cancer Care about the potential applications of the research results
Breast Cancer Care - Application form for external research collaboration

1. Title of Research Project (in plain English)

‘What are the helpful and unhelpful aspects in therapy that patients with a primary breast cancer identify?’

2. Contact Details of Researcher

<table>
<thead>
<tr>
<th>Name: Kate Harrison</th>
<th>Job title: Counselling Psychologist in Doctoral Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: 143 Ashley Rd, Hale, WA14 2UW</td>
<td></td>
</tr>
<tr>
<td>Tel: 07836 240 851</td>
<td></td>
</tr>
<tr>
<td>Email: <a href="mailto:Katherine.harrison-6@postgrad.manchester.ac.uk">Katherine.harrison-6@postgrad.manchester.ac.uk</a></td>
<td></td>
</tr>
</tbody>
</table>

Contact details of Principle Investigator – as above

3. Research Funding:

<table>
<thead>
<tr>
<th>Name of funders/partners:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No funding</td>
</tr>
</tbody>
</table>

Approved by The University of Manchester Ethics Board as I am a post grad doctoral student on the Counselling Psychology Doctorate

Has this project been through a process of peer review?

(Please circle yes or no)

| Yes - ethically approved by The University of Manchester |

If yes, please provide further details:

Ethically approved at ethics panel at The University of Manchester in May 2013

Supervisors:

- Professor Erica Burman (erica.burman@manchester.ac.uk)
- Dr Terry Hanley (Terry.Hanley@manchester.ac.uk)

4. Has this project received ethical approval? (Please circle yes or no)

Yes: I have attached a copy of the approval letter.

Please enclose a copy of the participant information sheet, your approval letter and your consent form with your application.

5a. How many people do you wish to recruit in total? 12
5b. How many people do you wish to recruit through Breast Cancer Care?  

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>6. What is the closing date for recruitment?</td>
<td>Dec 2014</td>
</tr>
<tr>
<td>7. What is the project end date?</td>
<td>Summer 2015</td>
</tr>
</tbody>
</table>

8. Plain English summary for service user and carer reviewers

Attached

Please attach to this form a lay (or simple English) summary of your project. It should be no longer than one-side of A4 (11 pt Arial) to answer the following questions:

**Aims and purpose of the research**

a) What is the research about?  
b) How will it benefit people affected by breast cancer?  
c) How does it build on research that has already been done?  
d) What is the research methodology?

**Service user and carer involvement**

e) Have service users and carers been involved in planning the research?  
f) How will service users and carers be involved as the project continues?

**Practical issues for research participants**

g) What will taking part in the research involve for participants?  
h) How will you obtain consent from participants?  
i) What support will be offered to participants during the project?  
j) How will you make sure no one is out of pocket by participating in your research?  
k) How will you keep the information you collect about people confidential?

Please tick if you are in agreement to the following statements:

*I undertake to provide a lay summary of the results of this research to the research participants and to Breast Cancer Care for dissemination to service users and carers.*  
Yes ☐

*I will acknowledge Breast Cancer Care in any publications or reports from this project.*  
Yes ☐

*I understand that by helping to recruit people to this project Breast Cancer Care is not taking any responsibility for the research and is therefore not liable for any claims concerning negligence, harm or oversight that might arise during the course of the research.*  
Yes

Applicant signature...........K. Harrison............... Date......27/2/14........
Feedback from the Breast Cancer Care Research Committee 24/3/14

SURP member 1 feedback:

The Only Interview Session-

To be a conversation about the clients experiences of the therapy session already undertaken, then later this becomes a semi structured interview session.

Location-

At a convenient location for the participant, then at participants home, then later still states it will be held at The Christie Hospital.

Timing of Interview- again not clear but after counselling course finished but before the participant will have forgotten them.

No indication of criteria for selecting participants other than they have received a course of formal counselling. Will she be recruiting a cross section of clients to reflect the diversities of needs/ culture etc & what the counselling sessions will have meant for them. Also treatment needs important as to how clients will see the counselling sessions & what they need from them. No mention of how long after diagnosis the clients will be as not all of them will have taken up the counselling offer immediately after diagnosis & some may be well down the line & thus reflect their perceptions of the sessions. Equally age pre menopause or post will affect this.

SURP member 2 feedback:

1. Aims and purpose of the research

<table>
<thead>
<tr>
<th>Is the project</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>In line with Breast Cancer Care’s mission and objectives?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant to people affected by breast cancer?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely to benefit people affected by breast cancer?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Important in your view?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Whilst it is important to understand whether therapy can benefit people affected by breast cancer, I don’t feel we have enough information to know whether this research will be of benefit.

### 2. Methodology and analysis

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the research design appropriate for the study?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the sample size feasible/adequate/appropriately calculated?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have appropriate means to analyse the data been considered?</td>
<td>X</td>
<td></td>
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</tbody>
</table>

**Comments:**
We have been given very little information about the findings of other relevant research. I would like to see more about the hypotheses, in particular what constitutes helpful versus unhelpful therapy, from whose perspective, and more about how the data will be analysed. Can she explain a little about “Grounded Theory Analysis” and why it will be appropriate?

### 3. Service user and/or carer involvement

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involved service users and carers in developing and planning this research?</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Planned to involve service users and carers in the remaining stages of the research?</td>
<td>X</td>
<td></td>
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</table>

**Comments:**
The researcher has given us little information about her work and why she has decided to explore this area.

### 4. Practical/ethical issues for research participants

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the researcher clear about how they will recruit people to take part?</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the researcher clear about how they will obtain people’s consent? X

Has the researcher outlined clearly how confidentiality will be maintained? X

Has the researcher outlined what support will be offered to participants during the project? X

Comments:
There is not much concrete information about how the researcher will handle distressed participants.

5. Information for participants

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Is the information which will be given to research participants (the patient information sheet) clear and easy to understand?</td>
<td>X</td>
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</table>

Comments:
There are some improvements which could be made to the participant information sheet. The “Aim of the research” lacks a verb at the end, and could at least give a little more explanation of how the research will help people affected by breast cancer, perhaps setting out some problems which therapy aims to help. The “will I be paid” section could add something along the lines of “but by taking part you will help others who may benefit from therapy”. The “where will the research be conducted?” section says “at home”, which may not be suited to all. Elsewhere the proposal says the research interviews will be conducted in a clinic.
Thank-you for the comments from the SURP members.

I have redone the 1 page summary - see attached.

I have incorporated the comments into my documents and I am looking forward to interviewing people. This can either be done on the phone or face to face depending on practicalities like location and what the participant would prefer.

The comments were:

10. Method of interview: This is a conversation based on a semi-structured interview which has a few questions to start the discussion but is then free flowing.
11. Location of interview: This will be at a location convenient to the participant or over the phone, not at The Christie Hospital.
12. Selection of participants: This is a qualitative study looking at individual experience not comparing individuals.
13. Benefits of the research: This is a study which will contribute to a research base about usefulness of therapy with cancer patients. It will also help services at the hospital I work at and the research will be fed back to Breast Cancer Care.
14. Hypotheses of the research: This is a qualitative study and is about individual experience, the findings are not pre-judged and the analysis will be done via grounded theory analysis, this is a bottom up approach where each interview will be transcribed and analysed line by line to devise themes and an overall theory will be produced linking to the themes.
15. Where I work: I work at The Christie in Manchester as a Doctoral Counselling Psychologist in Training - I have worked there for 18 months and I am in my final year of my Doctorate. I am passionate about helping cancer patients and I am specifically interested in breast cancer.
16. Distressed participants: If participants feel distress during the interview, the interview can be stopped at their request at anytime. In addition I will signpost them to services to help them.

Let me know what the next step is.

Many thanks

Kate
Aims and purpose of the research

The aim of this study is to explore the helpful and unhelpful process in counselling therapy that people with a primary breast cancer identify. The benefit to people affected by breast cancer is that counselling and psychological therapy can be improved in terms of both access and the way it works at diagnosis, through treatment and after treatment has finished. Research has already looked at this in the general cancer population but not specifically with people who have had breast cancer. Therefore this is a unique piece of research. This research is qualitative in nature and it is about exploring an individual’s experiences, it is not about comparing individuals. The methodology is to interview 12 people who have had breast cancer and counselling therapy using a few open ended questions. In addition there will be also time and space in the interview to explore individual journeys and reflections. The interviews will then be transcribed and specific themes of what is helpful and not helpful across all 12 interviews will be identified and evaluated.

Service user and carer involvement

This research project has been informed by my work at a cancer hospital as a Counselling Psychologist in Doctoral Training. I have worked there for 18 months and I am keen to develop the psychology service further to help breast cancer patients. The research will be used to help develop counselling psychology services for service users and carers.

Practical issues for research participants

If a participant decides to take part, they will be asked to take part in an individual interview with the researcher that would be audio recorded. The interview would last for approximately one hour in duration. The interview would be a conversation about their experience of therapy using a semi-structured interview approach, which will use a few questions to open up the discussion about their journey. The research would take place at a convenient location to the participant or over the telephone. Informed consent will be obtained through discussion about the participant information sheet with the participant in advance of the interview via telephone and/ or email and then via a signed consent form on the day of the interview. The participant has the right to withdraw at any point and this is made clear in the participant information sheet. As a professional working in a cancer hospital I will be especially sensitive to any vulnerability and further help the participant needs as part of the research interview and I will sign post them according to what help is available in their area and nationally. In addition reasonable travel expenses will be reimbursed. There is complete anonymity in any reporting of the research. All electronic data will be kept in password-
protected files and there will be no identifiable information contained within the write-up of the report. A participant will be referred to by a pseudonym in any written reports and any quotes used will be non-identifiable. These safeguards are in compliance with the University of Manchester regulations on data protection.
Dear Kate,

Thank you for addressing the comments made by our SURP members. I am happy to support this work going forward and help you recruit participants to your study. I can offer to place your study advert on our online forum, where we have a page dedicated to research studies.

The study can also be sent to our Breast Cancer Care Voices, who have a specific interest in participating in research.

I can send your advert out today to our Voices co-ordinator who can then circulate it on your behalf. Please do let me know if you receive any responses.

Kind regards, Jenny

Jennifer Finnegan-John
Senior Research Officer
Jennifer.Finnegan-John@breastcancercare.org.uk

Breast Cancer Care
5 - 13 Great Suffolk Street, London, SE1 0NS
Direct line: 020 7960 3424 Switchboard: 020 7960 3600

http://www.breastcancercare.org.uk/

Get together over a Strawberry Tea

Have a Strawberry Tea this summer and raise money for women facing breast cancer. Strawberries, tea, cake and friends are all the ingredients you need. Sign up today at www.breastcancercare.org.uk/strawberry and we’ll send you your free Strawberry Tea kit with everything you need to get started. Where will you hold yours?
Please consider the environment before printing this email.
Appendix f: Example email in response to first contact by potential participant, followed by approved participant information and consent sheet from The University of Manchester

-Email to potential participant in response to their first contact

From: Katherine Harrison <katherine.harrison-6@postgrad.manchester.ac.uk>
Date: 21 July 2014 16:10:38 BST
To: xxx
Subject: RE: Research proposal

Thank-you for expressing an interest in taking part in my research study.

I am interviewing people either face to face or over the telephone. Please let me know where you are based so we can work out the best option as I am in Manchester.

I have attached the participant information sheet, please review this information and if you are still interested in participating please let me know. I will then email you and arrange the interview. Interviews will take place at the end of August and in September.

Many thanks
Kate

Kate Harrison
Doctoral Counselling Psychologist in Training
The University of Manchester
- Participant information sheet

What are the helpful and unhelpful processes in therapy that individuals with a primary breast cancer identify?

Participant Information Sheet

You are being invited to take part in a research study that is being conducted as part of my work as a student undertaking a professional doctorate in counselling psychology. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?

The study will be conducted by Kate Harrison, a counselling psychologist in doctoral training from the School of Education, Ellen Wilkinson Building, The University of Manchester, Oxford Road, Manchester, M13 9PL.

Title of the Research

‘What are the helpful and unhelpful processes in therapy that patients with a primary breast cancer identify?’

What is the aim of the research?

The aim of this study is to explore the helpful and unhelpful process in therapy that individuals with a primary breast cancer

Why have I been chosen?

You have been chosen to participate in this study as you are an individual that has a primary breast cancer and you have had therapy. If you decide to participate, you will be one of approximately 12 participants contributing to this study.

What would I be asked to do if I took part?

If you decide to take part, you will be asked to take part in an individual interview with the researcher that would be audio recorded. The interview would last for approximately one hour in duration. The interview would be a conversation about your experience of therapy.
What happens to the data collected?

The audio recording of the discussion will be transcribed by the researcher. The audio recording of the interview will be deleted after transcription and the electronic document containing the transcription will be kept in a password protected file. Only the researcher will have access to the transcription. Some quotations may be used in the write-up of the research, but these will not be attributed to anyone in any identifiable way.

How is confidentiality maintained?

All efforts will be made to ensure that confidentiality is maintained. As mentioned above, the electronic data will be kept in password protected files and there will be no identifiable information contained within the write-up of the report. You will be referred to as a participant in any written reports and any quotes used will be non-identifiable. These safeguards are in compliance with the University of Manchester regulations on data protection.

What happens if I do not want to take part or if I change my mind?

If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

Will I be paid for participating in the research?

No

What is the duration of the research?

The duration of the research that you will be involved in, if you decide to participate, will be one interview that will last for approximately one hour.

Where will the research be conducted?

At a location convenient to the participant or over the telephone

Will the outcomes of the research be published?

The outcomes of the study will form part of a University thesis and there may be further publications in academic journals.

Contact for further information

Researcher:

Kate Harrison

Email: Katherine.harrison-6@postgrad.manchester.ac.uk
Supervisor:

Terry Hanley, Lecturer in Counselling Psychology, at the University of Manchester

Email: terry.hanley@manchester.ac.uk

Phone: 0161 275 8627

If there are any issues regarding this research that you would prefer not to discuss with the researcher or his supervisor, please contact the Research Practice and Governance Co-ordinator by either writing to 'The Research Practice and Governance Co-ordinator, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research-Governance@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093
Exploring the helpful and unhelpful processes in therapy that individuals with a primary breast cancer identify?

**CONSENT FORM**

If you are happy to participate please complete and sign the consent form below

<table>
<thead>
<tr>
<th>Please Initial Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information, ask any questions and have had these questions answered satisfactorily</td>
</tr>
<tr>
<td>2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason</td>
</tr>
<tr>
<td>3. I understand that the interview will be audio recorded and transcribed</td>
</tr>
<tr>
<td>4. I agree to the use of anonymous quotes in any write-up</td>
</tr>
<tr>
<td>5. I agree that any data collected may be published in anonymous form in academic books or journals</td>
</tr>
</tbody>
</table>

I agree to take part in the above project:

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
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Appendix g: Confidentiality agreement from transcription service

Confidentiality Agreement

I, Amanda Forshaw, HEREBY UNDERTAKE :-

1. That in undertaking the audio transcription of interviews recorded by Kate Harrison, I will keep confidential from all persons :-

   (a) all information made known to me during the course of such transcription;
   (b) any recordings in writing or otherwise which I may make of such information;
   (c) any storage on computer or other mechanical device of such information;
   (d) all and any other records whatsoever in respect thereof.

2. Upon completion of audio transcription and final approval and despatch of the typed documentation to Kate Harrison I will confidentially destroy, delete or surrender to Kate Harrison all such reports, records or documentation or other means of recording as detailed above.

3. That I will not retain any originals or copies of such documentation for my own use or the use of others.

DATED 1st September 2014

SIGNED
Appendix h: Sample part of transcript for TV02. Note: Full transcripts not included because of the sensitive nature of the material.

K: It will be last about an hour but it could be shorter if we have gone through all the questions, and you have the right to withdraw at anytime

V: Yeh

K: Ermm and you have checked the information sheet and signed that if you have any questions just ask me

V: Ok

K: I am just going to ask you about your experience of therapy and in terms of what your personal experience is so the first thing I am going to ask is of the events in the therapy you had following the breast cancer what were the events that were helpful? What helped?

V: What events in therapy?

K: Yes because my research is about

V: Or how did therapy help with the breast cancer?

K: Yes

V: It helped with all of it

K: Ok

V: It was such a shocking thing to get the diagnosis because working in palliative care cancer means death

K: Yeh
V: And so for me you know I think all of us who work in the hospice tend to be quite, when you get a headache you think you have a brain tumour

K: Cause you see so much

V: Yeh And then so far to actually get the full diagnosis to me just felt that what I know cancer is people die I don’t know it is not in my family

K: Right

V: There is not a history of it so you know it’s the patients I work with so it felt it was death so it was very traumatic

K: Yeh

V: So it was the whole process of what that would mean if I were to die who would be how would the children cope how was my husband to cope

K: Yes

V: So it was the whole process of thinking through all of that which I think I needed to do as well as getting it into perspective to serve some sort of recognition that maybe you don’t have to die

K: Maybe the link isn’t directly there even though you have the palliative care background. So was it helpful to have a separate place rather than talk to friends and family

V: Yeh yeh well its overwhelming for friends and family I suppose because they are all caught up with it, my husband isn’t fantastic talking about that, I have friends I talk to, but it is very nice to have a protected space you don’t ermm have any other obligations to anyone, just primarily for you, you don’t feel greedy if you are taking time up so you can use it just for yourself you don’t have to share it
K: Yeh ok

V: When you are with friends you do, so that was lovely

K: And so your therapist what kind of characteristics did she have? Can you remember what she was like?

V: Err very quite human

K: Was she?

V: And quite warm and erm because I was in therapy in the past

K: Ok

V: And that was very different

K: So you could compare it in a way

V: In the past it was Freudian

K: Oh psychoanalytic quite different

V: Lying on a coach, completely different, quite persecutory really and this was different, warm she was attachment based

K: Ok, yes so she was looking at transactional analysis

V: The relationship is just key, all about early attachments experience and also the attachment relationship with the therapist is quite crucial in helping you through the and how that interplays with the cancer

K: Yeh

V: Yeh and your capacity to be able to cope with stress

K: Yeh so that characteristic she had in terms of being warm
V: Yeh

K: It sounds like genuine human

V: Yeh

K: That created a kind of relationship between you two

V: I felt that she cared and that felt really important

K: Cared for you personally in what you were going through

V: Yeh that I mattered to her and she wanted the best for me really

K: Yeh

V: Yeh

K: That’s interesting it is that relationship having that trust
Appendix i: Example memos from the open coding stage of a transcript, for TV02. Completed for all 11 transcripts

Transcript TVO2 – Memos 10/11/14

1. **T2.P1&4**: Therapeutic input helps throughout the whole cancer journey after medical treatment finished: Therapy seems to be a companion along a traumatic, confusing, bewildering journey. Especially alongside medical treatment helped V. But also open at the end after medical treatment finishes.

2. **T2.P1&10**: Regardless of your experience cancer is a shock: V works in a hospice and regularly sees end of life cancer patients. Breast cancer causes a fracture in life, a crisis, a trauma.

3. **T2.P1&10**: Association of cancer and death extremely high: The link of cancer to death is frightening. Brings a person’s mortality into centre stage. V sees this at her work in the hospice everyday.

4. **T2.P2&8**: Therapy a place to air concerns about responsibilities associated with female roles: Being a mother and a wife comes to mind. Women usually in a coping, caring for others role and they then wonder at diagnosis how they will cope. Self less. ‘How is my husband going to look after them?’

5. **T2.P2&8**: Therapy is a space to process the trauma: V needed somewhere to talk openly about her thoughts and feelings in her inner world about death.

6. **T2.P2**: Therapy uses to gain a perspective on the breast cancer: This crisis needs time, helps to have someone to give different perspectives

7. **T2.P2&4**: Therapy provides a boundaried, protected, safe, open and guiltless space. This is helpful as a person can be really open and honest and not worry about hurting someone: Breast cancer patients don’t want to hurt those closest to them by telling them they have these very real fears and worries. If this bottles up it could turn into something more difficult to cope with; full blown depression or Generalised Anxiety Disorder or panic attacks. Able to put self first. Is this a specific area that women struggle with? Carving out time for themselves difficult.

8. **T2.P2**: Therapy is helpful as it is a space you don’t have to share with family or friends: Therapy provides freedom to focus on self.


10. **T2.P3&4**: Therapeutic relationship based on trust and care: The relationship is based on trust, care, security and is open. Provides a little certainty and consistency on an uncertain journey. Person feeling vulnerable


12. **T2.P4**: Helpful if therapy is personally recommended rather than comes from a leaflet. People don’t know what they need, they often don’t know how can therapy help.

13. **T2.P4&6**: Therapist is non-judgmental, accepts people where they are: Don’t have to put on a mask. Don’t have to put on a brave face. Don’t have to be positive. Can talk about it or don’t have to. If a person not functioning to a 100% it doesn’t matter.

14. **T2.P4**: Therapeutic space gives breast cancer patient some control: Can control when they have it, what happens in the session.

15. **T2.P4**: Therapy provides a space to share some of the burden on a person’s shoulders: Breast cancer is a heavy weight, the treatment is harsh, there are thoughts of reoccurrence and death.
T2.P5: Therapy helps to unblock stuck-ness: Therapy helps people process what is going on, to move forward.

T2.P5: Therapist doesn’t need to have cancer knowledge: Therapist relational qualities and personal attributes enough.

T2.P5: Therapist a women: Similar outlook, familiar and same age helped relating. Made it easier to talk about breast cancer, could be really open. Talk about intimate issues.

T2.P5&6: Relational depth helped to relieve and not add to distress: Built because therapist was a good match. Made it easy for V to express her self. Made it easy to trust her. Therapist interacted, warm not distant or cold.

T2.P6&7: Helpful if therapy easily available and easily accessible at diagnosis at the hospital and beyond: Therapy needs to be offered, available straight away and offered later on as a normal part of breast cancer diagnosis. The intensity of the experience at this point could be processed in therapy or therapy could be taken up later on. Should everyone have a quick chat with a psychologist at diagnosis? Practical?

T2.P7: Therapy helps process the overwhelming intensity & un-realness of diagnosis: It is happening to you. Overwhelming experience. Unbelievable. Person can dissociate as a defence mechanism.

T2.P7: Pressure to return to being an attractive woman: Look good feel better freely available. Trying to put a mask on pain and treatment side effects.

T2.P8: Therapy helps to discuss specific individualized issues: It may be a relationship, a side effect or existential issues.

T2.P9: Therapy can help with self through the crisis of diagnosis and the harshness of treatment: Breast cancer diagnosis a trauma, intense and threat. Body on high alert. Adrenalin flooding. Fight or flight reaction triggered. Can become highly sensitive to perceived as well as real threats. Treatment harsh. Breast cancer patients not ill at start, the treatment makes them ill and fatigued. They can lose themselves.

T2.P9: Therapy helps to come to terms with cancer immersing a person’s life: Cancer changes the pace of life, slows down, can’t work, can’t be as active because sick or fatigued or worried about catching a bug because immune system low.

T2.P9&10&11: Therapy after breast cancer crisis can help to adjust, shift self to be focused on a person’s own terms: It can help a person with breast cancer put their needs first. Make the choices in their life that they really what. Can build confidence and resilience. Person put back in control in a way again, can’t control the cancer coming back but can control who they spend their time with and what they want to do with their time.

T2.P10&11&12: Therapeutic protected space lives on without the therapist: The person learns how to put themself first in therapy and this extends after therapy; protecting their time and creating their own boundaries in their life. Making the choices they want. Trying not to focus what they can’t control, focus on what they can control. ‘More on top of life’

T2.P12: Breast cancer and therapy helps a person learn to be in control of what they can: ‘I think years ago I was avoidant’. Now V has the courage to face things. It puts a person in the driving seat of their life in terms of what they can control.

T2.P12&13: Therapy helped V be more compassionate: Threat system high, bringing out kinder self-soothing side helps when faced with a traumatic experience. Paul Gilbert’s work on 3 emotional regulation systems.

T2.P13: Therapy provides an external perspective: This can help to validate your experience from an other’s perspective. This is reassuring.
31. T2.P13: Therapy helps a person have access to another’s head which is not in the grip of a trauma: Think of other ways round a problem. Has distance from a person but cares for the person. ‘It is just like having a wiser head’. Talk things through. Be honest, not have to censor what you say about your thoughts or feelings.

32. T2.P14: Therapist stands alongside a person: A support through uncertainty, on your side, can help.

33. T2.P14: Therapy helpful if available to all but a personal choice to take it: Not everyone would want it.

34. T2.P15: Therapy location needs to be easily accessible: Therapy needs to be accessible location wise. People may be ill or fatigued, not feeling 100%, they don’t want to travel far.

35. T2.P15: Therapy not at hospital: Away from medical side
1. **HAVING ACCESS TO ANOTHERS HEAD**
The therapist has skills and knowledge.

They are skilled at listening (TS05: 2, TV06: 6, TS10: 15). The therapist has the ability to provide another perspective (TE08: 9). There is another head that you can have access to ‘a wiser head’ (TV02: 13).

A therapist’s cancer knowledge can help empower the person by providing information and normalising emotions and thoughts around diagnosis, treatment and survivorship (TS05: 2, TV06: 6&11, TS10:8).

The therapist is more of an equal, yes they have expertise but they are not being an ‘expert’ when they meet you. (TE03: 7)

2. **EXPERIENCING MALE / FEMALE THERAPISTS AS HELPFUL**
There were women who found they preferred working with female therapists (although they hadn’t worked with a man) because they felt they could relate better because of commonality of sex, age and culture (TV02: 5) or be more open (TJ01: 5). Others found male therapists helpful as they offered a different perspective and didn’t inject any of their own personal experience in the therapeutic space (TL07: 2). One person commented that she liked the fact the male therapist had power, expertise, was direct and at the same time looked after her (TS10: 4).

3. VALUING THE PERSONAL QUALITIES OF THE THERAPIST
The personal qualities of the therapist were mentioned many times across the transcripts.

The therapist provided emotional warmth (TJ01: 4, TV02: 3); they were trustworthy, open and approachable (TJ01: 4, TM04: 5, TS10: 8&14). The therapist was talked about as being charming and funny (TS10: 14). They provided ongoing support, reassurance, comfort; they were being real and human (TE03: 3&4, TS10: 10).

The therapist was also talked about as being calming, patient, objective and helping the person to relax (TS05: 2&5, TL07: 2&6). Some emphasized the caring side of the therapist or their gentleness, or their kindness (TV02: 3, TE03: 2&7, TM04: 5, TE08: 9, TL09: 14).

Another person described the therapist as easy going and laid back (TV06: 6).

The therapist was also seen as non-judgmental, non-conditional and not patronizing (TE03: 6, TL07: 2&5).

Note: There were also therapists’ personal qualities associated with experiences of psychoanalytic that were not helpful: Being cold, harsh, rigid and focusing too much on the past (TV02: 3, TL07: 4, TH11: 3&6).

4. EXPERIENCING THE THERAPISTS LIMITED SELF-DISCLOSURE AS INCREASING OPENNESS AND RELATIONAL DEPTH
There were three transcripts that mentioned their therapist’s self-disclosure and all in a positive way. It helped in two ways person to open up (TE03: 6, TV06: 7) and it helped to develop a stronger connection between the person and the therapist (TS10: 9).

5. RECOGNISING THE THERAPY NEED BY THE OTHER NOT BY SELF
It seems that often the therapy need was recognised by a trusted other:

A friend of a friend my recommend it (TJ01: 13) or someone who worked at their GP practice (TV02: 4) or by their surgeon (TL07: 1) or by a nurse (TS10: 3).

The therapy need was often not recognised by self:

This was a striking finding as it showed the importance of health care staff recommending psychological therapy to patients, as they often don’t know what it is and how it might help (TJ01: 1, TS10: 1). There is probably a stigma about psychological therapy being for a
mentally ill person, but it is also for people who have to adjust to a major life event like cancer diagnosis and treatment. People can turn down therapy a few times along their journey as they battle to just get through the harsh treatment regimes (TM04: 7). They have to be ready to accept it (TL09: 19) but they also must have it offered a number of times by a trusted person.

It also points to the question on whether leaflets given to people when they have their diagnosis or start treatment can get all the people who need therapy into therapy.

6. APPRECIATING ACCESSIBILITY AND FLEXIBILITY OF THERAPY
The therapy was often described as easy to access and readily available (TV02: 6, TE03: 14)

The psychological therapy contract was often described positively as flexible and very individualized (TJ01: 13). When real life got in the way, for example a person was ill through the treatment, then sessions would be moved with no penalty (TE03: 4).

In addition people valued an open-ended contract so they could return to therapy if they needed to (TJ01: 12, TE03: 1&15, TS05: 4, TS10: 9&15). The frequency of sessions was also noted as flexible (TL07: 3).

A person also mentioned that they needed therapy a number of times through their breast cancer journey (TE07: 3).

This accessibility also included the location of the therapy; some wanted it close to home rather than at the hospital, as they were fatigued and ill through the treatment (TV02: 15).

Note: However others described therapy as unhelpfully ending too soon (TL09: 19) or waiting via their GP for a long time for therapy (TH11: 4) or having many false starts in therapy with different therapists (TH11: 6). Therapy was described as too short by one person who had 6 sessions (TH11: 6).

7. VALUING AN APPROACH TO TREATMENT THAT IS WHOLE PERSON CARE – PSYCHOLOGICAL AS WELL AS MEDICAL
There were many comments about how an approach to the treatment process that treated the medical and the psychological simultaneously helped.

The psychological therapy helped people to find the strength to continue with the harsh medical treatment (TJ01: 11). People felt better when they were treated for both sides along their breast cancer journey (TE03: 14, TM04: 7, TL07: 3). They experienced therapy as a constant thread through the medical treatment (TS10: 14).

The women often said when they were being interviewed that they wanted and wished for this for all other breast cancer patients (TM04: 7&8)

TL11 wanted to be treated as a whole person in terms of all her psychological side not just the cancer ones, she was told she was too complex and this traumatizing as the cancer...
experience had reminded her of the child sexual abuse she suffered (TL11: 5&6). She wasn’t treated as an individual.

8. **BEING HELPED TO ACCEPT & IN SOME WAY DEAL WITH EMOTIONS AT THE END OF MEDICAL TREATMENT AND BEYOND**

It was also help if the psychological therapy could continue after the medical treatment was all over (TV02: 4). Often at this point people really struggled they had had their medical treatment, they didn’t need to go to the hospital as regularly and their friends and family thought they should be back to normal, but often the emotions they had been holding in when they were focusing on getting through the grueling treatment came out. In therapy they were helped to accept in some way what had happened and to not avoid (TJ01: 8, TV02: 12, TE08: 5). They felt different, not the same person.

One said the ‘hits and the waves’ of the cancer journey they had had would probably continue in life (TE03: 18).

9. **HAVING PROTECTED SAFE TIME & SPACE IN THERAPY FOR SELF**

The women talked about the therapy space as 100% theirs, they didn’t have to share it with anyone, it was protected and it was confidential. The space was guilt free they didn’t have to worry about the therapist’s feelings or thoughts (TJ01: 14, TV02: 2, TS05: 1, TL07: 2).

10. **BEING ABLE TO OFFLOAD / EXPRESS REAL FEARS WITH NO GUILT OR SHAME. HAVING TO PROTECT FAMILY AND FRIENDS FROM THESE FEARS.**

This was a repeated process that was mentioned to be helpful. People felt that they could be honest and open to the therapist about their real fears without worrying about the therapist. They could vocalize their fears out loud and open up (TV06:12&16)

They did not have to protect their therapist in the same way as they did with their family and friends (TJ01:2&3&15, TS05:1&2, TL07:3, TS10:13). This gave people a guilt free space to open up freely, offload so they did not become a ‘pressure cooker’, keeping their true internal worries to themselves, closed off (TJ01:16, TM03:3, TV06: 4&5&9, TL07:5, TL09: 12&13&15). This process often reduced the distress somewhat as they were able to express their feelings and thoughts (TJ01:2, TE03:7, TV06:10).

They were able to express their fears about death (TV02:1&8, TV06:5) which they could not express to family or friends (TV06:4). Saying the unsayable.

The therapist psychologically held the tension and was able to deal with their inner thoughts and emotions. The therapist was robust enough to manage the tension whilst at the same time providing a safe and compassionate space (TL09:14).
11. CENTRAL CATEGORY? MAKING SENSE OF EXPERIENCE, NAVIGATING, PROCESSING LIFE THREATENING ILLNESS AND HARSH TREATMENT – GOING FROM WELL TO ILL BECAUSE OF TREATMENT FOR BREAST CANCER.

The therapist was there to bounce things off to make sense of the experiences a person was having on their cancer journey (TJ01:3). They were helped along, moved forward? They were helped to understand, ‘unscramble’ (TV06: 5) what was happening to them psychologically (TV02:5, TE03:10, TM04:5, TV06:14, TL07:2&6, TS10:18). This involved sometimes going deeper into the experience psychologically with the therapist than they could with their medical team (TM04:4).

A person could be helped to make sense of existential areas like their own mortality (TE08:7). They could be helped to process the past (TL09:8&9&16). Or they could be just working out what was happening along the treatment phase, ‘smoothing’ the journey at this point (TS10:14).

12. NORMALISING THOUGHTS AND FEELINGS IN THERAPY

The therapy encouraged people to feel ok about admitting their vulnerabilities (TE03:7). It helped to normalize what was happening to them physically (e.g., fatigue, nausea) and psychologically (TJ01:2). Specifically thoughts and feelings were talked about as being ‘ok’ and being normal (TV06:14&16, TL09:12, TS10:4).

Note: One person described how it was unhelpful to be labeled given a diagnosis of ‘health anxiety’ (TE08:9). This was traumatic as they had gone so much with having cancer that it would be odd if they different have some anxieties about their health after that.

13. BEING HELPED TO REFRAME / RESTRUCTURE COGNITIVELY AND TO FOCUS ON HELPFUL BEHAVIOURS (CBT SKILLS)

People mentioned that is was helpful to be encouraged to recognise and notice the negative thoughts they were having and how they were directly affected their mood (low) (TE08: 4&6). They learnt how to reframe their thoughts, restructuring them to be more helpful (TV06:5&14, TE08:8). This helped to reduce rumination (TE08:8).

One person talked about reframing a situation about a second breast reconstruction operation as helpful as it stopped their guilt about taking up a surgeon’s time for a cosmetic reason as their first reconstruction had not produced a good result (TS10:5). They were helped to problem solve for themselves – what did they need to know to reduce their fears (TS10: 15).

Another area mentioned was identifying behaviour that was not helpful (TE08:4). In addition it was helpful when the therapist helped the person focus on behavioural activation and goal setting (TL07:4&6).
14. **LEARNING PRACTICAL COPING SKILLS (RELAXATION / VISUALISATION / MINDFULNESS)**

The women talked about how it was helpful to be taught practical coping skills, strategies and tools. Relaxation, mindfulness and visualisation helped people to relax and in one case helped by enabling blood to be taken (TM04: 6, TS05:3, TV06:3).

It was important to some that the space was not just a place to be listened to, they wanted to be helped to learn practical skills to cope between therapy sessions and after therapy (TE08: 2&5).

15. **BEING GIVEN PERMISSION TO PUT SELF FIRST**

There was a theme mentioned by the women about how therapy helped them to put themselves first (TL09: 10, TS10: 5&7). They allowed themselves to be cared for which was unusual as they were so used to caring for others (TE03: 13). They were worried about others for example if they died not themselves (TV02: 2&8).

16. **BEING EMPOWERED TO GET MEDICAL ANSWERS TO REDUCE GUILT OVER RECONSTRUCTIVE BREAST SURGERY**

One woman talked about how her therapist enabled her to ask specific questions of the medical team that would reduce her worries (TS10: 5&6&7&16&17). She was empowered to take the consultant’s time to get the specific answers she needed to enable her to get a clearer picture of how her second reconstructive surgery would look. The therapy space was used to investigate in detail what she needed to know and how she could best get the answers she needed.

17. **PUTTING LIFE BACK TOGETHER AGAIN THROUGH THERAPY**

A metaphor of a stained glass window was used by one women to describe how her life was being put back together slowly through therapy and that it could be more beautiful than before (TS05:4). Another person talked about experiencing falling to pieces and being put back together slowly in therapy (TL07: 6&7).

Another women talked about how she was helped in therapy to reprioritize her life for the better (TV02:10).

18. **BEING HELPED TO TAKE SOME CONTROL AGAIN**

Cancer throws people into an uncertain situation where they often suddenly realize they can’t control what is happening with the cancer and with the treatment (TS10:12). Through therapy the women talked about how they were helped to take some control over their life back again, they were encouraged to be more in control of what they could be (TV02:11). This was small steps often (TS10:12).

One women talked about shaving her hair off before the chemotherapy caused her hair to fall out, this person wanted some control over the situation she said (TV06:7).
19. GAINING POST-TRAUMATIC GROWTH BECAUSE OF BREAST CANCER AND THERAPY
People talked about experiencing a positive shift because they had experienced a crisis and they were helped to process this in therapy (TV02:11). They talked about seeing friends they wanted to, being boundaried with their time at work and socially.

There was a theme about becoming more confident, building psychological strength and resilience because of the breast cancer and working through this in therapy (TV06:17, TV02:9).

20. THERAPY ENABLED PEOPLE TO LOOK TO THE FUTURE AGAIN
The breast cancer stopped people in life. Life was on hold. They did not feel they could look to the future as they felt this was uncertain. They seemed not to be able to move forward with their life, therapy helped to unblock this (TE08:4, TS10:10, TL07:5).

21. VALUING INDIVIDUALISED THERAPY, PERSONAL APPROACH
One women talked about the importance of being allowed to experience the journey personally, not being told by the therapist what could happen (TE03:9). Others talked about the importance of individualized therapy materials from a CBT perspective as they felt it was unhelpful to have generalized CBT worksheets when they were struggling with a very real threat to their life, not an imagined fear (TJ01:7).

Note: It was unhelpful when the therapy was impersonal: therapist they were seeing changed, when assessments were completed over the phone (TH11:2&6).

22. BEING HELPED TO BE MORE FLEXIBLE LESS RIGID
One woman talked about how they were helpful to adjust their coping style to be more flexible (TV02:11). They related this to attachment theory and this links to the development of often rigid beliefs about self, others and the world.

23. BEING DIRECTED TO THE INFO THEY NEEDED TO REDUCE WORRIES
One woman spoke about how their therapist directed them to the information they wanted and needed to reduce their worries (TJ01:7). This was specifically about their diet.

24. BEING HELPED TO BE COMPASSIONATE TO SELF
One women talked about how they were supported to be less judgmental to self (TV02:12). They were being harsh to themself. They were helped to be kinder to self. This links to the work by Paul Gilbert; Compassion Focused Therapy.
25. **HAVING A PHYSICAL SEPARATION IN THERAPY LOCATION**
Some of the women described having therapy away from the hospital setting as helpful (TJ01:6, TV02:7). They found peace in this rather than experiencing the anxiety of going back to the place which made them ill through the treatment or was where they were told bad news about diagnosis or treatment or where they had uncomfortable and anxiety provoking medical tests.

Note: One person wanted their therapist to support them over the phone too and if they had had the therapeutic relationship for longer they would have called them, but it was early on in the therapy and they didn’t feel able to. Maybe therapists should say that if people are ill or tired and they can’t come in because of surgery, chemo or radiotherapy they can have a therapy session or support over the phone, (TS05:5).

**OTHER THEMES FOUND NOT ABOUT HELPFUL PROCESSES:**

26. **RECOMMENDING THERAPY TO OTHERS BECAUSE OF PERSONAL EXPERIENCE**
Many of the women wanted therapy to be available to other women who had breast cancer, they did not want people to go on the journey without the psychological support (TL07: 7, TE08: 5, TL09: 18, TS10:14). It should be a normal part of the breast cancer treatment, it should be routine (TM04:8).

Although they acknowledged that some would not think they needed it. There was a sense that some had taken up therapy later in their journey not at first. Early on some people were using all their energy just to get through the harsh treatment. They felt it should be available throughout the journey, on a number of occasions being personally recommended by the medical team.

27. **EXPERIENCING THE PAIN OF THE TREATMENT NOT BREAST CANCER**
The women often spoke about the harsh, gruelling treatment not the pain of the breast cancer (TV06: 6). There was a vivid metaphor used by two women about how the breast cancer treatment was a ‘dark tunnel’ to get through (TL07:8, TL09:18). This description felt like the women were alone, the road was long and they couldn’t really see what was really going on, they just had to keep going.

The treatment happened quickly after diagnosis, they were moved very quickly into treatment (TS10:2). They had little time to process what was going on, their thoughts and feelings. They felt forced to move through treatment quickly (TJ01:10).

28. **EXPERIENCING CANCER AS LIKE BEING IN A DIFFERENT CULTURE**
The experience was like being part of a different culture that their family and friends were not in; being treated in a cancer hospital, by specialized cancer staff, going for a wig fitting for example were their new world (TE03:17). They wanted their family to see it to help them understand their new environment.

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29. **LAUGHTER HELPED WITH OTHER PEOPLE, SOME OF WHOM HAD CANCER**
It helped to relieve anxiety, it helped to raise their mood, it helped them to keep going, keep fighting. Some times this was a support centres like hospices (TV06:13). It helped to feel able that they could laugh and it gave them relief (TJ01:9).

30. **EXPERIENCING BODY LOSSES AS EMPOWERING OR DISEMPOWERING (BREASTS, HAIR)**
The body losses were empowering to one person, they described their breast as ‘superfluous’ (TV06:2). For others facing the loss of a breast made them feel ‘scared’ (TL09:3). They were traumatised about two things death and the loss of their hair, (TL09:7). Equating facing the loss of their hair with the same kind of fear as facing the loss of their life was a powerful insight into how important a person’s hair was their sense of self.

Another felt that they had been violated which brought back memories of sexual abuse, they suffered many body losses; hair, eyebrows and breasts and this was extremely traumatic and retraumatising. Their identity was being threatened (TH11:2).
Appendix k: Diagram development for theoretical coding from axial/focused coding stage for helpful aspects version 1 through to final version 6:

Version 1: 22/12/14

**Causes (active variables)**
1. Having access to a wiser head
2. Valuing the personal qualities of the therapist or not
3. Experiencing the therapist’s self-disclosure as increasing relational depth
4. Experiencing the therapy need, not self
5. Others recognising the therapy need, not self
6. Valuing a whole person approach or not wanting just a medical approach
7. Having protected safe space & time for self
8. Valuing individualised personal approach to therapy, not wanting generic therapy materials
9. Experiencing the pain of the treatment not the breast cancer
10. Experiencing body losses as empowering or disempowering

**Context (background – moderating variables)**
2. Experiencing male / female therapists as helpful
3. Appreciating accessibility and flexibility or not having this
4. Experiencing cancer as like being in a different culture

**Phenomenon – mediating variables**
25. Having a physical separation in location for therapy or this not needed

**Intervening conditions**
8. Having psychological support continuing after medical treatment stops
9. Being able to offload / express real fears with no guilt or shame
11. Making sense of experience, navigating and processing
12. Normalising thoughts and feelings in therapy or being diagnosed with health anxiety not helpful
13. Reframing thoughts and focusing on helpful behaviours
14. Learning practical coping strategies
15. Putting self first
16. Being empowered to ask medical questions
22. Being more flexible
23. Being directed to right information
24. Being helped to be compassionate to self

**Action strategies**
8. Having psychological support continuing after medical treatment stops
10. Being able to offload / express real fears with no guilt or shame
11. Making sense of experience, navigating and processing
12. Normalising thoughts and feelings in therapy or being diagnosed with health anxiety not helpful
13. Reframing thoughts and focusing on helpful behaviours
14. Learning practical coping strategies
15. Putting self first
16. Being empowered to ask medical questions
22. Being more flexible
23. Being directed to right information
24. Being helped to be compassionate to self

**Consequences Intended or Unintended**
17. Putting life back together
18. Being helped to take some control again
19. Gaining post traumatic growth
20. Being enabled to look to the future again
26. Recommending therapy to others because of personal experience
29. Laughter helped

**Axial Coding**
Version 3: 23/12/14, Axial coding to central category

Central phenomenon: Helpful and unhelpful processes in psychological therapy for breast cancer patients

Context; background – moderating variables
28. Experiencing cancer as like being in a different culture

Conditions; causal
5. Others recognising the therapy need, not self
21. Valuing individualised personal approach to therapy or not having this being unhelpful
27. Experiencing the pain of the treatment not the breast cancer
30. Experiencing body losses as empowering or disempowering

Interactions
4. Experiencing the therapist’s limited self-disclosure as increasing the depth of the relationship
6. Appreciating accessibility and flexibility or not having this as unhelpful

Conditions; Intervening
1. Having access to a wiser head
2. Experiencing male / female therapists as helpful
3. Valuing the personal qualities of the therapist or having a cold therapist as unhelpful
7. Valuing a whole person approach or not having this as unhelpful
8. Having psychological support continuing after medical treatment stops
9. Having protected space & time for self
25. Having a physical separation in location for therapy or this not being mentioned

Strategies of action
10. Being able to offload / express real fears with no guilt or shame.
12. Normalising thoughts and feelings in therapy or being diagnosed with health anxiety not helpful
13. Reframing thoughts and focusing on helpful behaviours
14. Learning practical coping strategies
15. Being helped to put self first
16. Being empowered to ask medical questions
22. Being more flexible
23. Being directed to the right information
24. Being helped to be compassionate to self

Consequences; Intended or unintended
17. Putting life back together with therapist
18. Being helped to take some control again
19. Experiencing post traumatic growth
20. Being helped to look to the future again
26. Recommending therapy to others because of personal experience
29. Laughter helping
**Phenomenon – Helpful and unhelpful processes in psychological therapy for breast cancer patients**

<table>
<thead>
<tr>
<th>Conditions/context</th>
<th>Action/interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTEXT:</strong></td>
<td><strong>VALUES THE THERAPISTS' EXPRESSIONS:</strong></td>
</tr>
<tr>
<td>BEING THROWN INTO THE BREAST CANCER WORLD:</td>
<td>1. Having access to a wiser head</td>
</tr>
<tr>
<td>27. Experiencing the pain of the treatment not the breast cancer</td>
<td>4. Experiencing the therapist’s self-disclosure as increasing relational depth</td>
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<td>28. Experiencing cancer as like being in a different culture</td>
<td><strong>HAVING CONTINUING SUPPORT:</strong></td>
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<tr>
<td><strong>CONDITIONS:</strong></td>
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<tr>
<td>- VALUING THE PERSONAL QUALITIES OF THE THERAPIST:</td>
<td><strong>BEING ENABLED TO EXPRESS SELF:</strong></td>
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<tr>
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<td>10. Being able to offload / express real fears with no guilt or shame.</td>
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<tr>
<td>3. Valuing the personal qualities of the therapist or not</td>
<td><strong>BEING TAUGHT NEW COPING SKILLS:</strong></td>
</tr>
<tr>
<td><strong>HAVING PSYCHOLOGICAL NEED RECOGNISED BY OTHERS:</strong></td>
<td>11. Making sense of experience; navigating and processing (CENTRAL CATEGORY)</td>
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<tr>
<td>5. Others recognising the therapy need, not self</td>
<td><strong>BEING HELPED TO EMPOWER SELF</strong></td>
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<td>16. Being empowered to ask medical questions</td>
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<td>25. Having a physical separation in location for therapy or this not being mentioned</td>
<td><strong>BEING TREATED INDIVIDUALLY</strong></td>
</tr>
<tr>
<td><strong>BEING TREATED AS A WHOLE PERSON:</strong></td>
<td>21. Having individualised personal approach to therapy, not wanting generic therapy materials</td>
</tr>
<tr>
<td>7. Valuing a whole person approach or not wanting just a medical approach</td>
<td><strong>BEING HELPED TO PUT ACTIVE SELF BACK TOGETHER AGAIN AND GAIN AGENCY:</strong></td>
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<tr>
<td>8. Having protected safe space &amp; time for self expression</td>
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**Consequences**

**Intended** or **Unintended**

BEING HELPED TO PUT ACTIVE SELF BACK TOGETHER AGAIN AND GAIN AGENCY

17. Putting life back together
18. Being helped to take some control again
19. Gaining post traumatic growth
20. Being enabled to look to the future again
26. Recommending therapy to others because of personal experience
29. Laughter helping
Phenomenon – Helpful and unhelpful processes in psychological therapy for breast cancer patients

**Conditions/context**

**CONTEXT:**
BEING THROWN INTO THE BREAST CANCER WORLD:
27. Experiencing the pain of the treatment not the breast cancer
28. Experiencing cancer as like being in a different culture
30. Experiencing body losses as empowering or disempowering

**CONDITIONS:**
- HAVING PSYCHOLOGICAL NEED RECOGNISED BY OTHERS:
  5. Others recognising the therapy need, not self
- HAVING EASY ACCESS TO FLEXIBLE CONTINUING THERAPY:
  6. Appreciating accessibility and flexibility or not having this as unhelpful
  8. Having psychological support continuing after medical treatment stops
- VALUING THE PERSONAL QUALITIES OF THE THERAPIST:
  2. Experiencing male / female therapists as helpful
  3. Valuing the personal qualities of the therapist or not valuing them as unhelpful

**Actions/Interactions**

**BEING ENABLED TO EXPRESS SELF SAFELY:**
9. Having protected safe space & time for self expression
10. Being able to offload / express real fears with no guilt or shame.
11. Making sense of experience: navigating and processing
(CENTRAL CATEGORY)
12. Normalising thoughts and feelings in therapy or not having thoughts normalised as unhelpful
25. Having a physical separation in location for therapy or this not being mentioned

**BEING TREATED AS AN INDIVIDUAL WHOLE PERSON**
7. Valuing a whole person approach or not wanting just a medical approach
21. Having individualised personal approach to therapy, not wanting generic depersonalised therapy
23. Being directed to right individualised information

**ACCESSING THERAPISTS INNER SELF:**
1. Having access to a wiser head
4. Experiencing the therapist’s self-disclosure as increasing relational depth

**BEING HELPPED TO EMPOWER SELF**
15. Pulsing self first
16. Being empowered to ask medical questions

**BEING TAUGHT NEW COPING SKILLS**
13. Reframing thoughts and focusing on helpful behaviours
14. Learning practical coping strategies
22. Being helped to be more flexible
24. Being helped to be compassionate to self

**Consequences**

**Intended or Unintended**
BEING HELPED TO PUT ACTIVE SELF BACK TOGETHER AGAIN AND GAIN AGENCY:
17. Putting life back together
18. Being helped to take some control again
19. Gaining post traumatic growth
20. Being enabled to look to the future again
26. Recommending therapy to others because of personal experience
29. Laughter helping
CONTEXT: BEING THROWN INTO THE BREAST CANCER WORLD

CONDITIONS:
- HAVING PSYCHOLOGICAL NEED RECOGNISED BY OTHERS
- HAVING EASY ACCESS TO FLEXIBLE CONTINUING THERAPY
- VALUING THE PERSONAL QUALITIES OF THE THERAPIST

INTERACTIONS:
- BEING ENABLED TO EXPRESS SELF SAFELY
- BEING TREATED AS AN INDIVIDUAL WHOLE PERSON
- ACCESSING THERAPISTS INNER SELF

ACTIONS:
- BEING HELPED TO EMPOWER SELF
- BEING TAUGHT NEW COPING SKILLS

CONSEQUENCE:
- BEING HELPED TO PUT ACTIVE SELF BACK TOGETHER AGAIN
Appendix I: Diagram for theoretical coding from axial/ focused coding of unhelpful aspects dated 3/1/15.