Posttraumatic Growth as a Discursive Resource for Managing Identity after Breast Cancer:

Implications for Theory and Counselling Psychology Practice.

Jennifer Marie Hitchins

Thesis submitted in partial fulfilment of requirements for the degree Doctor of Psychology

Research Supervisor: Dr Anna Butcher

Department of Psychology

London Metropolitan University, London

2015

Acknowledgements

I am very grateful to the women who took part in this research, and gave up their time to talk with me.

I also express my thanks to my research supervisor Dr Anna Butcher, for her guidance and encouragement, and to my close family and friends who have supported me so well through the last four challenging years. Particular thanks are due to Beth Hore, Isabel Henton, John Baxter, and Kasia Campbell.

This thesis is dedicated to the memory of two very special men: David Hinds, who demonstrated the value of dedication, perseverance, and an inquisitive mind throughout his life, and also to Michael Hitchins, who consistently gave so much of himself for the benefit of others.

Abstract

Previous research conceptualises posttraumatic growth (PTG) as a phenomenon experienced by some people after breast cancer. In this thesis, I consider an alternative understanding of PTG; as discursive identity performance in the context of breast cancer survivorship. First, a critical review of literature on PTG after cancer is presented, with attention to rigour and methodological diversity and also with regard to the fit between existing research and counselling psychology values. It is concluded that much of the existing research is framed within a realist perspective, and accordingly, accounts of PTG are viewed as stable internal beliefs rather than socially constructed ways of managing identity. The social context in which survivorship occurs has not been adequately explored and there is a paucity of work from within the UK, and especially from amongst counselling psychologists, who, arguably, have a significant contribution to make within the psycho-oncology arena. An area for research is marked out, from the epistemological position of social construction, to explore women's' accounts of life after cancer, and how they orient to and make use of PTG in this context. Following consideration of the approach taken (a synthesis of two forms of discourse analysis), I present my research with four women who were interviewed about their experiences of life after breast cancer. The analysis highlights the fine grained features of the women's talk as they manage their post-cancer identities discursively negotiating the social and moral obligation to survive well. A number of discourses, including the 'PTG discourse' are drawn upon, making a number of subject positions available. Notably, the PTG discourse closes down talk of troubles. Implications for theory, and for counselling psychology practice within psycho-oncology, are discussed.

Contents

1   Reflexive statement: part one

Reflexive practice is an essential part of counselling psychology research and practice (BPS, 2005), a vital activity to aid awareness of how our assumptions and interests shape our research and clinical practice (Etherington, 2004). In this statement I present the background to my choice of topic and some of my thinking during the research process, so that, as Coyle and Pugh (2000) put it, my speaking position as author is visible.

I first became aware of the field of psycho-oncology when, as a health psychology research assistant, I worked on a project exploring women's experiences of participation in a trial about quality of life following mastectomy. During the set up, I spent time with women who had experienced breast cancer, and I was surprised by the way they appeared almost desperate to tell their stories when afforded the opportunity to do so. I was left with the feeling that this was not usually given to them. I wondered why this might be.

Later, I observed an encounter between two friends, one of whom had recently experienced breast cancer. Claire (a pseudonym) had residual physical effects which she found hard to manage. I had seldom heard Claire talk about her cancer experience or life afterwards, but on this occasion I witnessed her telling a mutual friend about her physical difficulties. My friend's response caught my attention. She responded emphatically, 'But, you're alive!' Claire hesitated, but agreed. I recall interjecting that, although this was the case, the difficulties Claire was experiencing were significant, however the conversation quickly changed topic and I felt uncomfortable for us all. On one hand I shared my friend's gratitude that Claire was alive, and yet I realised that Claire was living in a world wholly different to the one she had expected, one in which talking about the downside of survival appeared to be tricky. Around the same time, I watched a television programme in which a man was choosing a tattoo. As someone living beyond cancer diagnosis and treatment, he chose the word 'survivor'. I wondered how this

identity had come to be taken up. From observing Claire's struggle and this man's actions, it seemed to me that there was perhaps a moral obligation to survive victoriously or gratefully, but also a hidden world where surviving was associated with cost. I was curious to know more. Such understanding, it seemed to me would be crucial to inform my future practice.

As I progressed through the literature review process I became acutely aware that an emphasis upon the notion of 'survivorship' dominates the research literature. I found myself at first caught up in this definition. I noticed that there did not seem to be an adequate way of writing about life after cancer that did not have implications for agency. The term 'survivor', I realised, is a far from neutral term, but is imbued with meaning. Later, my focus narrowed to looking at the notion of posttraumatic growth (PTG) following cancer, which I saw was attracting increasing research attention, much of which was amongst women who had experienced breast cancer. As my review continued I began to appreciate how contentious this might be, and that there was no research which took a discursive or critical approach. Little research into this proposed phenomenon was taking place in the UK, and within counselling psychology.

The concept of PTG became personally relevant during the research process and I therefore add my voice to those who write of their own experience of trauma (Galgut, 2010, 2012; Hozman, 2005; McKinley, 2000; Willig, 2009, 2011). Firstly, my father was diagnosed with a terminal illness (although not cancer) early in 2011, and this, combined with my trainee placement in a hospice bereavement service, gave rise to a desire to focus not on terminal illness but on 'survivorship'. Later in 2011 I experienced the traumatic and unexpected death of my husband (again not cancer related) alongside the death of my father. Afterwards, as I began to re-engage with my studies I began to reflect on my own adjustment following trauma. I asked myself whether I might say I had experienced PTG. I noticed how in conversation I found myself responding to other people's questions in ways that best suited their expectations. Often I was told I was 'brave', and found this hard to respond to. I had found myself in a place I had not

imagined, and most vividly noticed this in conversation with others. I had little voice. I felt something of what Willig (2012) calls, 'discursive capture,' in questions around how I was managing being widowed at a young age.

My own epistemological position as a researcher has shaped my reading of the literature on growth following cancer. My background in the use of discourse analysis, and of social construction generally, has provided a critical lens through which I viewed the literature. During the process of the literature review I reflected on the 'goodness of fit' between my own personal assumptions about the nature and role of language and the underlying assumptions of counselling psychology as a discipline. This was significant for my developing sense of identity as a counselling psychology trainee.

During the research process I took up a placement in the psychological service of a breast cancer unit. I contacted a counselling psychologist working in this setting to find out her experiences and reflections, and also the head of psychological services within another psycho-oncology setting. These conversations were useful to highlight the unique contribution that a counselling psychologist might bring to psycho-oncology research and practice. I was interested in how my practice might be informed from what I learned as I listened to the accounts of the women who kindly took part in my research, and those I saw in clinic.

2   Introduction

2.1   Cancer survival in the UK

In the UK, around 250,000 people are diagnosed with cancer each year and approximately 1.8 million people are living with, or beyond, a diagnosis of cancer (Department of Health [DOH], 2011). Around half of those diagnosed reach the ten year mark (Cancer Research UK [CRUK], 2011). This is largely due to improvements in screening, diagnosis and treatment. Certain cancer types have better survival rates, with most improvement happening amongst breast, bowel, ovarian and non-Hodgkin's lymphoma cancer (CRUK, 2011). However as the incidence of cancer increases with age so an increasingly ageing society bring with it more cases of cancer (National Institute for Clinical Effectiveness [NICE], 2004). The term 'survivor' has now entered popular language and is chosen to describe this population within the medical and research literature in general (Doyle, 2008). In her narrative review of the concept of cancer survivorship, Doyle studied varied literature from 1996 to 2006 and concluded that, although frequently used across many disciplines, 'survivorship' often lacked precise definition, but generally begins when acute treatment has ended and continues through the years afterwards where the individual has no known cancer.

2.2   The consequences of cancer

Despite increased survival rates, cancer remains 'a life threatening illness characterised by fear and uncertainty about the future and accompanied by intrusive medical procedures and aversive treatment, pain and fatigue, changes in social roles and relationships and other disruptions' (Stanton, Bower & Low, 2006, p. 138). Galgut (2010), writing from personal experience, as well as in reference to informal interviews with women who have experienced breast cancer, notes that, rather than a single trauma, the physical and psychological experience

4

of cancer presents as a series of traumas beginning with diagnosis, surgery and acute treatment, extending into the years beyond with long term treatments and fear of recurrence. Accordingly, cancer is now conceptualised as a chronic life threatening rather than acute illness (Tritter & Calnan, 2002). Not surprisingly, improved survival rates are accompanied by increasing recognition that adequate psychological support must be provided for this challenging period (Stanton, Ganz, Rowland, Meyerowitz, Krupnick & Sears, 2005). NICE guidelines state that people living beyond cancer should be supported to promote the best possible quality in life (NICE, 2004) and in addition, in 2007 the National Health Service (NHS) launched the National Cancer Survivorship Initiative (NCSI, 2010) in order to explore the key physical and psychological issues facing cancer survivors through research.

2.3   Can the experience of cancer promote positive growth?

While the negative consequences of cancer are evident, within recent years, and as 'positive psychology' has emerged (Seligman, 2002), increasing attention has been given to the possibility that when faced with a traumatic stressor such as cancer, positive outcomes can be experienced (Aspinwall & MacNamara, 2005; Sheikh, 2008). Zoellner and Maercker observe that this stance rejects a sole focus upon trauma as bringing deficit and psychopathology and define PTG as 'the subjective experience of positive psychological change reported by an individual as a result of the struggle with trauma' (p. 628). Perhaps the most prominent theory is that of Tedeschi and Calhoun (2004) who posit that in response to a significant external threat the ensuing struggle with suffering produces growth for some. This is envisaged to take place across three key domains; sense of self (e.g. increased strength); improved relationships with others; and a changed sense of life priorities or values. Consistent with Tedsechi and Calhoun's theory, Janoff-Bulman (1992) has also proposed that after experiencing a trauma, such as cancer, an individual's core assumptions about the world, the self and the relationship between the two

are severely challenged, forcing confrontation with questions about the meaning of life in order to preserve a sense of self-esteem and mastery. According to Janoff-Bulman, successful adjustment after trauma involves re-piecing together one's beliefs in order to make sense of them by reframing to find meaning. Similarly, Affleck and Tennen (1996) have introduced the term 'benefit finding' to describe the identification of an advantage as an outcome of experiencing adversity.

Although arising as a research focus alongside positive psychology, the notion of growth after trauma is far from new, but rather is 'central to much of both ancient and contemporary religious thinking' (Calhoun & Tedeschi, 2006 p. 4). The struggle to search for meaning in adversity is also a prominent feature of existential theory (Frankl, 1946; Yalom, 1980). In a recent edition of The Psychologist, one proponent of positive psychology, Joseph (2012) writes persuasively under a title containing the widely used (paraphrased) quote from Nietzstche (1888) 'what doesn't kill us makes us stronger' endorsing PTG. PTG, is positioned here within humanistic theory (Rogers, 1964) as the universal and innate tendency to move towards personal growth and fulfilment even in the face of adversity. Joseph urges practitioners across the disciplines of health, clinical and counselling to consider how they might draw upon theories of growth after trauma to help their patients (including those who have had cancer).

2.4   Counselling psychology and psycho-oncology

Psycho-oncology is an interdisciplinary field concerned with (1) the psychological response to cancer by the patient and their family and (2) the understanding of the role of psycho-social factors upon risk, diagnosis and survival. (Breitbart & Alici, 2009). It is an arena in which counselling psychology practice is increasingly involved (Hession, 2008; Paton, 1999), and one where there is opportunity for a unique contribution to be made (Mrdjenovich & Moore, 2004; Nicholas, 2013). Altmaier, Johnson and Paulsen (1998) assert that this is due to counselling

psychology's distinct identity and, accordingly, there is a call to consider the 'goodness of fit' between this branch of applied psychology and the health care setting. But what is it that is distinct about our profession? In the division's guidelines for professional practice (British Psychological Society [BPS], 2005) the core values and emphases of the discipline are set out. Emphasis is placed upon engaging with 'subjectivity and intersubjectivity, values and beliefs' (p. 1). Furthermore, we are to 'know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (p. 1). Rather than adopting a 'one size fits all' approach with a particular client group, counselling psychologists are open to diversity, curious about accepting that there are many ways in which we might understand our clients' material, and yet simultaneously attuned to the privileging their accounts as unique. In addition, our practice is inherently client-centred yet informed by theory and related models. Finally, we do not consider our individual clients in isolation but consider 'all contexts that might affect a client's experience and incorporate it into the assessment process, formulation and planned intervention' (p. 7). Embedded within our discipline's core identity then, is an appreciation of how the wider social context cannot be separated from current experience. This, of course, is no less relevant in a psycho-oncology setting. Accordingly, Paton, (1999) writes, 'a counselling psychologist needs to be aware of the larger systems and illness metaphors that might influence a particular family' (p. 352). The work of a counselling psychologist, in a multidisciplinary team, is both a challenge and a privilege (Hendrick et al., 2006; Nicholas, 2013).

2.5   Understanding health and illness: the social constructionist perspective

Within the field of psychology, growing emphasis is being placed upon social construction, and the study of language or 'discourse'. In contrast to the realist position, from the epistemological

position of social construction, people construct and communicate meaning for both self and the social world through language. Language is therefore not a neutral medium by which attitudes and beliefs can be 'uncovered' but is an active and purposeful social practice characterised by variation (Burr, 1995). As Neimeyer (1998) writes, it is not 'a medium for merely reflecting or labelling an independent reality' but is 'the very medium by which social reality is constructed' (p. 139). The social constructionist approach demands that we rework our concept of self or identity (Neimeyer, 1998), and as Finlay (2009) notes, 'we cannot simply see participants' talk about their subjective feelings and experiences as a transparent medium through which to glimpse their (internal) worlds'. Instead, it is proposed, 'we need to focus on the performative and constitutive aspect of language which deconstructs any truths concerning a "subject's" lived experience' (Finlay, 2009, p. 11). In this understanding, the self is relational and socially constituted. As Lyddon (1998) proposes, the traditional view of the self as 'isolated, self-contained entity, separate from its social world is challenged, and instead attention is drawn to 'the ways in which selves are constituted by a vast multitude of contextual influences (gendered, cultural, historical, political, linguistic and so on)' (p. 215).

When a social constructionist approach is taken to understanding talk of health and illness, it is apparent that there is meaning beyond physical status and that accounts are 'both ideological and dilemmatic' (Radley & Billig, 1996, p. 220).

> 'Accounts of health and illness are, therefore, more than descriptions of one's physical condition and more than views about what people in society should do to avoid disease. They also articulate a person's situation in the world and, indeed, articulate that world, in which the individual will be held accountable to others' (Radley & Billig, 1996, p. 221).

Health and Illness are not experienced in a social vacuum (Paton, 1999). Membership of the category of health is preferred, since it affords an identity which is fundamentally associated

with normality and conformity (Crossley, 2003). In her seminal work 'Illness as metaphor,' Sontag (1979) writes;

> 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, 1979).

Talk of illness, Sontag continues, is infused by metaphors. One disease which attracts metaphoric speech is cancer. Charting a path through the historical understandings of cancer (and also TB), Sontag shows how the disease's meaning is socially held and perpetuated, primarily through factual and fictional writings. Cancer, both disease and treatment, she notes, has been commonly described in terms of warfare. Indeed, as Grant and Hundley (2009) note, the term 'survivor' is itself a product of the widespread adoption of the war metaphor. Looking at media representations of cancer over a ten year period from 1995, they conclude that the title 'survivor' is assigned to winners of the battle with cancer, however an alternative position is available; those who die, or have non curative disease can be assigned the label of victim because they have lost the battle. The language around cancer would, Sontag believed, change as more people survived because the associated metaphors were bound to what she describes as 'the large insufficiencies of this culture, including our fear of dying and inability to tolerate anxiety' (p. 89).

2.6   Accounts of cancer, and life afterwards, from a social constructionist perspective

In their discourse analysis of breast cancer focus group members' talk during treatment, Wilkinson and Kitzinger (2000), focussed upon 'troubles-talk', that is talk of difficulty requiring careful management by the speaker in order to construct and maintain identity and manage

accountability for their actions (Jefferson, 1980). Wilkinson and Kitzinger show how references to 'positive thinking,' within accounts serve a rhetorical function rather than revealing a coping style. They conclude that 'positive thinking' is both a discursive practice, and also a moral obligation, and is a valuable means by which the women manage their identities during illness. Wilkinson and Kitzinger stress that in conversation this 'moral order' (p. 98) is constructed, and is open to adoption or rejection. Kitzinger (2000) takes up the theme of 'think positive' again in the closer analysis of this talk, and shows how the women in the study employ three strategies to resist this hard to challenge way of speaking. More recently, Willig (2009, 2012) has written, from a personal perspective, of cancer diagnosis recounting her negotiation of dominant discourses, including the think positive discourse, and also discourses of 'war' and of 'cancer as a moral concern'. Willig sums the strength of the dominant discourses aptly in her title: 'Cancer diagnosis as discursive capture' (2012). Together, these studies highlight the pervasive and powerful ways of speaking about diagnosis and treatment, and of the potential consequence as people try to make sense of, and live with their illness.

But what of survivorship? Once the 'battle' has been won and threat to life is deemed to have passed, Little, Paul, Jordens and Sayers (2002), question whether sympathies for the individual fade and the 'survivor' enters something of a 'no man's land' in which their status is unclear, and the problems of survival poorly understood. The 'survivor' they claim 'has, as yet, no specially defined status, no modes of performance that are socially validated. The survivor can therefore fit only into pre-existent and inadequate paradigms of the normal or the chronically ill, into metaphors of the 'victim' or the 'hero'' (Little et al., 2002, p. 176). What of the growing emphasis upon the possibility of growth following the trauma of cancer? To what extent does this reflect the social context in which survivorship takes place? How does this landscape influence the way life can be lived?

In the following section I review papers illustrative of the research literature on PTG in the

context of life after cancer, and question whether there is strength of evidence, sufficient rigour and methodological diversity. I also consider how this research fits with counselling psychology's values and emphases, and question whether counselling psychologists are engaging with the topic. Following this review, a gap in the existing knowledge base is identified and the rationale for the research within this thesis is proposed.

3 Critical literature review

3.1 Aims

The purpose of this narrative review is to critically evaluate literature illustrative of existing research on PTG in the context of life following cancer. The aims broadly follow those advocated by Baumeister and Leary (1997), who propose that through the use of narrative reviews conclusions about the value of 'existing conceptualisations' can be made (p. 312) and the strength of evidence, methodological rigour, and diversity evaluated. In addition, the literature is critiqued with regard to its congruence with the core values and emphases of counselling psychology (BPS, 2005), and with regard to the extent to which counselling psychologists are engaging in the research. From the review of literature the focus for further research is explicated.

3.2 Method

To generate a body of research literature for review, internet searches were conducted within specialist databases (EBSCOhost, PsychINFO, Psych Articles) using the search terms 'cancer' or 'psycho-oncology' and 'survivor(ship)' in combination with specific keywords ('growth', 'PTG', 'meaning making', 'benefit finding', 'positive life change' and 'positive meaning'). The snowballing technique was employed (Ridley, 2008), whereby references contained within the material were followed up. Original research articles published in English, and involving adults who had experienced cancer, had completed acute treatment, and had no known cancer at the time of participation were included.

3.3 Overview

Across the studies the research focused predominantly upon populations who had experienced

breast cancer. Much of the research stems from the US and employs quantitative research methods. Rather than a clear cut dichotomy between quantitative and qualitative methodologies, research methodologies can be thought of as lying on a continuum from a position of realism on one end to the social constructionist or relativist position on the other, each underpinned by epistemology, that is a theory of knowledge (Willig, 2008). What can be 'known' about positive outcomes after trauma is made possible by the understanding of the nature of language and the self inherent within the epistemological position to which it is anchored.

3.4   Distinguishing between PTG and benefit finding.

Positive outcomes are sometimes conceptualised as benefit finding and sometimes as PTG and most often studies focussed upon one or the other. There has been debate as to whether benefit finding and PTG are overlapping or distinct constructs. Mols, Vingerhoets, Coebergh and van de Poll-Franse (2009) examined reports of PTG and benefit finding in a group of breast cancer survivors in the Netherlands, ten years after diagnosis, and found both were reported by their participants and conclude that there is an association between benefit finding and PTG, however they note that their study is limited by its cross sectional design. In their longitudinal study of US breast cancer patients from completion of treatment until one year later, Sears, Stanton and Danoff-Burg (2003) report that while benefit finding was predicted at one year follow up, by characteristics such as optimism and hope and level of education, PTG was not. Instead, PTG was predicted by positive reappraisal, which they argue differs from benefit finding because it involves an effortful style of active coping. Tomich and Helgeson, (2002), again situated in the US, rejected the term PTG and situated their research in adjustment to trauma theories, including Janoff-Bulman's cognitive processing model (1992). Reports of growth were elicited via their own measure of 'meaning in life' using the term 'deriving benefit.' Matching

survivors (five years after diagnosis) with healthy controls (who had experienced non-cancer stressors) they found that although breast cancer survivors stated they had derived at least one benefit, they perceived the world as being more random, and reported no beneficial changes in religiosity, meaning in life or in sense of self or relationships with others. In other US research Carver & Antoni (2004) appear to show an apparently beneficial and long term effect of benefit finding, whereby benefit finding predicted lower distress and improved quality of life four to seven years later (controlling for baseline distress/depression). In contrast, Tomich & Helgeson (2004) have reported that initial benefit finding at baseline actually predicted elevated distress nine months later, for those with more severe disease. There are some notable differences between the studies, for example Carver and Antoni, included less severe disease in their sample and conducted follow up much later, whilst Tomich and Helgeson's study sample included those with more severe disease, and their follow up period was much earlier. Although both studies focused on benefit finding they used different measures. Tomich and Helgeson query, whether benefit finding is akin to denial, providing short term relief (by focussing on finding something positive in a traumatic event), but that over time this cannot be sustained, and may interfere with adaptive coping and therefore be unhelpful.

3.5   The evidence for PTG

The majority of PTG research utilises Tedeschi and Calhoun's theory, and corresponding measurement scale, the PTG inventory (PTGi, Tedeschi & Calhoun 1996), which measures growth across five areas (the opening up of new possibilities, closer relationships with others including those who are suffering, increased sense of personal strength, greater appreciation for life, and deepening or changed spirituality).

Some studies focused upon predictors of PTG such as age, marital status, employment, religiosity and ethnicity. For example, Bellizzi and Blank (2006) report finding that in the US

younger women appear to experience higher rates of PTG, drawing attention to how the point in the life course where breast cancer intersects may influence how it is experienced. Bound by epistemological position, Bellizzi and Blank's work is illustrative of the quantitative work in this area, where understanding of context is limited to these kinds of objective and measurable factors. Whilst these are important aspects of the participants' lives, they do not tell us about the wider societal context in which women live their post-cancer lives or of socially shared expectations as to how this should be managed.

Across the research on PTG generally, the notion that active coping facilitates the development of PTG as an outcome is evident. Sheikh (2008) notes that in this style of coping, rather than being avoidant of the pain of the trauma, the individual actively searches for meaning, by reframing or reappraising the experience, and by expressing emotion, for example by talking about adverse experience. Active coping is operationalised via a number of measures, for example the Brief COPE scale or its positive reappraisal sub scale (Carver, 1997). Bellizzi and Blank (2006) again in the US, found that active coping (measured via the COPE) was associated with reports of PTG. Bellizzi and Blank's study was cross-sectional and therefore conclusions about the development of PTG over time or causal relationships are not possible.

Much of the existing research subtly conceptualises PTG as concrete, and, as Zoellner and Maercker (2006) point out, do not adequately term the phenomenon 'subjective perceptions of PTG' (p. 629). Sumalla, Ochoa and Blanco (2009) observe that a key debate exists regarding the ontological nature of accounts of growth; are they real or illusory? Moreover, if they are illusory do they serve a beneficial function? Attention to studies which report a relationship between reports of PTG and other outcomes, thought to signify positive adjustment, is vital here. Although they acknowledge that longitudinal studies are necessary, Zoellner and Maercker argue that cross-sectional studies should still show a relationship between PTG and measures of psychological adjustment. Findings from cross-sectional studies show a mixed pattern in terms

of associations however. For example, both Cordova, Cunningham, Carlson and Andrykowski (2001), in the US, and Ruini and Vescovelli (2013) in Italy, found PTG was unrelated to psychological well being. And, while Lelorain, Bonnaud-Antignac and Florin (2010) report a slight association between PTG scores and mental health related quality of life amongst their French sample (MHRQoL; Ware, Kosinski & Dewey, 2000), Bellizzi et al (2009) showed that increases in rates of PTG were associated with decreased mental MHRQoL.

Amongst the few longitudinal studies, Sears et al. (2003) report PTG enduring at three months, and also at one year following diagnosis, and Danhauer et al (2013) report the presence of PTG soon after diagnosis and eighteen months later in their sample of US women who had experienced breast cancer. In Low et al's (2006) study PTG is reported at baseline, and then at six and twelve months later. With regard to the proposed link between active coping and PTG, while Danhauer et al report that active coping predicted PTG, Low et al report that although active coping was associated with PTG at baseline it was not a predictor of PTG six or twelve months later. Silva, Crespo & Canavarro, (2012) report PTG emerging during treatment and show that some aspects of active coping (cognitive strategies) measured at baseline (at the time of surgery) were associated with PTG six months after the end of treatment amongst their sample of Portuguese women after breast cancer. While they do not report an association between PTG and psychological adjustment the authors state this effect occurs via PTG, that is, they propose that PTG rather than an outcome per se may be better thought of as a coping strategy in itself which boosts self-efficacy and confidence.

Ransom, Sheldon and Jacobsen (2008) note the debate as to the validity of PTG accounts and argue that even when longitudinal studies are conducted, there is no pre-trauma baseline for meaningful comparison. The authors point out that, essentially, when reporting PTG respondents are making comparisons between their current self-view and their pre-cancer selves. Because, often PTG reports are measured retrospectively not only are they are

subjective, but also rely on recall and may be influenced by cognitive distortions (self-serving errors which favour more positive current perceptions of self). Ransom et al's sample included individuals who had experienced breast cancer or prostate cancer in the US, and measured perceived change and actual change, (of personal attributes and aspirations) over a period of six weeks (before and after radiotherapy). Although a relatively short time period, they report finding PTG present at baseline and that scores increased over time. However, participants later showed inaccurate recall of scores for personal attributes and aspirations from the first time point. Here, rather than recalling their earlier scores less favourably in comparison to their current scores, the participants inflated them, perhaps as the authors state, to preserve a sense of stability in self-identity over time, or to demonstrate that the stress of this cancer treatment type was coped with well. In addition, the nature of the aspirations shifted from extrinsic (e.g. wealth) to intrinsic (e.g. personal development). They conclude that PTG reports represent actual change as well as inaccurate recall and urge caution in translating research findings into interventions to promote PTG without adequate resolution of the debate regarding what the accounts signify, and call for more research to be conducted.

Validity has also been attempted by comparing PTG scores with that of healthy controls (Cordova et al., 2001; Tomich and Helgeson, 2002), or with the spouses of breast cancer survivors (Weiss, 2002). Cordova et al. (2001) found that growth in 'relationships', and 'spirituality' was apparent in both groups (breast cancer vs. healthy controls) alongside 'greater appreciation of life'. The extent to which participants had talked about their cancer experience appeared to have a bearing on growth, such that those who reported talking more reported higher growth scores. While this appears to support the use of active coping, it might also be considered to endorse the notion that meaning is co-constructed with others. Weiss, in the US, reports positive correlations between the reports of PTG in couples, although the women's scores were higher. Weiss concludes that this validates the ontological nature of PTG reports,

and that this may change societal perceptions about physical illness, and foster greater acceptance of reports of growth. Alternatively however, this finding together with the conclusions drawn from longitudinal studies could show that as cancer is experienced socially, there are strong societal attitudes towards living post cancer lives in certain ways. Before fostering growth we need to pay attention to this way of speaking about life after cancer, and the potential consequences of its use, in particular for the positions that are made available through its use.

Much of the PTG research is situated within Western countries and amongst predominantly white populations. Accounts of PTG are therefore embedded within certain socially shared meanings. As Neimeyer (1998) points out, 'western discourses of gender specify appropriate roles, responsibilities and respective positions of power for men and women, which are further buttressed by sources as diverse as biblical authority and biology' (p. 138). For example in one study Bellizzi & Blank (2006) used a version of the PTGi, adapted for use with a breast cancer population in the US and found, of the three domains of PTG which their adapted scale measured (appreciation of life, new possibilities and relating to others), 'relating to others' was the domain where participants reported experiencing most growth. The authors suggest this may be because 'women's relationships generally play a central role in their everyday lives. As a result, a disruption in this domain is likely to get the most attention with respect to reflection and adjustment' (p. 53). In research with more ethnically diverse samples, Amongst a Chinese population, one study by Ho, Chan and Ho (2004) grounded in existential theory, claims that active coping is an essential facet of PTG. In this study the PTGi is used, however because their data suggested a different factor structure when administered to a sample of Chinese cancer survivors (with multiple cancer types) the scale's validity across multiple populations is called into question. Furthermore, like Bellizzi et al. (2009), Ho et al. draw attention to the fact that the inventory was validated amongst college students in the US who had experienced acute

traumatic events rather than chronic illness. Using the PTGi, Bellizzi et al. (2009), found that African American women reported higher PTG scores than white or Hispanic women in their study. The authors explain the relationship between ethnicity and PTG scores as mediated by religiosity, which in turn, they suggest, reflects the coping resources that religiosity may afford, perhaps indicating the presence of increased social support and opportunity to talk about adverse experience.

Sumalla et al draw the conclusion that even if self-reported PTG is illusory, psychotherapeutic work might function as a way of encouraging this apparently beneficial process. Many authors share this view (e.g. Cordova et al., 2001; Ho et al., 2004; Lelorain, Bonnaud-Antignac & Florin, 2010; Mols, Vingerhoerts, Coebergh & van der Poll-Franse, 2009; Porter et al., 2006; Ruini & Vescovelli, 2013; Sears et al., 2003; Silva et al., 2012) and conclude that we might facilitate the adoption of adaptive coping strategies to promote PTG, since this represents a possible predictor of PTG which is potentially modifiable. Generally, the need for sensitivity is noted, in agreement with the authors of PTG theory, Calhoun and Tedeschi (2006), who caution against imposing the expectation that individuals ought to grow following cancer and that instead, clinicians should listen for accounts of PTG during sessions with their clients, and work with them. Tomich and Helgeson's (2004) work on benefit finding raises interesting questions relevant to research on PTG here. They argue that participants may respond in socially desirable ways generally when presented with measures concerning growth after trauma, and this may lead to higher reports of benefits found particularly where participants cannot tell of negatives because the response scales begin at 'no change', rather than including a response for change for the worse, or where measures assessing negative outcomes are not included in the study measures. Tomich and Helgeson also note that the way instructions are worded convey expectations to participants, and that care should be taken to include the understanding that while some people appear find positive change happens, others may not.

The tension between the promise of a useful intervention to promote growth, and the need to resist communicating to clients that they are obliged to grow after a cancer experience is tangible. Sheikh (2008) notes that Tedeschi and Calhoun (2006) state that clinicians should listen for accounts of PTG during sessions with their clients and work with them, and recommend some ways of encouraging growth with clients. The way in which this is approached will be influenced by, as she puts it, 'counsellor values and behaviours' (p. 91), which are bound up with the counsellor's stance as co-explorer or expert. Counselling psychology's emphasis on optimal equality in the therapeutic relationship is significant here. Moreover, our openness to multiple ways of understanding yet critical stance towards research methodologies and how they shape what we can know about a given phenomenon is vital. If we consider that accounts of PTG represent a stable measurable phenomenon then we can take the findings at face value and work sensitively with individual clients who appear to be talking about growth in the context of adversity, while upholding and privileging the uniqueness of their experience. However, as Baumeister and Leary (1997) advocate, we must be sure to consider alternative understandings which could shed a different light on existing conceptualisations. For counselling psychologists, a greater emphasis upon social context might further highlight the importance of how cancer survivorship is experienced, or worked through, in interaction with others within frameworks of culturally or socially held beliefs that shape how survivors can talk about their experiences and what can be expressed. In attending to the wider context we might conclude that the level of societal influence upon survivorship is sufficiently strong that the compulsion to survive 'well' (demonstrating a sense of resolution and mastery of the experience) is experienced by individuals as well as by their families.

3.6   Self-reported PTG as 'identity work' in cancer survivorship

Some research has explored PTG accounts explicitly in connection the management of identity.

For example, research by Park, Zlateva and Blank (2009) asked participants, with mixed cancer types including breast cancer, to select labels that they identified with from a given list; 'survivor', 'person who has had cancer', 'victim' or 'patient'. 'Survivor' (83%), was a dominant identity, however because the participants were able to choose more than one label, alongside 'survivor', many participants (81%) also chose the label, 'person who has had cancer,' and 58% also chose the term 'patient'. Least endorsed was the term 'victim' (18%). The identities were minimally correlated with each other and also to self-reported cancer related activities e.g. wearing cancer-related items and talking about prevention. The survivor identity was associated with improved psychological well-being and functioning, and with PTG, and the victim identity was associated with poorer functioning. The authors advocate that 'future research is needed to understand the interplay of these simultaneously held identities, the meanings they hold for individuals, and the impact they have on health and wellbeing' (p. 434). As Park et al note that post cancer 'identities' are far from value free. A critical consideration here is whether these identities fluctuate according to context, and the extent to which taking them up is socially obligated. The mode of data collection prevents us from seeing how identities are taken up in interaction, or of how meaning after cancer is created through dialogue. As counselling psychologists the interplay between social understandings of post-cancer identity and the individual's personal adoption of self-identity is of interest. In addition, as practitioners co-constructing meaning and identity with our clients, we need an awareness of both our own underlying assumptions of what survivorship might entail alongside awareness of those in the social world in which post-cancer lives are lived out.

Although, there is acknowledgement that more qualitative research is needed in order to better understand PTG following cancer, there is a paucity of this kind of research, and in particular of qualitative research which takes a critical stance, seeking to understand accounts of PTG from an alternative perspective.

In one qualitative study, Gall and Cornblat (2002) conducted a content analysis upon written reports of PTG, from a breast cancer sample in Canada, to explore the role of spiritual factors in long term adjustment. One of five themes emerging from the data was 'life affirmation and growth'. The majority of the participants described cancer as 'setting the stage for personal growth and transformation' (p. 530), a challenge affording the opportunity to evaluate what matters most and to grow and mature. Gall and Cornblat highlight how self-reflection was seen as vital for PTG, and transferable to other problems encountered. Benefits in self-esteem were noted, such as a self-appreciation as having become more compassionate, thoughtful, understanding and accepting people. The authors conclude that spiritual factors may have a special role in helping long-term cancer survivors cope with existential concerns.

Two qualitative studies from Australia (Connerty & Knott, 2013; Elmir, Jackson, Beale & Schmied, 2009), and a third from France (Lelorain, Tessier, Florin & Bonnaud- Antignac, 2012) carried out a thematic analysis of accounts of life after breast cancer. Thematic analysis concerns the systematic organisation of qualitative data for patterns or themes, for the phenomenon being explored (Boyatzis, 1998). In Connerty and Knott's (2013) thematic analysis of the accounts of fifteen cancer survivors elicited during group interviews, including three women who had experienced breast cancer, 'growth after trauma' featured as a theme. Respondents reported change across perceptions of life, self, relationships and spirituality. Significantly, PTG was positioned as the product of a process which included experiencing support from others, seeking information, making lifestyle changes (adopting healthy behaviors such as physical activity), and participating in activities that help others affected by cancer. These represent, the authors conclude, modifiable factors that could be targeted by interventions to facilitate growth. Elmir et al's study acknowledged the paucity of research on the experience of breast cancer in younger women, and recruited four women in their thirties and forties. The authors argue that breast cancer in this life-stage is associated with a poor

prognosis medically and also psychologically, not least because it affects fertility, can result in an altered body image, and brings disruption to sexual relationships. Although fertility has a biological age limit, body image and sexual relationships are not necessarily more relevant to women of a younger age, and perhaps suggest gender and age related assumptions. 'Finding strength within' was one of four themes emerging from the analysis, described in terms of the 'belief that breast cancer and related breast surgery had made them stronger individuals' (p. 2535). In contrast, the other themes concerned the overwhelming all-encompassing experience of having been diagnosed and treated for breast cancer, and the fear of recurrence. Although not recognising the possible rhetorical function of the accounts, the authors do note that the study 'adds important insights into younger women's experiences of sense of self and body image following surgery' (p. 2537). Finally, in Lelorain et al's (2012) study, with twenty eight women who had experienced breast cancer between five and fifteen years previously, thematic analysis, aided by software to classify word use, resulted in four themes being named including 'PTG'. The accounts included talk of difficulty and disruption that continued after treatment had ended. Notably, the interview questions were ordered to firstly elicit accounts of experiencing cancer. The participants were then asked about any resulting changes. Here, there was no mention of PTG to the participants, who were simply asked to state if there had been changes to life or self as a result of cancer, or whether they had experienced no change. Finally, the participants were asked if there was anything they had forgotten to mention, or anything they wanted to emphasise. Lelorain et al note the possibility that having given accounts where negative consequences had been offered by the women, the accounts of PTG which occurred towards the end of the interviews, in response to this third question, may have afforded the opportunity to end on a positive note. Whilst the authors conclude this endorses the importance of PTG to the women, arguably this emphasises the presence of a social and moral imperative to demonstrate growth from trauma, and of the possible discursive function of talk

of PTG in repairing identity. Although the participants were not asked directly about their experiences of PTG, they were recruited from an existing quantitative study (Lelorain, Bonnaud-Antignac & Florin 2010) which involved the use of the PTGi, and therefore the notion of PTG had, arguably, already been communicated.

One of the few studies in the UK has explored the relationship between sense of self and body image more recently (Hefferson, Grealy & Mutrie 2010). Hefferson et al conducted an interpretative phenomenological analysis (IPA) on accounts of the lived experience of ten women diagnosed and treated for breast cancer. IPA (Smith, Flowers & Larkin, 2009) involves in-depth exploration of a participant's individual subjective experience, and the researcher is active in the interpretation of meaning. Thus, IPA demands awareness on the part of the researcher of how their own assumptions and experiences might shape this interpretation. The authors argue that cancer-related changes to the body act as ongoing reminders of the threat to mortality posed by the illness (or its recurrence), and that this may act as a spur for PTG, as a means of countering the negative self-image that can result from treatment effects. One theme of 'new body', comprising three sub themes ('fear of the new body', 'negative effects of chemotherapy', and 'reconnection with the body'), was highlighted as connected to the women's experience of psychological growth through the experience of physical changes, such as hair re-growth after chemotherapy. The authors note that the women described how, as physical health returned, they also began feeling psychologically stronger, and conclude that the process of regaining health after a threat to life aids the process of psychological growth. Again, the effect of framing and context warrant attention. The interview schedule contained one key question 'what does finding positive benefits from your trauma mean to you?' which, arguably, subtly constructed PTG as a concrete phenomenon that might be experienced post-trauma. In addition, the women in this study were taking part in an exercise-based intervention, which the authors acknowledge may have heightened their attention to their bodies.

These five qualitative studies took an approach in line with counselling psychology's regard for the need to understand subjective experience rather than objective reality. Common to all is an epistemological position aligned to the realist perspective. Underpinning all of the studies is an understanding of the nature and function of language, as a vehicle for revealing an internal reality (thoughts, beliefs, experiences) rather than as a constructive social practice. If however, we took a social constructionist approach to the participants' accounts, viewing them as socially occasioned and performative, we might understand the function of PTG differently. Rather than a phenomenon experienced as a result of trauma, with determinants aiding it's development, might PTG be understood as a discursive resource for repairing or enlarging identity in the context of survivorship?

3.7   Research summary and identified gap in the knowledge

Applying Baumeister and Leary's (1997) purpose for narrative review, the current body of research lacks methodological diversity. This has implications for the value of existing conceptualisations, and the strength of evidence seen. Presently, there is little critical appraisal of the concept of PTG from outside of the realist paradigm, which underpins the majority of research. Although some research considers accounts of PTG with regard to the management of identity, offering an interesting insight into the possible function of PTG, consideration of the role of language as a socially available resource through which identity is accomplished is lacking, as is a focus upon the wider social context in which survivorship is lived. The notion of identity, within the current research, is in line with the dominant research methodologies used and underpinned by their epistemology. Accordingly, identity is understood as stable, internally and individually held, rather than fluid and socially occasioned. Further research is needed which seeks to explore the function of accounts of PTG from an alternative epistemological position in which language and the concept of self are considered differently.

Within the paradigm from which the research stems, there are many design issues, for example the paucity of longitudinal studies and the question of validity of the measures commonly used to elicit reports of PTG. In addition, the PTGi's development amongst a sample of college undergraduates and not in a population who had experienced cancer again hampers the conclusions that can be made. The method by which reports of PTG are elicited can be criticised in terms of the way that this may frame responses. This is apparent in the way that studies are presented to prospective participants as well as the lack of opportunity for participants to indicate negative changes. Both subtly endorse the construction of what survivorship should entail.

A substantial body of the quantitative research has been conducted in the US, and in the West generally. However, we cannot assume that what appears to happen in one country or amongst a particular population will necessarily be the case in another. Indeed, this argument is supported in some research, in non western samples, which calls into question the applicability of the scale structure most commonly used to measure PTG amongst different populations. Little research has taken place in the UK.

In this review the literature has also been critiqued with regard to its congruence with the core values and emphases of counselling psychology (BPS, 2005), and with regard to the extent to which counselling psychologists are engaging in the research. In some respects the current research body has 'goodness of fit' with the values and emphases of counselling psychology, in that there is some consideration of the importance of social context in the development of PTG. As Thorne, Paterson and Russell (2003) note, the experience of chronic illness occurs in the context of complex human lives' (p. 1348) and as counselling psychologists we recognise that the context in which accounts of PTG occur must be explored, particularly where it may exert an influence upon how life after cancer is experienced. We are also mindful of the role that ways of speaking about illness might exert an influence upon doing survivorship. Notably however,

across the research the voices of counselling psychologists are largely silent. This is problematic since, if we have a unique contribution to bring to this client group and setting, then we must engage in key debates regarding the validity of PTG as a phenomenon and how best to work with survivors of cancer, and indeed of chronic illness in general. Commonly, PTG is linked to the adoption of adaptive coping, and accordingly, there is a call for clinical interventions that facilitate this in cancer survivors. Studies advocating that clinicians should work with clients to promote growth do not generally propose frameworks or guidelines by which this can be achieved. Arguably, counselling psychologists working in psycho-oncology in the UK need to engage in research, and add to the debate around PTG in those who have experienced cancer, in order that we might translate theory and research into meaningful practice. Because the majority of the research has been conducted amongst women who have experienced breast cancer, as a cancer type with growing survival rates (CRUK, 2011) there is a rationale for firstly exploring the social construction of PTG amongst this same population.

In this narrative review it is argued that, in line with counselling psychology's openness to multiple ways of knowing, we might consider alternative ways of understanding the nature and function of PTG. In particular a focus upon how in social interaction individuals construct and orient to PTG actively in their talk, in the context of life after breast cancer is warranted.

A research focus is therefore proposed. In talking about life after cancer, how do women who have experienced breast cancer construct and orient to PTG? What discourses are drawn upon, and what subject positions are made available, and to what effect? Finally, what insight might this add to existing research, for those working therapeutically in psycho-oncology, and specifically with women who have experienced breast cancer?

4   Research

4.1   Method

4.1.1   Design

This qualitative study employed a discourse analytic approach, synthesising two modes of analysis, to women's accounts of life after breast cancer taken from individual interviews, with a specific interest in the notion of PTG.

4.1.2   Methodological considerations

There are many forms of discourse analysis (Stubbe, et al., 2003) however because this methodology is tied to the epistemological position of social constructionism, common to all is an assumption about the nature of language as an active and constructive socially available resource.   In this study, two previously polarised approaches are synthesised (Edley & Wetherell, 1997, 1999, 2001; Wetherell, 1998). This approach draws upon both discursive psychology (DP; Edwards & Potter, 1992) and also critical discourse analysis (CDA; Parker, 1992). DP, informed by ethnomethodology and conversation analysis, is concerned with a fine grained analysis of text, in order to show its rhetorical devices and functions, which construct a version of 'truth' relative to the situation in which the talk occurs. Wooffitt (2005), although a proponent conversation analysis, acknowledges that this method 'cannot address the wider historical, cultural and political contexts and meanings which are invoked by and reflected in the kinds of words and phrases we use in everyday communication (2005, p. 158). Similarly, Wetherell (1998) argues it cannot explain why speakers say particular things because it is simply not focused upon what is external to the text in hand. The context of the interaction in which the talk occurs is the 'primary site' and 'what is of interest is what the conversation means for the participants as they intersubjectively build a social order' (Wetherell, 1998, p. 393).

In contrast, CDA is informed by post-structuralist theory (e.g. Foucault). Here, analysis is conducted at a macro level, for dominant discourses 'available' for speakers to draw upon, but which also constrain what is able to be said (Willig, 2008). Available discourses, as Banister, Burman, Parker, Taylor and Tindall (1994) note, are 'broader contextual concerns such as cultural trends and political and social issues to which the text alludes' (as cited in Coyle 2000, p. 258). A critical discourse analysis studies the text concerned, but holds the position that the text is a 'context-bound and social phenomenon and can be properly understood only by paying due attention to the social and cultural contexts in which it occurs' (Benwell & Stokoe, p. 44). CDA considers that discourses have ideological consequences (Fairclough & Wodak, 1997), for example they can perpetuate social inequalities between certain groups. Perhaps, unsurprisingly as Fairclough asserts, analysts aligned to this method are concerned with understanding social problems, noting that it is ''critical', first in the sense that it 'seeks to discern connections between language and other elements of social life which are often opaque' (p. 230). Critical discourse analysts are therefore actively engaged in understanding and confronting powerful ideologies (van Dijk, 2001). In criticism of CDA, Schegloff (1997) has argued that due to the inattention paid to fine grain features, or the interactional nature of talk, critical discourse analysts can produce analyses which are not easily substantiated. In a similar vein, Wooffitt argues that 'there is a clear lack of consistency as to what counts as evidence for the presence of discourse: it could be a single word, or a short stretch of talk, or a slightly longer account or narrative…no clear method by which to establish the presence of any particular discourse in any specific sequence of talk-in-interaction' (2005, p. 183).

The differing versions of discourse analysis carry implications for the notion of identity or subjectivity, and specifically for agency. In drawing upon a discourse a number of subject positions (or selves) are made possible and can be used by speakers to locate themselves and others within given categories and with certain rights and responsibilities (Davies & Harré,

1990). In contrast, in DP the positions occupied by subjects are localised to the speakers in the conversation in hand (Wetherell, 1998). When we analyse talk through this lens we see the performative nature of language, characterised by variability. Subject positions, become apparent in the context of the talk in which they are operating as 'troubled' or 'untroubled,' as Wetherell terms them, fluctuating according to the ways of speaking that are drawn upon. In contrast, in CDA, discourses shape individual subjectivity (Willig, 2012) and identity is located relevant to certain ideological positions (Benwell & Stokoe, 2006). In certain contexts, particularly powerful discourses offer limited subject positions constraining the speaker and carrying implications for actions.

Edley and Wetherell have advocated the synthesis of micro (DP) and macro (CDA) analytic approaches (Edley and Wetherell, 1997, 1999, 2001; Wetherell, 1998) stating that in this way the relationship between the speaker and discourse, characterised by dilemma and inconsistency can be best appreciated. Combining these approaches is not without tension however. For example, Korobov (2001) raises the argument as to whether this kind of synthesis can 'effectively reconcile the theoretical tension that we both constitute and are constituted by the social and cultural discourses in/by/through which we speak' (p. 1). By combining approaches however, we can at least appreciate some of the forces at work that shape talk even though we perhaps cannot fully know why although more than one discourse is 'available' one is taken up. Arguably, the synthetic approach lends itself well to concerns of identity construction and management, which occurs in relation to a social context where moral and social obligations are present. A number of studies have now employed this approach (Bishop & Yardley 2004; Seymour-Smith & Wetherell, 2006; Stephens, Carryer & Budge, 2004).

4.1.3   Using individual interviews to elicit accounts of life after cancer

Individual interviews were chosen as the interactional space in which talk of life after cancer

was elicited. The interview method was chosen because of the observation, both professionally and personally, that women who had experienced breast cancer did not appear to have much opportunity to give their accounts (see reflexive statement). It was hoped that individual interviews might afford a space where the women could talk at length without being closed down or interrupted by others. The use of interviews as a mode of data collection has been widely used within discourse analytic work, and as Potter (1996) observes, in contrast to naturally occurring talk, allows exploration using the same set of themes across a number of research participants. Although interviews might be seen as an artificial meeting where the participant responds to pre-determined topics chosen by the researcher, they can also be spaces where participants have opportunity to orient to issues that concern them (Hutchby & Wooffitt, 1998). Indeed, by virtue of their participation respondents have already demonstrated that they have a stake in the discussion to which they are invited. Willig (2008) argues that when we understand interviews as interactions between two people, the interviewer and the participant, both invested in the interaction, we move away from an understanding of interview data as superficial. Key to this is the acknowledgement of the researcher's place within the research.

4.2   Participants, materials, procedure

4.2.1   Participants

4.2.1.1   Inclusion/exclusion criteria

The study aimed to recruit approximately four adult women with a past history of breast cancer, but with no known cancer at the time of participation. In order to elicit accounts where the participant had sufficient time to experience life after cancer, women were recruited into the study who had finished acute treatment more than six months previously. There were no

restrictions around age, although as previous research has highlighted that the stage of the life-course in which cancer intersects may have a bearing on reports of PTG (e.g. Bellizzi & Blank, 2006) with younger women more frequently reporting PTG, it was hoped that younger women (under 65 years) would be recruited into the study alongside older women (over 65 years).

4.2.1.2   Recruitment procedure

Posters invitations were displayed in several locations (e.g. coffee shop and garden centre notice boards). Participants registering an interest were sent a comprehensive research pack by post. The research pack comprised a detailed information sheet and consent form (included in Appendix A). Four women responded to the poster invitations, and subsequently consented to take part in the study. Their details are presented in the following table.

Table 1. Participant's details.

	Ali	Tessa	Sue	Anne
Age	41	55	57	71
Time since diagnosis	6years	3 years 9mths	2 years	10 years
Treatment type	Chemotherapy Radiotherapy	Chemotherapy Radiotherapy	Bi-lateral mastectomy	Radiotherapy
Surgery type	Lumpectomy	Lumpectomy	Lumpectomy followed by Bi-lateral mastectomy	Lumpectomy
Ongoing treatment	None	Hormone therapy	None	Hormone therapy

4.2.2   Materials

The poster invitations (included in Appendix A) detailed the nature of the study ('an exploration of the experience of life after breast cancer') without explicit focus on survivorship or PTG, to

avoid offering a construction, or expectation of this and thereby framing the participation. The posters introduced the researcher, and her identity (a counselling psychology doctoral student) and provided phone contact details. The posters informed prospective participants that taking part would entail attending an audio-taped interview.

4.2.2.1 Semi-structured interview schedule

Because research questions inevitably position participants, and construct the topic in some way, it is essential that interview schedules are developed carefully, sensitively and reflexively. In developing the interview questions, attention was given to the possible influence of the researcher's own assumptions upon the participants' talk of life after cancer, and specifically PTG. With this in mind, the interview questions were designed to be relatively value free and non-directive e.g. the questions used to stimulate participants' talk of life following cancer did not include reference to positive change, benefit finding or PTG until later in the question set when this was explicitly raised, to avoid conveying the notion that positive change was expected. Prompts were included in the form of encouragements to share more fully e.g. 'Can you tell me a little more about that?' The interview schedule was structured so that the participants could tell their stories sequentially, that is talk about diagnosis and treatment and then of life after cancer. At a stage in the interview when the participant had voiced their story of diagnosis, treatment and life after, the question about PTG was then posed. When doing this, rather than research 'findings' being presented to the participants; e.g. 'research shows that', the researcher stated that 'some people who've had breast cancer say that....'

4.2.2.2 Piloting and revisions to the interview schedule

The interview schedule was piloted and revised before use, with two women, known personally to the researcher, who had experienced breast cancer. Notes were made after each pilot interview, and the interviewees were asked to comment on their experience, and particularly

their response to the wording of the questions. The interview schedule was revised slightly, particularly with regard to the addition of a question asking the participants how they would describe themselves before diagnosis. The data generated from the pilot interviews was not included in the analysis. The final interview schedule is included in Appendix B.

4.2.3   Data collection procedure

Each interview was fundamentally an interaction between researcher and participant and because the question set had been designed to encourage a sequential narrative of the cancer experience, a 'naturalistic' flow of conversation was experienced with the questions being covered spontaneously and with very little need for prompting. Each interview lasted between one and two hours. Demographic information was recorded at the beginning of each interview e.g. Age, ethnicity, time since diagnosis, type of treatment received, cancer type if known. (see appendix A).

4.3   Ethical considerations

The British Psychological Society's ethical guidelines for good research practice (BPS, 2010) were adhered to. Clearance was also obtained from London Metropolitan University's Research Ethics committee. The data generated within this study was handled in line with chapter 29 of the Data Protection Act (1998). The data will be stored securely for a period not exceeding five years.

4.3.1   Informed consent

The information sheet detailed how the participant's data would be used (e.g. as excerpts within a research thesis and future publications). On contacting the researcher, participants were given the opportunity to ask questions before a mutually convenient date and location for the interview was arranged.

4.3.2   Confidentiality

Participants had the option of being interviewed in their own homes or in a mutually convenient location, where privacy could be assured. Although anonymity was offered, as a standard research procedure, two participants (Sue and Anne) stated that they would prefer to keep their own personal names. Pseudo names were applied to the people or places mentioned in all of the accounts however. Recently, Grinyer (2002) has reflected upon the anonymisation of participants accounts as standard practice in research, and questions whether this denies them the opportunity to own their stories.

4.3.3   Right to withdraw

Participants were advised of their right to withdraw at any point before submission of the written thesis.

4.3.4   Managing potential distress

As the interviews involved discussion of potentially emotive topics, some strong feelings were expected, and a distress protocol was designed and adhered to. The opportunity to stop or temporarily suspend the interview was offered. Contact details of organisations offering support following cancer were provided after the interview. The distress protocol and the participant debrief sheet are included as Appendix C.

4.4   Analytical procedure

For the purpose of analysis, the interviews were audio-taped and transcribed verbatim using a method of notation adapted from Gail Jefferson (1985) and adapted by Edley (2001), Potter (1996), and Parker (1992). This is included in Appendix D.

Discourse analysis is a perspective, a way of seeing or being in the world, and the actual process

of analysis is not easily elucidated (Gill, 1996). Many analysts have however highlighted some considerations which were drawn upon to inform the stages of analysis carried out within this study.

The analytical procedure was implemented in the following stages. The first stage involved transcription of the audio-recorded interviews, which, as Potter and Wetherell (1987) highlight, facilitates familiarity with the talk, and is in itself constructive, as the audio-taped talk is presented in text form and decisions are made regarding format and organisation. Early readings were carried out while listening to the audio-recordings to confirm the notation used in the transcription and to aid familiarity. Next, the transcribed data was coded broadly by the nature of the talk; sections of text were highlighted as relevant to the research aims (e.g. sections of talk of life after cancer). Once the data had been coded in this way, comments and reflections were noted in the left hand margins of the transcripts regarding the discourses that appeared to be in use, and the subject positions made available. Possible broader contextual concerns to which the accounts appeared to allude were also highlighted on the left hand side. In the right hand margin the fine grain features of the text were noted, that is the rhetorical devices used by the speakers. Talk where the PTG discourse was not evident was also included in the analysis. In this way, variation could be highlighted and the function of talk of PTG best understood. The position within the interview was noted e.g. whether the extracts occurred before or after the notion of PTG was raised by the interviewer. The analysis then comprised a systematic and methodical organisation of the data with attention being given to emerging patterns and effects. As Potter and Wetherell (1987) note is so often the case with discourse analytic work, the process of analysis was iterative.

Analysis of qualitative data involves interpretation by the researcher. Willig (2012), argues that this fundamental facet of analysis is generally under-considered. Interpretation, she writes, 'in its most basic sense, refers to the construction of meaning. Interpretation is concerned with

elucidation and explanation and understanding' (p. 5). Within discursive work, Willig argues that the process of interpretation is inherently linked to the epistemological position of the chosen research method. It is through this lens that the text is engaged with, and the process of interpretation framed. Willig (2012) proposes some points to bear in mind when negotiating the challenge of interpretation, these are: to remain mindful of the research aim and the limits of what can be made known through it, to be open to other possible interpretations of the text, and to maintain a strong focus on the participant's voice. These considerations were held in mind throughout the process of analysis and demanded reflexivity, both epistemological and personal. Across the research process, reflexive practice was engaged with e.g. the keeping of a journal for thoughts and reflections, and the continual questioning of personal assumptions which might influence the design, analysis or writing up. Reflexivity is one means by which researchers can strive for quality in their work (Willig, 2012), and indeed a large body of recommendations are available in the literature (Antaki, BIllig, Edwards & Potter, 2003; Elliott, Fischer, & Rennie, 1999; Willig, 2008). In order to privilege quality within this work, alongside reflexivity, the analysis is presented with extracts of data in order to ground the analysis, and the analytic procedure adopted has been presented to ensure transparency. An example of analysed data is included as appendix E.

5   Analysis of talk of life after breast cancer

This analysis comprises two sections. In the first, I show how the women in this study managed their identity discursively as people living after breast cancer in the context of their 'troubles talk' (Jefferson, 1980) before the notion of PTG was raised within the interviews. In talking about the negative consequences of having had cancer the women manage a potentially troubled subject position discursively in a number of ways, including drawing upon a number of discourses in order to carry out vital repair work. There are few instances where positive benefits or PTG are offered and where this occurs PTG is used discursively to do repair work. In the second section, I present analysis of talk after the notion of PTG has been introduced and where the women are asked to orient to this, and subsequently where the women demonstrate as Little et al. (2002) term it 'identity enlargement', working up of an active and successful subject positions through talk of participation in key post cancer-related activities through which they manage accountability.

Taking a social constructionist approach to the analysis of talk of life after cancer, the responses are seen as talk which is contextual, socially occasioned as purposeful. Attention to the variation within the accounts highlights the way in which the women's accounts of troubles are minimised, or reframed in the presence of talk of PTG. Overall, the analysis shows how the women negotiate a moral and social obligation to survive 'well.' This includes the need to be grateful and stoical, to waste neither pain nor knowledge gained, to transition from patient to expert in self-care, and to negotiate the polarised and competing positions of health and illness, normality and suffering.

Because of the scope of this thesis it is not possible to include analysis of the talk of cancer diagnosis and treatment, however constructions of cancer and treatment are highlighted where they are present in talk about life after cancer.

5.1   The discourses

The discourses drawn upon by the women in this study in talk of troubles, and in orienting to PTG are described below.

Biomedical. This hegemonic discourse was used in accounts of diagnosis and treatment, and in accounts of life after cancer. In particular, the biomedical discourse was used to manage fears of recurrence in troubles talk. The biomedical discourse was drawn upon to construct cancer as a life-threatening trauma, and to describe the methods used to remove it from the body and restore normality. Within this discourse, patients are largely positioned as passive recipients of care from a paternalistic system holding power and knowledge. Medical rather than lay terms are used and the body is objectified and subject to what Foucault describes as the 'gaze' of medical power (1973).

Fortune discourse. This discourse includes words and phrases such as 'lucky' or 'blessed' and allows speakers to construct their position in a more positive light. This discourse externalises difficulties by placing them outside of the individual's control and positions the self favourably in relation to others in a more troubled subject position.

'Think positive'. This powerful discourse is something of a cultural imperative (Wilkinson & Kitzinger, 2000; Kitzinger, 2000; Willig, 2011). In using this discourse women display optimism that they will experience a positive outcome to their difficulties. Alternative negative outcomes (such as fear of recurrence) are bracketed off.

Expert discourse. In this discourse knowledge and experience are worked up allowing accountability to be managed. The discourse makes available an active subject position whereby transition from passive patient at the start of their cancer journey to a more expert and knowledgeable position after treatment has finished is negotiated. The expert discourse helps

the speaker to show they have gained knowledge through their experience, to demonstrate that they can manage their own health, and allows them to meet the moral imperative to give back.

PTG discourse. This discourse offers a strong agentic subject position. The PTG discourse privileges appreciation of life, interpersonal relationships and positive personal qualities. Through its use, cancer is constructed as a 'wake up call' that affords the opportunity to re-evaluate what really matters, or to promote growth and change in some way. This discourse allows negotiation of the moral and social obligation to be seen to survive 'well' thereby managing accountability. Talk of troubles is muted in this discourse.

War discourse. In this discourse cancer is constructed as an invader of the body, and treatment is a weapon used to eradicate it. In life after cancer treatment the title 'survivor' is assigned to winners of the battle who have fought bravely. Ongoing difficulties in the aftermath of war are minimised, thus creating a stoical subject position. Those who die, or who have non-curative disease are deemed to have lost the battle and are victims. In this discourse, cancer is also constructed as an acute rather than chronic event.

5.2   The discursive management of identity in troubles talk of life after cancer

In the following section I present extracts showing the discursive management of identity after breast cancer, in 'troubles talk'. This talk occurred after talk of diagnosis and treatment, but before the question regarding PTG was posed. When participants told their stories, their accounts were characterised by talk of negative physical or psychological consequences (fear of recurrence, treatment related consequences and career disruption). This kind of talk has been termed 'troubles-talk' (Jefferson 1980). As Wilkinson (2000) explains, troubles talk requires skilful discursive management so that identity can be preserved. Analysis of the talk shows the

tension between living with the effects of breast cancer and its treatment yet needing to comply with the moral and social obligation to 'do survivorship' in certain ways; as healthy, as grateful and stoical, and as expert rather than passive patients. To accomplish these tasks the women drew upon key discourses which carry rhetorical force. Exemplary extracts are presented, with analysis.

5.2.1   Fear of recurrence

Talk of fearing recurrence of breast cancer was particularly prominent in the women's accounts. This talk places speakers under the shadow of illness once more. As Radley and Billig (1996) argue, occupying the category of ill health leaves speakers in a troubled position; deviating from 'the norm'. It is to the position of normality that the women repaired their identities. In this talk, the women drew on the 'think positive' discourse and the 'fortune discourse' to manage being in a troubled position (worried, or at high risk of the cancer returning). Some of the women also worked up the power of medicine and technology, drawing on the biomedical discourse when they talked about 'if the cancer came back'.

In the following extract Tessa demonstrates this and she uses a number of rhetorical devices to manage a troubled subject position.

Extract no 1: Taken from Interview (2) with Tessa.

457	Tessa	Mm mm, er, you didn't, I didn't, I don't think I knew what to expect after it
458		finished em I think the one thing you always think about and still do
459		occasionally, will it come back?
460	Jennie	Mm
461		Now is that something that can happen again? Em and when you talk to the
462		doctors they say 'well, you've got as much chance as anyone else'
463	Jennie	Right
464	Tessa	Of it happening to
465	Jennie	So how do you sit with that then? How do you work that one out? 'As much

466		chance as anyone else' what does that mean? How do you make sense [of
467	Tessa	[I don't think you can, you just have to get on with life, and if it crops up again (.)
468		You go through the process again, and hopefully it'll be a similar sort of process
469		where, no, you have a lumpectomy, you don't have your breast removed um.
470		I mean scars you can live with, they don't matter. It's being here at the end of it
471		it that matters, and being able to see your children and your grandchildren,
472		and husbands and whatever
473	Jennie	so relationships

Tessa constructs the period after treatment as unpredictable (line 457-8), noting recurrence as a key concern. This appears difficult to say, and so Tessa switches between use of personal pronouns 'you' and 'I'. Adopting 'you' removes her slightly from the focus of the problem, because she is constructing fear of recurrence as common place. In line 461 she poses the question about whether her cancer is 'something that can happen again?' Risk is then positioned relative to others, using the fortune discourse, ('you've got as much chance as anyone') affording Tessa category membership of health, and distancing herself from personal vulnerability, as someone who has had cancer. She also draws upon the biomedical discourse to provide the answer, positioning 'doctors' as powerful experts, responsible for giving this information and deciding risk. In line 465 I question how easy this is to live with in practice. Tessa responds with a stoical stance 'I don't think you can, you just have to get on with life' suggesting that is a socially sanctioned imperative. Using an 'if-then' clause Tessa sets outs the sequence of events involved in a new diagnosis and treatment. If-then formulations are used to describe events that follow in a logical sequence (Edwards, 1997). In the first part of the clause 'if' is followed by a description of a particular event of circumstance 'if it crops up again' and 'then' is followed by a conclusion; 'then you go through the process again'. The 'think positive' discourse is used here in that 'hopefully it will be a similar sort of process'. The subject position of stoical acceptance is worked up towards the end of the extract where Tessa talks of 'Scars

you can live with'. Being scarred is positioned against the worst possible scenario of death affording it a comparatively positive flavour ('It's being here at the end of it that matters'). Here, cancer is constructed as a threat to life and as troublesome. By drawing upon the PTG discourse Tessa manages the troubled position of having been threatened by death, and of having the threat to future life by talk which prizes life and relationships and backgrounds fear and suffering. At the end of the extract (line 471-2) Tessa uses a three part list 'children, grandchildren and husbands' to add emphasis. Jefferson (1990) describes three part lists as a common feature within talk, with a variety of forms and functions. Here Tessa's reference to key social relationships (pluralised to perhaps once again diffuse the personal effect of occupying this troubled position alone) works up a position of gratitude and appreciation, of surviving well.

Similarly, in the extract below, Ali talks of living with the fear of recurrence. Prior to the extract below, had talked Ali of the felt sense of obligation to live balancing two polarised positions as 'an amazing success story' having been successfully treated, yet in the context of long term consequences which she termed 'fall out', synonymous with the after effects of nuclear explosion. These are powerful and evocative words and I pick up on this theme of striving for balance at the beginning of the extract.

Extract no 2: Taken from Interview (1) with Ali.

200	Jennie	Mm, mm. What was it like getting the balance between living an 'amazing success
201		story' and dealing with the 'fall out'?
202	Ali	It was quite hard really, even, because you've got a lot of side effects you're
203		dealing with. I'm lucky, I didn't have to take all the hideous hormone
204		treatments some people have to live on for five years, but I had an arm that
205		wasn't working brilliantly um, I think it took a good year to recover energy
206		levels to any proper extent
207	Jennie	so just the physical post-treatment
208	Ali	[yes

209	Jennie	[side of things, yeah, in its own right
210	Ali	Yeah absolutely. Um mentally, quite a bit of that getting used to that, not freaking
211		out every day, was it going to come back?
212	Jennie	Mm
213	Ali	But I was quite lucky, the success story bit there could be my mantra 'they've fixed
214		me once they could, do, fix me again'
215	Jennie	Mm
216	Ali	You know they're clever people
217	Jennie	Mm
218	Ali	But, which was also really important with the triple negative thing, there weren't
219		any other strings to the bow, we'd used every bit of treatment we'd got <u>um</u> (.) so
220		that's one of the only buggers about being triple negative really (.) erm (.) yeah so,
221		it was a difficult to balance all of that, and people do this, they always say, don't
222		they with all cancer don't they, 'Oh positive thinking'
223	Jennie	Mm
224	Ali	And when you're bouncing back from all of that, you can't live every day like
225		you're having a party, and live life to the full', you've got a young family to look
226		after there's very practical things you just have to bite the bullet and <u>get on with</u>
227		don't you?
227	Jennie	Mm
228	Ali	So some days life can feel a bit disappointing I suppose (.) and then other days I
229		Just feel very spoilt and very lucky, so it swings from one to the other really.
230		So it definitely does, that 'stay positive' thing does help. Keeping buoyant, but it
231		doesn't help in the <u>afterlife</u> when you're not having a positive '<u>whoopee</u>, shall I go
232		sky diving today?' type thing

Ali acknowledges that balancing is; 'quite hard really' (line 202). 'Quite' is an example of an extreme case formulation (Pomerantz, 1986), which Willig (2008) notes minimises the effect, of what could be a strong statement. Ali draws upon the biomedical model by taking up the words 'side effects', but then repairs the troubles talk she has engaged in, by drawing upon the fortune discourse in line 203, ('I'm lucky'). Using the fortune discourse allows Ali to externalise difficulty

and works up a less troubled subject position in contrast to others required to take 'hideous hormone treatments' for a number of years after acute treatment has ended. When she completes her sentence after the use of 'but', the effect of the troubles talk (fatigue that lasted for a year, and impaired use of her arm due to lymphedema) is again minimised. In line 207 I position these effects as 'just physical post treatment' which can either construct them as standard and expected, or carries implication that they alone are enough to contend with. Ali's reply takes up the latter, and offers up a psychological post treatment difficulty in line 210-11 ('not freaking out every day, was it going to come back?'). 'Freaking out' here works up a picture of acute anxiety, and 'every day' further heightens the relentless, consuming nature of the fear. As Crouch and McKenzie (2000) point out 'women do this work mostly alone, more often than not in the dark, toiling away at one of the most stressful occupations humans can have: keeping pervasive anxiety at bay'(p. 210). Once again, we can see the dilemma that speakers have when they use troubles talk, placing themselves in difficult discursive spaces. Ali repairs this troubled position by use of the fortune discourse once more, ('quite lucky') and furthers this by formulating a 'mantra', a saying used repetitively to oneself as a means to allay the fear accompanying thinking or talking about recurrence. This saying is an example of the think positive discourse in action. In line 213-14 it is strengthened by use of the biomedical model, ('they fixed me once, they could do, fix me again') and later in line 216 where the medical profession are imbued with knowledge and therefore power, ('you know, they're clever people'). As she does this Ali draws the hearer on board by use of 'you know' thus minimising the worst case scenario imaginable; the failure of biomedicine if next time she might not be 'fixed'. In line 218 Ali presents the evidence for her worry by orienting to her treatment experience, in that because her breast cancer tested negative for a definite cause (oestrogen, progesterone, or HER2 receptive), her treatment options were reduced to acute treatments only (chemotherapy and lumpectomy) with no option of follow up treatment (hormone or

protein therapy). This is a troubled position to occupy and Ali contests the use of 'positive thinking' which she notes hearing from others in her social world in line 221 ('people do this'), which is quantified with the use of an extreme case formulation (Pomerantz, 1986) 'always'. Contesting such a dominant discourse is in itself troubling, and so Ali softens this position by posing it as a question and broadening out the scope to 'all cancer' and therefore not just something she personally has experienced. When she states that the problem here is 'Oh positive thinking' she does so by using active voicing. Active voicing (Hutchby & Wooffitt, 1998) is an externalising device through which speakers present information in a current conversation in the way it appeared in another on a different occasion. Through active voicing the validity of what is being said is strengthened. In line 223 my implicit agreement is given ('mm'). In lines 224 to 227 Ali constructs having cancer as involving a fall but also requiring recovery ('And when you're bouncing back from all of that,') however, she also orients to the expectation that life must now be 'lived to the full.' Here the discourse of PTG, with the pressure to be appreciative and visibly living life in a new way, is subtly alluded to but also contested. Life after cancer has demands of its own such as 'a family to look after' and 'practical things' which is worked up by the use of an extreme case formulation 'very'. Meeting these demands requires a stoical facing up to the unavoidable, and to actively 'get on with'. Again Ali pulls in the hearer by posing this as a rhetorical question. In doing so she is working up her difficulties as one that everyone faces at some time ('you just have to get on with it, don't you?). She uses an idiom 'bite the bullet' which evokes the battle metaphor of cancer, and signifies an acceptance of difficulty. Paired with 'you have to' this alludes to the obligatory nature of this. In lines 228 to 232 Ali further works up the difficulty negotiating this social obligation to live successfully after cancer by framing the two opposing positions possible. Life can sometimes feel 'a bit disappointing' or at other times one can feel 'very spoilt' and 'very lucky'. Here, 'disappointing' alludes to the pressure to live in a certain way after cancer. By her use of the adjective 'spoilt' Ali aligns herself

as one who does not recognise the value of what has been lavished upon them, and perhaps is ungrateful. To be disappointed, or perhaps to be seen as disappointed, is troubling. In comparison, to be spoilt is perhaps more positive. The effect of both is worked up by the use of extreme case formulations. 'Disappointing' is minimised by use of 'a bit' and 'spoilt' is maximised by use of 'very'. Ali then uses the fortune discourse again in line 229 'lucky' again maximising this with the extreme case formulation 'very' to make sense of her position and repair the troubles. In line 230 Ali aligns herself to the think positive discourse which is constructed as useful during treatment (interestingly this is in variation to Ali's early talk of treatment where she positions this kind of talk as unhelpful), but not in the 'afterlife' (itself reminiscent of life after death), where she uses a concrete example with active voicing of someone living a celebratory and successful life ('whoopee shall I go sky diving today?') This is offered with a sarcastic tone, contesting the felt obligation to live a life less ordinary amongst the very ordinary tasks of life and the challenges of life post-cancer. Here, Ali has resisted an idiom (Kitzinger, 2000).

5.2.2   Treatment consequences

The women also talked about living with the after effects of treatment. In the following extract, Tessa talks about the long term consequences; physical (collapsed veins) and psychological (fear of needles).

Extract no 3: Taken from Interview (2) with Tessa.

88	Tessa	think the worst, the worst thing is it's given me is, I've got such a bad vein,
89		anyway after all the ops. Erm and that was my good vein (laughs)
90	Jennie	So they had that one as well
91	Tessa	They can't use that one any more. So um, yeah, and I'm petrified of needles
92		now
93	Jennie	Right.
94	Tessa	Never used to be, used to be a blood donor, used to never bother me having

95		injections giving blood. Now it's quite funny when I have to have blood taken, I
96		go there twenty minutes to half an hour before. They find the vein, I then apply
97		X (brand name) then it doesn't worry me cos I know it's not going to hurt. Um
98		because one of the times when I was unwell they had to (.) canulate me and it
99		took two attempts
100	Jennie	So you've really been through the mill
101	Tessa	(laughs) yes my feet and arm were black and blue
102	Jennie	You were a pin cushion
103	Tessa	I was. Yeah so, no, I'm <u>alive.</u>

In the opening lines, Tessa talks about the impact of cancer treatment on her veins, already compromised by numerous operations to repair hernias. Procedures related to her cancer treatment have turned her one remaining good vein into 'a bad vein'. In line 91, she uses the biomedical discourse which objectifies her body and constructs her veins as a tool which the medical profession ('they') use. The psychological consequence is worked up as long term and interferes with exemplary acts (being a blood donor, line 95). Tessa repairs a troubled subject position by working up agency and expertise in lines 95-97 through her account of managing having blood taken. Here, rather than a passive recipient of care (with consequences) she partners with the medical profession ('they find the vein, I then apply X'). In lines 98 and 99, Tessa works up the difficulty that having a collapsed vein has given her in the past. Again she uses the biomedical discourse, by using a technical term 'canulate'. As Jefferson (1980) notes, hearing troubles talk is a difficult task, and so, in line 100, I reflect that Tessa has 'been through the mill' signifying I think she has experienced extreme difficulty. Tessa's laughter (line 101) signifies agreement, but that she perhaps finds it hard to occupy this troubled position for long. Laughter, as Jefferson urges, should be attended to in talk as it is a conversational device which speakers can use in troubles talk to switch the focus of the topic to amusement. In the next line, I join with her and use a more amusing metaphor 'you were a pin cushion'. Together, Tessa and

I have made a repair. In the final line of the extract, Tessa reclaims an untroubled subject position by closing the interaction with a short statement which has powerful rhetorical force 'Yeah so, no, I'm <u>alive</u>' drawing on the PTG discourse and again demonstrating appreciation of life even with the difficulties she has talked about (and in contrast to the opposite pole; death).

The treatment of breast cancer may require surgery; partial (Lumpectomy) or total (Mastectomy) removal of the breast. Scarring and lack of symmetry can result which women often strive to conceal in order to maintain visible 'normality' (Crouch & McKenzie, 2000). Here, Anne talks about feeling self-conscious after lumpectomy.

Extract no 4: Taken from Interview (4) with Anne.

304	Anne	I am self-conscious of what I look like, um it's not, cos I'm quite mis-
305		shaped and it's, it's this one, this one's up here. There's a different shape and I
306		think, and it's scarred. I am self-conscious of what I look like.
307	Jennie	Mm
308	Anne	And I remember saying to X (husband), 'you will come in and have a look at me',
309		do you want to have a look?' he said' it doesn't matter to me what you look like,
310		you're my wife' and um, it didn't bother him, didn't bother him at all.
311	Jennie	Mm. Has that changed with time for you? When you look now?
312	Anne	I don't think you notice now, the only time, I have to go and get bras made
313	Jennie	Mm
314	Anne	I go to a shop in X (location) and um in fact I took X last time cos she's got this
315		scar (gestures down length of sternum)
316	Jennie	Oh gosh!
317	Anne	And I said, 'X (friend) how do you get on with bras and she said ' I have difficulty
318		here', so I said 'I go to this place in X, this lady's lovely, do you wanna come?
319		Why Don't you come with me?' So she's in one cubicle, and I was in the other.
320		And I said to the woman, 'my friend's there because she's got this scar,' she
321		knows me there, and I said 'I'm here because I can't fill this left one out'.
322	Jennie	Mm, mm
323	Anne	And it was fine, we were having a good laugh after it, and we both got ourselves
324		sorted. It was a lovely place. I've found a nice place where I can be fitted

325		properly.
326	Jennie	So that makes a difference
327	Anne	So I'm just so grateful that I got through it, and I'm sure I'm going to be fine, I'm
328		going to be fine for the rest of my life. I'm quite positive. So no I think to myself
329		'put that now in a cupboard, and forget about it'

Anne's account has a number of discursive features through which she manages her troubles talk. In lines 304-310 Anne constructs breasts as objects which could reveal her post-cancer status to those around her (if someone can tell when she is dressed), and also a part of her sexuality, making her attractive to her husband. Having twice used the statement 'I am self-conscious of what I look like' Anne has worked up being concerned as her own personal opinion. Anne then uses active voicing to relay a conversation with her husband in which she emphasises that her misshapen breast 'did not bother him at all'. Despite Anne having used the present tense 'I am' at the beginning of the sentence in line 311 I pose the question whether she still feels this way, thereby offering Anne an opportunity to repair her troubled position. Anne responds by taking up this position and states it is perhaps less noticeable now. She goes on to give an account of how she manages the problem 'I get bras made' and then, using the fortune discourse, she positions herself against a friend with a significant scar. In line 316 my response indicates shock at the friends scar ('gosh'), and highlights that as a hearer I have accepted Anne's relatively positive position and the discursive strategy has been effective. Following this, Anne introduces an element of comedy, recalling a conversation in the shop, and lightens the situation further by talking about the way in which she and her friend coped with the situation, ('And it was fine, we were having a good laugh after it, and we both got ourselves sorted'). In lines 327 -329, Anne orients to her position as a survivor with gratitude, ('I am just so grateful I got through it'), employing the think positive discourse to afford security for the future as she subtly manages fear of recurrence ('I'm sure I'm going to be fine, I'm going to be fine for

the rest of my life. I'm quite positive'). This allows for a position in which the experience of cancer and the troubled subject position can be bracketed off, ('put that now in a cupboard, and forget about it').

5.2.3   Career disruption

For Sue and Anne, returning to work marked a return to normal life. For Tessa, and particularly for Ali, there was a significant disruption to their career. Tessa could not return to work because of loss of sensation in her foot (due to chemotherapy) leaving her unable to drive. In the following extract she makes sense of her changed work life, working up a positive post-work identity in which the reason for her stopping work might go unnoticed.

Extract no 5: Taken from Interview (2) with Tessa.

232	Tessa	Um I think the one thing it, this whole thing has taught me is that um life is for
233		living, um I was in, I was a care home manager with the elderly, working anywhere
234		between 45 or 50 hours a week
235	Jennie	Gosh
236	Tessa	Um
237	Jennie	That's quite a full on job [isn't it?
238	Tessa	[yeah, yeah. And because I couldn't drive any more for a time, I decided to actually
239		um (.) leave, and I didn't actually think about work for a good eighteen months.
240		My GP was really good um now I said I d-didn't feel I was ready to go back to work
241		and er he said 'well, with your medical history for hernias and everything, um,
242		we'll just sign you off sick until you are ready' (.)

Tessa begins by constructing cancer as having afforded her the opportunity to re-evaluate her life priorities, although she does not explicitly name the cancer. In doing so she uses the PTG discourse. She goes on to construct her job as a care home manager working up an image of sacrifice and dedication. This could be heard as an exemplary life, or as a burden. As the hearer I

pick up on the latter in line 235 by exclaiming, and then voicing that her job was 'quite full on' in line 237. Having positioned her work hours as problematic, in line 238 Tessa works up the change as having been her decision and draws upon the biomedical discourse where the medical profession give advice. Here, her GP's opinion is given, and other illnesses (hernias) are brought into focus while the cancer is largely hidden. In this extract we see how Tessa manages her career loss discursively, at times foregrounding her cancer and drawing upon PTG after cancer as a means of constructing this loss as beneficial, and at other times foregrounding her other illnesses as causative to the loss. Tessa and I have negotiated a path through a difficult problem.

For Ali, the disruption to her sense of self-identity was huge, and came when she was at the height of her career. Ali could no longer continue with her career as a pilot, having had a flight ban imposed due to risk of recurrence.

Extract no 6: Taken from Interview (1) with Ali.

286	Ali	Yes, yeah. And I lost my job as a result of it
287	Jennie	Gosh, so that
288	Ali	they took my medical away for <u>five years</u>
289	Jennie	Right
290	Ali	because of the likelihood, with it having gone to my lymph, the stats of it
291		coming back as a brain tumour were quite high, and so they won't let you
292		back in charge of a plane
293	Jennie	[Mm
294	Ali	If you're likely to have a fit from a brain tumour and that sort of thing (inhales
295		sharply) so the fallout from <u>that</u> has been <u>massive</u> and er (.) <u>very</u> traumatic
296		for quite some time for me er (.) but in the long run I can see it's meant I've
297		had a wonderful time with my <u>children</u>, when they're little, when they're
298		behaving obviously, other days, the little bastards, <u>and I look up at the sky</u>
299		<u>and go 'arrgh!'</u> (laughs) so that's what upsets me about this 'get on with life',
300		it's get on with a completely different life

301	Jennie	Mmhmm
302	Ali	(.) so that decision about do I go back to work, or do I <u>treasure</u> time with my
303		family because I've been ill all got taken away from me, erm and that's just
304		what happened. Get on with it.

In lines 286 and 288 Ali talks about how, because her employers were concerned she might develop secondary cancer in her brain, she lost her pilot's licence. Her lack of agency here is worked up in relation to powerful others, 'they,' who made the decision based upon medical information about risk. The biomedical model is drawn upon to construct the way that information is held and processed ('stats,' line 290) and the possible symptoms of a brain tumour is given, 'a fit', and 'that sort of thing'. In line 294-95, Ali's sharp inhalation suggests that thinking about having brain cancer and also the repercussions of this while in charge of an airplane are difficult. What follows is also difficult to say. In line 295 Ali orients to the life disruption that she has experienced as 'fallout' which is further emphasised by use of an extreme case formulation 'massive.' Ali's career loss is constructed as a personal trauma again emphasised with the use of an extreme case formulation 'very', and one which is chronic ('for quite some time for me'). This troubling position is difficult for Ali to be in, and so she attempts a repair by stating that career loss has 'in the long run' afforded time with her children which she works up through use of the descriptor 'wonderful'. Here, Ali has drawn on the PTG discourse to do repair work. Certain criteria are given to the benefit experienced, 'when they're little' suggesting that there are times when being at home is more sanctioned than at others, and that there are times when this is more pleasurable than others, ('when they are behaving'). This, and the expletive that follows, are said with humour. The aching loss that Ali experiences at being physically grounded is worked up emotively but also with humour to soften the effect in line 298-99 ('and I look up at the sky and go Arrgh!') In the closing lines, we see variation to Ali's claim of finding benefit earlier when she states that she has had no choice but to 'treasure

the time with my family' (lines 302-303). Ali constructs the choice that she might have made if the decision had been hers and, in doing so, we can see the possibility that might have been afforded. This is constructed in relation to her cancer experience, ('because I've been ill'), which in some respects ties her to membership of the category of 'ill' and reads almost as a punishment. In lines 303-304 she adopts the stoical attitude prescribed within survivorship to repair this troubled position; 'that's just what happened, get on with it.'

5.3   Orienting to PTG: Constructing a positive post cancer identity

Although the PTG discourse had been used discursively in some instances to managing identity in talk of troubles, when the notion of PTG was framed and presented during the interview the women were asked to orient to this explicitly e.g. to respond whether this was something they had experienced. Sue, Ali and Tessa answered the question and aligned themselves with both positions, e.g. that negative consequences and positive benefits or growth had both been experienced. Ann however stated that she had not experienced growth.

In the following extracts I highlight responses which appear to show the women reporting PTG. However, in attending to context and variation, between these and previous accounts, we can see how identity work is being accomplished. The extracts are organised around the area of PTG that they appear to support.

5.3.1   Changes to sense of self

In contrast to her account of career loss which occurred within troubles talk (see extract 6), in the extract below Ali works up her agency by constructing herself as stronger after cancer, and in constructing cancer as an event which on one hand brought negative consequence but on the other afforded spaces for change to occur that otherwise might not have happened.

Extract no 7: Taken from Interview (1) with Ali.

505   Ali   Yeah, so I get a bit of both really

506   Jennie   Mm

507   Ali   Some of it was very traumatic and I think that's why it's left me a bit twitchier,

508   more neurotic person at the other end of it, I think, at a deep seated level of all

509   that grief and loss and change and eurgh

510   Jennie   Mm

511   Ali   And then other parts of me, um feel stronger because I survived it. I've culled a

512   lot of the nonsense in my life, all that juggling work and this sort of thing, it

513   wasn't me that culled it, but it's completely shaped definitely who we are as a

514   family, and I don't think I would have been strong enough to bin my career if it

515   hadn't have happened. Do you know what I mean? So it's a positive thing that's

516   come out of it, despite whatever my mood swings are, for family. So I could do

517   both camps on that

518   Jennie   Mm mm

At the outset, Ali orients to cancer as having brought both positive and negative consequence. Cancer is constructed as a trauma, and an extreme case formulation is used ('very'; line 507). Ali draws upon the mental health label 'neurotic' which pathologises her residual anxiety. She softens the effect of this discursively by switching to a more informal label 'twitchier,' which is worked up with the use of a minimising extreme case formulation ('a bit'). The cancer journey is given a beginning and an ending in line 508 ('at the other end of it') which constructs her current position implicitly as post-cancer. Ali uses the synonym 'deep seated', which constructs the change as chronic and enduring. Ali's experience of cancer happened just before her mother's death, and so this is part and parcel of her cancer story. We see this in line 509 through her use of a three part list 'grief and loss and change', which could include her bereavement and invokes a sense of multiple losses. At the close of the list, Ali ends with a sound 'eurgh' which is felt by us both, almost viscerally. This sound embodies the grief, loss and

change. Ali negotiates the social and moral obligation to demonstrate that she is surviving well, which I have put before her, (511-517) when, in contrast to the subject position of one who has suffered loss, she positions herself as stronger by virtue of having survived. Here she re-phrases the widely adopted Nietzsche (1888) quote 'what doesn't kill you makes you stronger.' Cancer is then re-constructed from trauma to vehicle, something that allowed her to 'cull some of the nonsense' including work, which was heard in earlier account to form part of the loss and grief. This is paradoxical of course, since it could be argued that Ali would not have wanted to 'bin' her career. Although she has reclaimed some agency, Ali's claim is offered tentatively, and the use of the question 'do you know what I mean?' (line 515) suggests recognition that this position could be contested.

The concept of cancer highlighting the presence of qualities that facilitate coping, is picked up in the next extract where Anne, who describes herself as a Christian, responds to my question about the role her faith has played in her cancer experience.

Extract no 8: Taken from Interview (4) with Anne.

662	Jennie	Do you think you experienced any changes with your faith, how did your faith,
663		What was it like to be a woman of faith, Christian faith, coming through that
664		experience?
665	Anne	I don't know how people would do it, who didn't have faith. My faith has
666		carried me all the way through all circumstances and I don't know how people
667		cope who haven't got a faith and I think the Lord is looking after me, no doubt,
668		(inaudible) and I'll be fine. That's how I look at it now. And I will be fine, I'll be
669		fine. Please God (laughs).

Anne had been open about her Christian faith during the interview, and after she had oriented to the question of PTG following her breast cancer, saying she had not experienced growth, in line 662 I ask her whether her faith has been changed. In her answer Anne constructs faith as a

support to her through her cancer experience. Whilst this does not construct a change in her faith as such, it shows how faith is mobilised as a discursive resource in her talk allowing her to position herself using the fortune discourse, 'the Lord is looking after me, no doubt'. 'No doubt' here makes this assertion uncontestable (line 667). Anne predicts her future survival by using the think positive discourse; 'I will be fine, I'll be fine' (line 668-669) although at the end of the extract the fragility of this position is constructed with the appeal 'please God' which positions Anne as dependent upon a higher power. Anne accompanies this with laughter to reduce the rhetorical force of what has been said.

In the following extract, Tessa orients to the notion of PTG by responding that she feels a sense of increased optimism after cancer.

Extract no 9: Taken from Interview (2) with Tessa.

```
540    Tessa    yeah I think I've, I think I'm more optimistic I think in some things than I used to
541             be, um yeah I know my limit, patience, things I can and can't do, um but I will
542             try most things
```

In line 540 Tessa uses the phrase 'I think' three times, clearly staking a personal claim; that she is now more optimistic in some areas in comparison to her pre-cancer self. There is an implicit acknowledgement that this position could be contested and, in the following line, she works up the rhetorical force of her statement further by citing the things that she 'knows' 'limit, patience, things I can and can't do', before taking up a subject position that is adventurous and engaged in living 'I will try most things'.

5.3.2   Improved relationships with others

The experience of breast cancer as a traumatic life event was also worked up as something that afforded an improvement in certain social relationships.

57

Extract no 10: Taken from Interview (2) with Tessa.

100	Jennie	What about the kind of, this idea about benefits afterwards, you know, kind of
101		growing as a result of it all?
102	Tessa	I think you grow closer to people after something like this, em and that you're
103		able to talk (.) more freely. I don't think so many things worry you, em, once
104		you've had any type of cancer
105	Jennie	Why's that do you think?
106	Tessa	Because the c word was always something to be afraid of
107	Jennie	Because it was?
108	Tessa	Because, like twenty years ago, very limited if you were going to survive

At the beginning of the exchange, I asked Tessa how she might have benefitted following her breast cancer experience. In her reply (lines 102-103), Tessa cites closer relationships in which there is more freedom in conversation. In line 103 she constructs cancer as being something causing great worry, and in relation to this other life problems appear less taxing. The effect of cancer as 'putting worries into perspective' is maximised by the broadening of the category of cancer type from breast cancer to any cancer type. Use of the personal pronoun 'I' is suspended in favour of 'you', which again is more general. When I press Tessa, as to why this is the case (line 105), she responds in line 106 by using a common way of speaking about cancer, in which the actual word remains unspoken ('the 'c' word'). This invokes cancer as synonymous with suffering and death, talk of which raises anxiety. Noticeably, Tessa uses the past tense ('because the c word was always something to be afraid of'). In line 107 Tessa draws upon the biomedical discourse and locates this construction historically in a period of time in which she constructs survivorship as greatly reduced in comparison to now. In doing so, Tessa weakens the constructions of cancer that she has made elsewhere, as traumatic and life threatening. What is also noticeable in this extract is Tessa's assertion that she can talk more freely following cancer, when in other areas of the interview this had been disputed.

5.3.3   Changes in sense of life priorities and values

Immediately before the extract below, Tessa had been talking about her job as a care home manager working forty to fifty hours per week. Having talked previously of leaving this job because she could no longer drive due to chemotherapy related side effects, Tessa is describing the life she now lives in comparison, working up a change to life with a new found perspective on what matters.

Extract no 11: Taken from Interview (2) with Tessa.

611	Tessa	Yeah, to actually now where, um, where we ring each other saying 'are you free
612		on so and so a date? Do you want to go out for lunch? Where are we going?
613		Who's picking you up? Um (.) yes so being quite relaxed (.) so
614		um, and I think, you know, 'I'll do the housework today, no I won't it's not worth
615		it'll need to get done tomorrow so we'll leave it today'. So no, no, whereas when
616		you're working, you know yourself, that you have to fit everything in to such a
617		a few hours. Now it's quite laid back, and there's no actually rushing around
618	Jennie	Mm. How much of that do you, you think is your kind of way of thinking post
619		cancer, and how much of that because you're no longer working full time
620		do you know what I mean?
621	Tessa	Yeah, I think most of it is (.) post cancer (.) um because even when I was off sick
622		before the cancer, so I wasn't working was still made myself do the housework
623		everyday um you know, the washing, the ironing, the hoovering, the dusting, the
624		polishing. Um so then I was doing something every single day, so now I think
625		'does it need doing today, does it look untidy'? Um.
626	Jennie	So like a new perspective on what matters?
627	Tessa	Yeah, what's important
628	Jennie	Yeah
629	Tessa	Say it's more important to actually sit down and have a natter to X (husband)
630		than it is to do the hoovering (.) um (.) which I think it's more important to spend
631		some time with him than it is to do the housework some days um (.) because it's
632		not just me that's gone through the cancer, it's him (.)

Tessa describes how in her new way of living she has time to make spontaneous social arrangements. She uses active voicing in lines 611 and 612 to work up the rhetorical effect of this changed pace of life, and strengthens this further with an extreme case formulation 'quite relaxed'. Tessa switches between 'I think' and 'you know' in an attempt to draw the hearer into her understanding of what matters. A possible alternative understanding might be that Tessa is displaying laziness, or that due to her previous illness she cannot manage the housework. In line 615 she draws the hearer in further by orienting to me as a busy working woman 'you know yourself, you have to fit everything in to such a few hours' (line 616). This, on one hand, constructs Tessa's new life as carefree and re-prioritised, but also works up a construction of gender in which women work, and also are responsible for household duties, which she then rejects in favour of her new life philosophy. In lines 618-620 I query whether her new found philosophy is the product of re-evaluation after cancer or because she has more free time now. Tessa evidences her response that it is mostly the result of the cancer by giving an account of being off sick after a hernia operation yet still attending to cleaning tasks daily. Tessa's talk here is interesting in that in orienting to the notion of PTG she has worked up an account of valued life change. In previous talk (see extract 5) Tessa instead attributed the change of work role as not being due to cancer, and works up agency in having been able to make the decision herself. Towards the end of the extract Tessa makes it known that she has arrived at this decision, to leave the housework on some occasions, because she prizes social interaction with her husband, 'it's more important to sit down and have a natter with him'. Finally, she works up cancer as being relationally experienced; 'it's not just me that's gone through it, it's him'. In this way her husband is afforded the survivor position too, and partners with her in the new post-cancer lifestyle.

Similarly, in the following extract Sue works up the notion of cancer as a vehicle through which she could re-evaluate her life.

Extract no 12: Taken from Interview (3) with Sue.

913	Sue	I think I might be somewhere in the middle
914	Jennie	Mm
915	Sue	Um (.) I think the only difference that it's really made to my life is maybe
916		of taking a look at it and thought 'no I'm going to do something for me',
917		Instead of just being a wife and carer and all of those things, so (.) but cancer
918		doesn't really come into it any more.
920	Jennie	Mm, but that's the thing, so this is the experience that's kind of allowed that
921		new kind of thinking to happen?
922	Sue	Yeah

In line 913, Sue positions cancer as affording the opportunity to renegotiate previously held roles. In line 917 Sue names these roles 'wife and carer and all those things,' giving additional effect by the use of a three part list. However, Sue constructs the link with cancer as a single event and not something she orients to now, 'but cancer doesn't really come into it now.' In my response I contest this distancing, gently, by linking the new thinking as caused by the cancer (line 921) and in doing so take up the PTG discourse myself.

In the following extract, Tessa continues with the theme of changed life priorities and goals and talks about a greater sense of appreciation of life following cancer.

Extract no 13: Taken from Interview (2) with Tessa.

557	Tessa	Yeah, um so, and just enjoying, you know, what life throws at you now, I think,
558		and being prepared for the good things and the bad things. Um and my eldest
559		granddaughter was ten on Saturday, and um we, my daughter only lives about
560		three miles away so we spent the day there with about 25 other children.
561	Jennie	Oh God
562	Tessa	(laughs) and um having a really nice birthday party, and my husband adores
563		fireworks, so we had a big firework display in the evening (.) and um and just
564		thoroughly relaxed and just watched the children, you know all the stupid and

565		'Ooh they're going to hurt themselves' and thinking, 'they're just enjoying
566		themselves'
567	Jennie	Mm
568	Tessa	and enjoying watching what they're doing, and I don't think I did that as much
569		beforehand
570	Jennie	Mm
571	Tessa	Em I mean I don't think I appreciated what was going on around me as much as
572		I do now, um, no I mean, as I said to you I don't like gardening but I do enjoy
573		coming out here of an evening and watering the garden

Tessa constructs life after cancer as living in the moment, embracing and accepting the good and being prepared for the bad (line 558). Tessa uses the example of attending a birthday party (her granddaughter's) and of sitting and watching the children to work up her position of appreciation of life. A scene of twenty five children celebrating a birthday conjures up the notion of life well. However, to some it might be an unpleasant situation to be in, and I voice this alternative position with humour in line 561 ('Oh God'). Tessa's laugh acknowledges this however she works discursively to strengthen and defend this event as pleasant and celebratory. Her use of emotive words 'adores' (line 562) accompany extreme case formulations to maximise the effect ('really nice' birthday party, 'big' firework display). In lines 564 Tessa prefixes the state of relaxation with an extreme case formulation 'just thoroughly' (relaxed), 'just' (watching the children) and then follows this by acknowledging that to other people these things might seem trivial and unimportant ('all the stupid and silly things'), and evidences her relaxed state by reframing what others might consider worrying using active voicing ('Ooh, they're going to hurt themselves' to 'they're just enjoying themselves'). Tessa works up a position of new found awareness of the things that other people overlook in line 571 ('I don't think I appreciated what was going on around me as much as I do now'), and of finding pleasure in ordinary things like watering the garden (line 573).

5.3.4 Constructing a socially visible positive post-trauma identity

After directly orienting to the question of PTG after cancer, the women continued to construct positive identities discursively, crafting subject positions that went beyond a return to normal life after cancer, demonstrating flourishing lives as successful survivors. Significantly the subject positions were socially visible and were chiefly accomplished through talk of participation in cancer related activities (e.g. taking part in research, fundraising, helping others at the early stages of the cancer journey).

In working up accounts in which they demonstrate giving back, standing by or advocating for others, and in honouring those who died, gratitude and appreciation for life is displayed. The women show, through their talk, that they have earned the right to survive in a social context where survivorship is prized, and set against a social reality where cancer cannot always be cured. In working up participation in these events, the women are making use of social spaces in which to transcend the problematic categories of illness and suffering to what Hozman (2005) calls an 'upbeat and grateful image' (p. 39). They women are, in effect, doing accountability. As Wetherell (1998) claims, accountability is managed by talk, and in the context in which the talk takes place.

In the following extract in which Ali orients to activities which form part of the category membership of the flourishing survivor.

Extract no 14: Taken from Interview (1) with Ali.

779	Jennie	It turned, literally into a [race for life?
780	Ali	[yeah, I suddenly realised I was upset by it. None of them had got, have you
781		ever done or seen one? People put these labels on their backs for who you're
782		running in honour of. Me and x (daughter) were the only ones who were
783		running in honour of anybody, and x being x (daughter) went 'Mummy,
784		Mummy why are we the only ones with things on our backs? Within the school

785		group. And I said 'I don't know' and that should have been alarm bells. It was
786		more about racing. We did raise nearly six grand, you know so I'm not saying it
787		was just about racing. So some of the emotion, I was looking forward to this
788		'women empowered'
789	Jennie	Mm
790	Ali	'We're fighting it, some of us have actually got it but are still fighting it', and
791		this sort of thing. It just turned into the slightly nasty, you know overly
792		competitive bickering race. And that was when I think the whole thing of
793		monday being clinic day, being seen by the oncologist, Wednesday having a
794		row with my daughter half way round the race for life thing, when I was
795		supposed to be doing it in honour of my mother and I didn't feel fit enough, or
796		I could have been fit enough if this bloody woman hadn't said, told me not to
797		run it.

Hozman's (2005) upbeat grateful image is notable in the extract above. As Kaiser (2008) points out, survivorship is honoured at public events, of which Cancer Research UK's 'Race for Life' is one example. Ali and her daughter took part in the 'Race for Life', running with a group. By taking part, funds are raised to aid current patients, but runners often take part in honour of someone who has died. Ali ran in honour her mother, while her daughter ran to celebrate Ali's survival. Prior to the extract shown, Ali has spoken of being told that the group would walk. Ali's position (and her daughter's) is worked up as taking part in the ethos of empowerment, support and honour. This position is worked up against others who do not have a personal stake in the disease (780-788). In line 790, Ali brings together three possible cancer related identities in one context; survivors who still have the disease, survivors who are cancer free, and a third; those who have died, and uses the pronoun 'we' and the verb 'fighting' in relation to cancer, here labelled as 'it'. She employs a three part list to powerful effect ('We're fighting it, some of us have actually got it but are still fighting it, and this sort of thing'). Using the term 'fighting' invokes the battle metaphor of cancer talk invoking an image of camaraderie. In this context

one might expect an underlying philosophy of mutual support and encouragement. However Ali's experience is constructed as being the opposite of this. It is the juxtaposition of her expectations for the day as an opportunity to unify with others against cancer, and the construction of a competitive race, that works up the rhetorical force of another key event that Ali experienced that same week; her sign off by the oncologist. Being signed off means that Ali will now only have routine screening for recurrence. Taking up the position of one who has survived and is cancer free is not without difficulty for Ali, since having been told she need not run Ali found that actually everyone did, and this highlighted that she was not fit enough for the event (795). Although she does not have cancer, Ali is re-consigned to the category of unhealthy.

All of the women spoke about support that they have given to others who were going through investigation, diagnosis or treatment for breast cancer. Here Sue talks about being able to help others understand what a member of their family might be experiencing.

Extract no 15: Taken from Interview (3) with Sue.

949	Sue	Yeah. So but actually that's something that happened, that's not something
950		that I live, and I think that's the difference, it's something that happened,
951		something that I went through, but actually I'm not going through it on a daily
952		basis, I'm not even going through it on a monthly basis
953	Jennie	Mm
954	Sue	Um it's not something that comes back to me really
955	Jennie	Mm
956	Sue	It's something that I can relate to, and you know I've got a colleague in work
957		now whose stepmother is going through um, whose, sorry whose mother in
958		law is going through. She's just had the biopsies done and they don't know the
959		full story because actually she's not telling them anything
960	Jennie	Oh
961	Sue	Um, so I've been able to stand alongside her and say, 'this is what's happening'
962		she'll, she'll not have the surgery. Um so I think I use my experience in that

963		way
964	Jennie	Mm
965	Sue	But it's not something I want to relive. Because actually I've got a future

Sue's account highlights the difficulty of creating an identity which is distanced from cancer. By orienting to activities that are associated with giving back, she manages a potentially troubled subject position. Giving back, here by providing insight into what is being kept secret by the step-mother of a friend, allows for a sense of expertise or mastery and insider knowledge to be worked up, and importantly places Sue further down the time line of cancer than the women she relates to in her account.

In the following two extracts Sue negotiates a positive identity, acknowledging that she has had cancer and is shaped but not owned by it. Significantly, Sue's extract shows the tension between living beyond cancer as a survivor who is fundamentally still tied to the disease, and yet striving for a positive post cancer identity.

Extract no 16: Taken from Interview (3) with Sue.

999	Sue	There's no way round or under it, if you've gotta go through something,
1000		you've, but I guess in my own way I did, but once you've faced it and you've
1001		gone through it (.) you don't have to keep facing it any more, and going
1002		through it, and it's not a forget about it' because it's something that shapes
1003		You
1004	Jennie	Mm
1005	Sue	Because we're all shaped by our past
1006	Jennie	Mm
1007	Sue	Um but I don't have to let it own me
1008	Jennie	Mm. Yeah, I get that. So it's something that's kind of shaped and defined who
1009		you are now but you're not tied to it in a, kind of, unhealthy way
1010	Sue	It's like having a car crash and saying I'm never getting into a car again, you
1011		get into it and drive it, you know you get on with it

1012	Jennie	Mm. Do you think that philosophy is shared? Do you think that many people
1013		think like that?
1014	Sue	Probably not everybody. You get people in life that have lived in the situation
1015		and wallow in it and then there are people who get on with it

At the opening of this extract Sue works up stoicism as essential when facing cancer. In line 1000, she works up a tentative claim for having accomplished this, ('in my own way, I did'). In her subsequent talk Sue navigates the tension brought about by two competing subject positions which are possible after cancer, using the PTG discourse with effect. On one hand she can take up the troubled subject position which foregrounds the relationship she has with breast cancer as someone who has undergone diagnosis and treatment and who might be defined by this experience and its consequences. Sue constructs this possibility by drawing upon the concept of cancer as a trauma, like a car accident, that might result in the conscious decision to live life with limitations. On the other hand, the experience of cancer is acknowledged as something that shapes identity but does not hinder future life. In line 1010 active voicing is used to quote the imagined survivor of the car crash, using the first person. In doing this she distances herself from identifying with this position. Sue then uses a three part list in the third person 'you get into it, you drive it, you get on with it' demonstrating agency. Connected with 'you know' Sue signifies this is socially shared knowledge. In line 1012 I contest this by asking if this is common practice. Sue acknowledges this may not be the case for everybody, and continues by working up this possible subject position as troubled, and emphasises this by generalising trauma rather than limiting it to breast cancer. In life, there are people who might occupy a socially unacceptable position of pitying themselves or revelling in their difficulty and there are those who are stoical and outward focused. Sue highlights once again the effect of the PTG discourse in muting talk of trouble, and of the privileging of certain subject positions in life after cancer.

Continuing from the last extract, Sue highlights the identities open to someone who has lived beyond cancer, here she negotiates a way of transcending the cancer experience, and its shadow, by using the PTG discourse to its extreme, crafting a subject position that acknowledges the past experience but transcends it.

Extract no 17: Taken from Interview (3) with Sue.

919	Sue	Yeah. I think in life you can be a victim, a survivor or a great pianist. And I'd
920		rather be a great pianist
921	Jennie	I don't understand (.) explain?
922	Sue	If you're in, say you've got something that's going, or say you've been in a
923		domestic, or abusive relationship
924	Jennie	Mm
925	Sue	You can be a victim, you can go through that and come out the other side and
926		keep reflecting on it, and be the survivor or that person that keeps telling that
927		story or you can go on and be a great pianist, or an architect, or, and not keep
928		referring back to that story
929	Jennie	OK so in victim and survivor you're very much anchored to the [story
930	Sue	[you're still anchored to the past, and I will always have that past, but I don't
931		need to keep reflecting back to it
932	Jennie	Mm
933		Because actually I need to move on

At the beginning of the extract Sue stakes a personal claim in what she is about to say by use of 'I think,' which implicitly acknowledges this position could be contested. Three possible subject positions (in a three part list) are offered, with varying degrees of agency and social desirability ('victim, survivor, great pianist'). One is then constructed as Sue's goal ('great pianist') in comparison to the others. After signalling (line 921) that I don't understand, Sue clarifies her statement (in the third person),and details the victim position 'you've been in a domestic, or abusive relationship' (lines 922-923) constructing cancer as a psychological and physical assault,

and positions the response in its aftermath as either looking backwards (reflecting) or looking forwards. Interestingly, Sue ties together the victim and survivor subject positions, by reflecting that the victim becomes the survivor. As I pick up in line 929, reflecting means that an individual is still tied to their story. Sue subtly negotiates the construction of a post-cancer identity by stating that although cancer may be part of the past, it is the process of reflection that maintains the relationship. In the final line (933) Sue states simply that she needs to 'move on' working up the desire to assign cancer to the past, and distance herself from it while showing she is picking up the reigns of life and going forward. Notably, the subject positions that transcend the cancer experience are creative, and involve a public face. The great pianist performs their masterpiece to an audience, the architect builds something that is visible. These are socially prized identities; imbued with creativity and accomplishment.

6   Discussion

In this research, four women's accounts of life after breast cancer were analysed. Particular attention was paid to the discursive performance of identity, and of how the women oriented to the notion of PTG, before and after the question of whether they felt they had experienced this kind of growth themselves was posed in the interviews. While previous research has approached this topic from a realist perspective eliciting 'beliefs' about subjective experiences of PTG, instead through the synthesis of two forms of discourse analysis this research highlights the way in which the women used language actively to carry out identity management in life after cancer and in doing so negotiated the ideological dilemma of health and illness, and the moral and social obligation to survive well.

In this study, by synthesising two discourse analytic approaches, a fine grained analysis of the talk shows the building blocks of language that were used to construct certain objects (e.g. cancer), and analysis of the talk in relation to its wider social relevance shows powerful available discourses in operation. The available discourses made certain identities available within them, positions that could be taken up or rejected by the women in their talk as those who have experienced diagnosis and treatment of breast cancer. This approach has made it possible to see how identities are occasioned to the local interaction in which they are made relevant, as well as in negotiation of ideological dilemmas.

6.1   Key themes from the analysis of women's talk, and their implications for theory

The women were not explicitly asked whether they had experienced PTG until a point in the interview when they had given their account of diagnosis and treatment, and had been afforded opportunity to talk about life after acute treatment had ended. Before this point, the women constructed life after cancer as troubled due to the negative consequences they had experienced, or were still living with (fear of recurrence, treatment consequences and career

disruption). This troubles talk made for troubled subject positions, and the women worked discursively to do repair work using a number of rhetorical devices and drawing upon prominent discourses as they did so.

Of note, the presence of the think positive discourse, which has been such a prominent feature of talk during diagnosis and treatment (Wilkinson & Kitzinger 2000; Kitzinger, 2000), was drawn upon, showing the hegemonic status of the discourse. The think positive discourse offers a means, in relation to the after-effects of illness and treatment, to bracket off what is uncomfortable; fear of future recurrence, or losses incurred. As Crouch and Menzies (2000) have argued, the difficulties encountered after acute treatment has ended are largely invisible to those around and this further fuels attempts to bracket off distress and difficulty. Similarly, amongst the troubles talk there were instances where the fortune discourse was used reparatively for the same purpose. In the troubles talk, the PTG discourse was taken up sporadically, and in some case it was resisted by speakers.

Through the analysis it is possible to appreciate the tension between living a life not chosen, where the effects of cancer must be accommodated privately, whilst meeting the personal and social obligation to survive in an apparently grateful way publicly. Two passports are held simultaneously (Sontag, 1979). Repeatedly we see the women negotiate their way in and out of troubled subject positions, repairing their talk discursively with effect. Because the poles of health and illness, patient and survivor are set apart we see fluctuating identities in the talk, where each position is foregrounded or backgrounded to the self in the social world where health and normality are privileged (Radley & Billig, 1996). Perhaps unsurprisingly, in this talk, cancer is constructed as a trauma.

When the notion of PTG was introduced to the women, explicitly in the interviews, a number of positions became possible. The women could agree that growth was experienced, that it had

occurred alongside negative consequences, or they could choose to reject the notion of growth following trauma. PTG was offered as a discourse, a way of speaking about life after cancer making possible its associated subject positions and offering new ways of constructing cancer. Three of the women positioned themselves as having experienced both positive and negative consequences, and the fourth concluded that she had only experienced negative consequences.

The women's talk showed variation in contrast with the previous troubles talk (concerning fear of recurrence, treatment consequences, and career disruption); previous accounts were reframed (e.g. careers cut short are reframed as choices made or as opportunities), troubles largely silenced, and whereas in troubles talk discursive repair was carried out to manage identity and return to a 'status quo' of sorts, in their responses to the question of PTG the women crafted more positive and agentic identities. Setting this against previous research we might see this as positive reappraisal, however a social constructionist approach highlights the performative nature of the reports and the socially sanctioned positions made available within them. Cancer itself, as a discursive object was constructed differently with greater emphasis upon the disease as a vehicle affording positive change and the re-evaluation of life priorities. When PTG discourse was used new identities became possible that transcended the troubled positions that accompanied talk of difficulty and ill health.

Finally, in the accounts of life after cancer, again after the PTG discourse had been explicitly brought into the interviews, I presented extracts where the women took up agentic subject positions of life after cancer by 'giving back'. This positive position was worked up in relation to the active participation in cancer related activities (e.g. fundraising, helping others at the early stages of the cancer journey). These accounts primarily provide a means of accomplishing accountability in survivorship. In this talk the women also negotiated the transition from passive patients of biomedicine to expert patients. The women demonstrated in their talk that they have learned through their experience, and worked up gratitude and appreciation of being alive

by giving back and helping others. The women worked hard discursively to claim their place as survivors, by showing they have neither wasted the pain experienced or the knowledge gained, and to even transcend this status where it felt problematic because it fundamentally tied them to the cancer identity, however imperceptibly. Talk of participation in cancer related activities, was used to demonstrate 'giving back,' standing alongside others, and honouring those who did not survive. Within the theory of PTG talk of giving back might appear to signify an increased empathy and desire to help others. However, taking a discourse analytic approach, it offered a means of producing socially acceptable, indeed prized positions affording an opportunity to carry out identity enlargement. As Sulik (2011) has pointed out, such events are imbued with meaning for those taking part. They construct cancer, and endorse the socially held understanding and expectations of survivorship. Their language, is, Sulik argues, an imperative to show optimism, fighting spirit and a celebratory position. As Little et al. (2002) comment, in life after cancer those who have survived can take up the position of the victim or hero; in doing so they are forced into dichotomised categories of ill-fortune and fortune, normality and abnormality, illness and suffering, or health and well-being. Almost twenty five years after Sontag's writings, the battle metaphor prevails, and has been accompanied by other ways of speaking about cancer that support and strengthen it. Notably, this research has shown that constructions of cancer still draw upon hegemonic discourses, and their metaphors in life after cancer. As Grant and Hundley (2009) note, ways of speaking about cancer such as the war metaphor continue to powerfully construct the disease, and to position those who experience it. Arguably, because cancer is constructed as a war, survivorship is then framed as the aftermath of this event. Here, Little et al's concept of the no man's land after battle is significant. Those living beyond cancer often experience ongoing psychological and physical difficulties, and despite the imminent threat to life having passed the risk of recurrence reminds the survivor that they may once again have to do battle. This makes for something of a collision

between the call to celebrate victory whilst still living under the threat of war, and between the personal experience of cancer as chronic, a series of traumas, and the contrasting societal understanding of cancer as a single trauma. In talking of life after cancer the PTG discourse has become well established. The think positive discourse buttresses the PTG discourse, which comes to the foreground as a discursive resource to enable identity enlargement to take place as a particular kind of survivor.

Integrating the research with the existing knowledge base of PTG, if we took the accounts of life after cancer at face value from the epistemological position from which most of the research has to date been conducted, we might well conclude that the women have experienced posttraumatic growth in a number of dimensions, if we read their accounts as reflecting stable internal beliefs about concrete experience. However, looking through a social constructionist lens, rather than an experience, or a coping response, we can see PTG as a discourse, a way of speaking about life after cancer offering a platform upon which more positive subject positions or identities can be purposefully claimed in order that life after cancer can be showcased as lived well. The discourse of PTG affords a means for the women to 'do' identity differently in their talk. In orienting to PTG the women took up a specific place in the interviews, and in response to a question raised by the interviewer, but they were also spoken in relation to others who have not survived. As such these accounts cannot be separated out into single issues or effects, but rather they are intrinsically linked to the tensions created in balancing loss and change in lives after cancer where there is a social and moral obligation to survive well, and to dwell in the land of the healthy once more, at least publicly.

Discourses construct objects and subjects, therefore calls for participation, or measures used to gather data, are imbued with meaning. I have argued in this thesis that previous research on PTG, drawn predominantly from within the positivist paradigm, has implicitly endorsed socially held imperatives to survive in certain ways. In the same way that some measures for PTG do not

allow participants to respond with troubles talk (that negative consequences have been experienced), hegemonic discourses such as the PTG discourse mute troubles talk. In this study, the opportunity was afforded for the women to talk about their experiences of life after cancer, and care was taken to avoid constructing the notion of PTG as expected. The initial call for participation was therefore framed as 'an exploration of the experience of life after cancer' without reference to either negative or positive consequences. Riggs (2005) notes the focus on personal experience is well established in critical psychology research, however he points out that we need to hold in mind the differing epistemological positions involved in researching experience as a real event being recalled, versus experience as social practice of self. Here, as analysts we can enable our participants to give their accounts as they understand them, but in our analyses we can see these accounts differently. As Riggs puts it 'by locating subject experiences in this way, it is possible to examine experience not as a privileged site of real knowledge, but rather as a site of ongoing contestation and struggle over meaning making' (p. 91). In this analysis, PTG is seen as a discursive resource for women to draw upon after breast cancer. At the point in the interview when the notion of PTG was explicitly raised, it was worded to afford a number of positions. Before this point an environment was created in which the women could tell their stories without interruption. Arguably this is not an everyday situation i.e. they were fundamentally giving accounts to a psychology trainee for research purposes. What this research highlights, nonetheless, is the effect of the PTG discourse and the difference in the nature of the accounts before and after the notion of PTG was raised and oriented to.

This study has shown that drawing upon the PTG discourse has an apparently positive function even if, as Sumalla et al. (2009) and Zoellner and Maercker (2006) have proposed, the accounts may have an illusory quality, that is they are reported by participants but do not translate into objectively measurable change. We might conclude that accounts of PTG, may be largely beneficial even when we look at them through a different epistemological lens. They appear to

synchronise with the view that they are ways of coping actively with the demands of survivorship. Tedeschi and Calhoun (2006) have themselves stated that PTG accounts may signify denial or avoidance and in part they may be illusory, providing a means by which self-esteem or mastery may be accomplished, but that they should be sensitively accepted alongside accounts of difficulty. However, what must be taken into consideration, again highlighted by looking through a social constructionist lens at how identity is managed in talk, is the effect of dominant hegemonic discourses such as PTG, and the limited subject positions made available within it. Significantly, in this research, in talk where the discourse of PTG was oriented to, the negative consequences of life after breast cancer become backgrounded and muted. Arguably, talk of trouble is already difficult to voice, and this is highlighted by the repair work that was done discursively in this context. Considering the context of the interviews, troubles talk was possibly enabled to a greater extent than in naturally occurring interactions, because the talk took place with a psychologist who perhaps represented a listener well versed in hearing talk of troubles. However, we might imagine that had the notion of PTG been raised from the outset, accounts of negative experiences might then have been closed off. As it was, they were carefully repaired numerous times in the talk. The women not only negotiated an interaction with one particular hearer, but also in relation to the wider context in which they live. Arguably then, the discursive space to talk about the tensions and dilemmas of living life post cancer is small, and ways of speaking about growth appear to further contract the space available to talk about residual problems lived with. As Wooffitt (2005) observes, 'talk occurs in an 'ideologically charged context' (p. 159). Significantly, those whose lives feature suffering, change, loss, and fear for the future, can become marginalised, and those who live with recurrence, perhaps more so. The PTG discourse can be thought of as having a light and a shadow side, the privileging of growth can afford opportunity to meet the social and moral obligation to showcase positive survivorship, but it also marginalises difficulty and backgrounds suffering.

The shadow side of the discourse as it relates to clinical practice will be discussed further in the following section.

6.2   Implications for counselling psychologists working in psycho-oncology

This research aims to inform counselling psychology practice by offering a differing, but not necessarily directly opposing, way of thinking about growth after trauma, and to apply this insight to our work with women who have had breast cancer who enter our therapy rooms feeling disordered, and at odds with the social world which appears to require them to return to normal, or to even transcend normality, but who live with difficulties as a consequence of breast cancer.

Lyddon (1998) urges caution in attempting to translate the emphases of social constructionism to counselling psychology into, 'truths' that lead to the creation of a set of guidelines, but proposes that instead we search for area of compatibility between this epistemological position and counselling psychology research and practice. This is a need espoused in our professional guidelines (BPS, 2005). Neimeyer (1998) acknowledges how incorporating social constructionist ideas into this context can be both disquieting as well as exciting. To work therapeutically from within a social constructionist stance requires us to hold a fresh understanding of the nature and function of language, and of the objects and subjects constructed through its use. We must also see identity as fluid and socially occasioned, rather than stable and unitary. Moreover, we must consider our place in the process of construction, and of how as clinicians and members of society we perpetuate ways of speaking and being in the world as we co-construct meaning in interactions inside and outside of the therapy room. Fundamentally, as counselling psychologists we must be aware of the potential for our discourses to position our clients in troubled ways, for example as disordered individuals whom we need to help to re-integrate in to normal life after trauma. Taking a constructionist approach can provide an outworking for

our discipline's societal obligation to consider the impact of our client's context in all phases of our work (BPS, 2005). Perhaps the closest area of compatibility is found at the heart of counselling psychology, in the emphasis upon relationship, between therapist and client, and between each individual and their wider social context. Dialogue in the therapeutic setting is both localised and part of a broader context. When negative feelings cannot be accommodated, or there is a prevailing belief that they should be alleviated, then our clients are likely to feel disordered, or obliged to change, or at least to repress such talk. As Crouch and Menzies (2000) put it:

> 'the collective defence against suffering and fear consists of the confinement of these feelings, by means of expert attention to the troubled, and let's face it troubling individuals. But professional help may also wall them in by constructing their apprehension and pain as purely personal problems and seeking their resolution through individualistic strategies. Accepting one's feelings dealing with one's feelings is not the same as having those feelings meaningfully embedded in a social context which explicitly recognises them as valid and responds to suffering in an authentic way. The lack of recognition is social isolation in real terms' (p. 210).

Lyddon (1998) suggests that rather than isolating psychological problems and locating them within the client a 'social constructionist analysis highlights the ways in which individual experience (including experience of emotional disorder) cannot be separated from social processes and contexts' (p. 215). Riggs (2005) echoes this point and argues for the value of externalising subject positions as socially and culturally produced, when he writes; 'by looking at experience as a site of subject construction, and by critiquing the exclusionary practices that construct certain people as 'normal' it may be possible to offer modes of resistance to these normalising practices' (p. 92). Specifically, within psycho-oncology this means being aware of the way in which illness and survivorship are imbued with meaning and lived in landscapes of

expectation. To work with those who have lived beyond the trauma of breast cancer involves a subtle shift from providing therapy that encourages clients to actively engage with their difficulties and learn something new, but to also provide an arena where our clients can, as Willig (1999) advocates, set about resisting certain discourses and the subject positions they afford. As Kitzinger (2000) has shown, this could take the form of enabling our clients to at times resist idioms around doing survivorship in ways that bury talk of difficulty, and coerce the individual to take up certain socially visible positions that are at odds with their felt internal reality. Rather than further problematising troubles, this could facilitate the de-pathologising of the consequences of trauma, if they were to result in awareness that socially held imperatives have a function of easing anxieties and diminishing what is distressing and troubling. The site for pathology would subtly be shifted from its individual location, and contextualised; the 'discursive capture' (Willig, 2011) resisted. Neimeyer (1998) advocates the use of narrative constructivism with the aim of re-authoring life stories, which he considers to augment the social constructionist approach. This emphasis, he argues, can greatly strengthen reflexive and creative clinical practice. A significant contribution here is the exposition of discourses which problematise individuals. 'The role of therapy', as he sees it, is: 'to muster resistance to the dominant narrative of such problematic identities by externalising the problem, examining its real effects on the individuals who are subjected to it and searching for the unique outcomes or 'sparkling moments' when dominated persons resist its influence'(p. 146).

Importantly, our work needs to take into account those who are particularly at risk of being marginalised, those who do not feel able to use the PTG discourse, or take up its subject positions. Those who cannot speak about growth need not occupy the unhealthy subject position; the victim, the fearful, the wounded, the loser of the battle.

Of course, this work need not be confined to our clinical practice, but can also be performed when counselling psychologists conduct research, and then disseminate the findings across

disciplines in order to add to the existing knowledge base. Indeed, this is a professional responsibility as set out in our guidelines for professional practice (BPS, 2005).

6.3   Limitations and directions for future research.

There are a number of limitations in this research to acknowledge. Firstly, the analysis offered is one possible construction, involving interpretation. As Willig (2012) cautions, 'it is essential that we remember the act of interpretation is both a responsibility and a privilege. When we analyse a text, we transform it and ourselves, in the process. Interpretation always involves both the opening up and the closing down of possibilities, and it always has consequences' (p. 165). This research has taken an in depth discourse analytic approach to a corpus of rich contextualised data. The data has been analysed through a social constructionist lens, and the conclusions made relevant for academic and clinical reading. In addition, because this research focussed on the accounts of women who had completed treatment and who had no known cancer at the time of interview it might be argued that survivorship or PTG has been constructed as relevant only to these women, and not to women who have secondary or incurable disease. Further research might well extend the exploration of the discursive management of identity into the talk of those living with non-curative disease.

To some extent in engaging with this research I have considered my own position (this is taken up in my reflexive statement). Reflexivity has enabled transparency in the analysis, which itself has been grounded; supported by extracts from the data and linked to existing literature to further ensure quality. Willig (2008) considers that the process of writing up is in itself a construction on the part of the researcher. As Gill (1996) points out as discourse analysts like our participants, we construct objects and subjects with our language, and communicate purposefully in relation to the context in which we write.

This study employed the use of semi-structured interviews. One potential argument against the use of individual interviews might be that the talk analysed was not naturally occurring. A

rationale for the use of interviews has been provided within the method section of this thesis. The interview method is a useful means of data collection where, arguably, there might be little opportunity to access naturally occurring talk. We might have found in the analysis of naturally occurring talk an absence of troubles talk, whereas in the current research the use of individual interviews with a psychologist researcher perhaps made these troubles more easily spoken. With this understanding, future research might focus upon social interactions between 'survivors' of cancer and the members of their immediate social world, for example through analysis of written interactions in social media, or in talk within focus groups.

7   Concluding words

In this research, from the position of a trainee counselling psychologist with an interest in social construction, and a personal stake in the topic area of growth after trauma, I have proposed that existing research on PTG after cancer has lacked methodological diversity, and that considering accounts of PTG is essentially a question of interpretation. Each interpretation is made through the lens offered by a certain epistemological position and accompanying research method. In this study, the lens applied has been that of social constructionism. In taking a discourse analytic approach to the data I hope to have highlighted the perspective afforded when language and the self are thought of in differing ways to the realist perspective. In addition, the analysis has shown the importance of attending to context, both local (the features of the talk in the text as they occur in interaction) and also the wider social context in which the talk is situated. Some of the consequences of the use of discourses and the subject positions they make available have been considered alongside attention to their implications for theory and clinical practice. Some areas for future research have been proposed.

8   Reflexive statement: part two

At the completion of this research I have a renewed commitment to work sensitively with women who live in the complex social terrain of 'survivorship' after cancer, to attend to the talk that occurs within my clinical practice, and to listen for the ways in which my clients craft identities discursively, wrestling between telling their troubles, feeling pathologised by their experience of difficulty, and taking up authentic positions open to them as those living life 'post-cancer'. Creating a discursive space where this can happen is a privilege, but requires constant attention to my own position, to the discourses I use, and to the wider social context that makes some more available and, to an extent, irresistible than others.

Creating a reflexive space has been invaluable while conducting this research, and in recognising my relationship with it. One of the ways I have done this is through the use of a reflexive journal, although this has entailed a sometimes less than systematic approach, involving, as Etherington (2004) writes, the collating of numerous pieces of paper onto which thoughts, comments, mind maps and memories were collected.

Reflecting on my experiences, I am aware that my trauma, like the experience of breast cancer, has offered me certain subject positions in the immediate aftermath of my bereavements, but over time, to the world around me my trauma has had something of a 'shelf life'. In conversation I notice that the subject positions open to me now are somewhat narrowed. I feel subtly coerced into a position of normality, where my bereavements are situated in the past. Recently, when I began a new relationship, I sensed a collective sigh of relief within my social circle, perhaps signifying celebration that I had survived, moved on, and no longer occupied a position that deviated from the norm. I find there are a few precious friends who recognise the difference between my outer and inner world and some who will listen to my 'troubles talk'. I am often silenced from telling of the legacy of my experience. It is hard to live life 'well' yet grieve losses

simultaneously. It is hard to contest, what Galgut calls 'the myths of trauma' (2012).

In this thesis I have shared something of my personal life, and have wrestled with my own questions of survival and growth. My reflections are contextualised, they are offered as the author of this thesis, a researcher in the field of counselling psychology, a trainee practicing in the field of psycho-oncology, with a particular way of understanding the function of language, and the social construction of identity.

9   References

Altmaier, E. M., Johnson, B. D., & Paulsen, J. S. (1998). Issues in professional identity. In S. Roth-Roemer, S. E. Robinson Kurpius, & C. Carmin (Eds.), *The emerging role of counselling psychology in health care* (pp. 7-29). New York: W.W. Norton & Company.

Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). *Discourse analysis means doing analysis: A critique of six analytic shortcomings.* Retrieved December 1, 2011, from Discourse analysis online: https://dspace.lboro.ac.uk/2134/633

Aspinwall, L. G., & MacNamara, A. (2005). Taking positive changes seriously. Toward a positive psychology of cancer survivorship and resilience. *American Cancer Society*, 2549-2556.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology.* Buckingham: Open University Press.

Baumeister, R. F., & Leary, M. R. (1997). Writing narrative literature reviews. *Review of General Psychology*, 1(3), 311-320.

Bellizzi, K. M., & Blank, T. O. (2006). Predicting posttraumatic growth in breast cancer survivors. *Health Psychology,* 25(1), 47-56.

Bellizzi, K. M., Wilder Smith, A., Reeve, B., Alfano, C. M., Bernstein, L., Meeske, K., Baumgarter, K.B., & Ballard- Barbash, R. R. (2009). Posttraumatic growth and health-related quality of life in a racially diverse cohort of breast cancer survivors. *Journal of Health Psychology*, 15(4), 615-625.

Benwell, B., & Stokoe, E. (2006). *Discourse and identity.* Edinburgh: Edinburgh University Press.

Bishop, F., & Yardley, L. (2004). Constructing agency in treatment decisions: negotiating

    responsibility in cancer. *Health, 8*(4), 465-482.

Bolam, B., Gleeson, K., & Murphy, S. (2003). 'Lay person' or 'health expert'? Exploring the

    theoretical and practical aspects of reflexivity in qualitative health research. *4.*

    Retrieved October 2, 2010, from http://www.qualitative-research.net/fqs-texte/2-03/2-

    03bolametal-e.htm

Boyatzis, R. E. (1998). Transforming qualitative information: Thematic analysis and code

    development. London: Sage.

Breitbart, W., & Alici, Y. (2009). Psycho-oncology. *Harvard Review of Psychiatry, 17*(6), 361-376.

Bitish Psychology Society. (2005). *Professional practice guidelines.* Leicester: BPS.

British Psychological Society. (2010). *Code of human research ethics.* Leicester: BPS.

Burr, V. (1995). *An introduction to social constructionism.* London: Routledge.

Calhoun, L. G., & Tedeschi, R. G. (2006). *Handbook of posttraumatic growth: Research and

    practice.* Mahwah, NJ: Lawrence Erlbaum Associates.

Cancer Research UK. (2011). *All cancers combined.* Retrieved from http://www.publications.

    Cancerresearchuk.org/downloads/Product/CS_KF_ALLCANCERS.pdf

Carver, C. A. (1997). You want to measure coping but your protocol's too long: consider the brief

    COPE. *International Journal of Behavioural Medicine, 4*(1), 92-100.

Carver, C. S., & Antoni, M. H. (2004). Finding benefit in breast cancer during the year after

    diagnosis predicts better adjustment 5 to 8 years after diagnosis. *Health Psychology,

    23*(6),595-598.

Connerty, T. J. & Knott. (2013). Promoting positive change in the face of adversity: expereinces of cancer and posttraumtic growth. *European Journal of Cancer Care. 22*, 334-344

Cordova, M. J., Cunningham, L. L., Carlson, C. R., & Andrykowski, M. A. (2001). Posttraumatic growth following breast cancer: A controlled comparison study. *Health Psychology, 20*(3,)176-185.

Coyle, A. (2000). Discourse analysis. In G. M. Breakwell, S. Hammond, & Fife-Shaw (Eds.), *Research methods in psychology* (pp. 251-268). London: Sage.

Coyle, D., & Pugh, A. (2000). The construction of counselling psychology in Britain: a discourse analysis of counselling psychology texts. *Counselling Psychology Quarterly, 13*(1), 85-98.

Crossley, M. (2003). 'Would you consider yourself a healthy person?': using focus groups to explore health as a moral phenomenon. *Journal of Health Psychology, 8*(5), 501-514.

Crouch, M., & McKenzie, H. (2000). Social realities of loss and suffering following mastectomy. *Health, 4*(2), 196-215.

Danhauer, S. C., Case, L. D., Tedeschi, R., Russell, G., Vishnevsky, T., Triplett, K., Ip, E. H., & Avis, N. E., (2013). Predictors of posttraumatic growth in woman with breast cancer. *Psycho-Oncology. 22*, 2676-2683.

Data Protection Act (1998). Chapter 29. http://www.legislation.gov.uk/ukpga/1998/29/data.pdf

Davies, B., & Harré, R. (1990). Positioning: the discursive production of selves. *Journal of the Theory of Social Behaviour, 20*(1), 43-63.

Department of Health, Macmillan Cancer Support and NHS Improvement (2010). The National

Cancer survivorship Initiative Vision. Retrieved from http://www.dh.gov.uk/em/Publ

icationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277.

Department of Health. (2011) Improving outcomes: a strategy for cancer. http://www.gov.uk

/government/uploads/system/uploads/attachment_data/file/213785/dh_123394.pdf.

Doyle, N. (2008). Cancer survivorship: evolutionary concept analysis. *Journal of Advanced

Nursing, 62*(4), 499-509.

Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemas and

subject positions. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as data: a

guide for analysis* (pp. 189-225). Milton Keynes: Open University.

Edley, N., & Wetherell, M. (1997). Jockeying for position: the construction of masculine

identities. *Discourse and Society, 8*(2), 203-217.

Edley, N., & Wetherell, M. (1999). Imagined futures: Young men's talk about fatherhood and

domestic life. *British Journal of Social Psychology, 38*, 181-194.

Edwards, D. (1997). *Discourse and cognition.* London: Sage.

Edwards, D., & Potter, J. (1992). *Discursive psychology.* London: Sage.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative

research studies in psychology and related fields. *British Journal of Clinical Psychology,

38*, 215-229.

Elmir, R., Jackson, D. B., & Schmied, V. (2010). Against all odds: Australian women's expereinces

of recovery from breast cancer. *Journal of Clinical Nursing, 19*, 2531-2538.

Etherington, K. (2004). *Becoming a reflexive researcher.* London: Jessica Kingsley Publishers.

Fairclough, N., & Wodak, R. (1997). Critical Discourse Analysis: The Critical Study of Language. In T. van Dijk (Ed.), *Discourse studies: A multidisciplinary Introduction* (Vol. 2, pp. 258-284). London: Sage.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice, 3*(1), 6-25.

Foucault, M. (1973). *The birth of the clinic: An archeology of medical perception.* (A.M. Sheridan. Trans). London: Routledge.

Frankl, V. E. (1946). *Man's search for meaning.* London: Rider Books.

Galgut, C. (2010). *The psychological impact of breast cancer: A psychologist's insights as patient.* UK: Radcliffe Publishing.

Galgut, C. (2012). Trauma: challenging the myths. *Private Practice*, 10-14.

Gall, T. L., & Cornblat, M. W. (2002). Breast cancer survivors give voice: a qualitative analysis of spiritual factors in long term adjustment. *Psycho-Oncology*, *11*, 524-535.

Gill, R. (1996). Discourse analysis: Practical implementation. In J. T. Richardson, *Handbook of qualitative research methods for psychology and the social sciences* (pp. 141-156). Leicester: BPS.

Grant, J. A., & Hundley, H. (2009). Images of the war on cancer in the associated press: centering survivors and marginalising victims. *American Communication Journal, 11*(4), 1-16.

Grinyer, A. (2002, June 1). *The anonymity of research participants: Assumptions, ethics and practicalities.* Retrieved from University of Surrey: www.soc.surrey.ac.uk

Hefferson, K., Grealy, M., & Mutrie, N. (2010). Transforming from cocoon to butterfly: The potential role of the body in the process of posttraumatic growth. *Journal of Humanistic Psychology. 50*(2) 224-247.

Hendrick, S., Hershberger, A., Cortez-Garland, M., Fleshman, S., Hutcherson, S., & Rozycki, A. (2006). Psychosocial oncology: Gains and losses. *Journal of Loss and Trauma, 11*, 115-130.

Hession, N. (2008, June). Psycho-Oncology: The role of the Counselling Psychologist. In McGrann , A. (Chair),*The contribution of counselling psychology in medical health settings.* Symposium conducted at the Joint conference of the Divisions of Counselling Psychology. Dublin.

Ho, S., Chan, C. L., & Ho, R. T. (2004). Posttraumatic growth in chinese cancer survivors. *Psycho-Oncology, 13*, 377-389.

Hozman, S. (2005). The other cancer story: Is this a breast cancer competition? *American Journal of Nursing, 105*(11). 39

Hutchby, I., & Wooffitt, R. (1998). *Conversation analysis.* Oxford: Blackwell Publishers Ltd.

Janoff-Bulman, R. (1992). *Shattered assumptions:Towards a new psychology of trauma.* New York: Free Press.

Jefferson, G. (1980). On 'trouble-premonitary' response to inquiry. *Sociological Inquiry, 50*, 153-185.

Jefferson, G. (1985). An exercise in the transcription and analysis of laughter. In T. Van Dijk,(ed.) *Handbook of discourse analysis. Vol 3. Discourse and dialogue* (pp. 25-34). London: Academic Press.

Jefferson, G. (1990). List construction as a task and resource. In G. Psathas (Ed.), *Interactional competence* (pp. 63-92). New York: Irvington Publishers.

Joseph, S. (2012). What doesn't kill us... *The Psychologist, 25*(11), 816-819.

Kaiser, K. (2008). The meaning of the survivor identity for women with breast cancer. *Social Science and medicine, 67*, 79-87.

Kitzinger, C. (2000). How to resist an idiom. *Research on Language and Social Interaction, 33*(2), 121-154.

Korborov, N. (2001). Reconciling theory with method: from conversation analysis and critical discourse analysis to positioning analysis. *Forum: Qualitative Social Research, 2*(3). Retrieved December 1, 2010, from www.qualitative-research-net/fqs/fqs-eng.htm

Lelorain, S., Bonnaud-Antignac., & Florin, A., (2010). Long term posttraumatic growth after breast cancer: prevalence, predictors and relationships with psychological health. Journal of Clinical *Psychology in Medical Settings. 17*, 14-22.

Lelorian, S., Tessier, P., Florin, A., & Bonnaud-Antignac. (2012). Posttraumatic growth in long term breast cancer survivors: relation to coping, social support and cognitive processing. *Journal of Health Psychology. 17*, 627-639.

Little, M., Paul, K., Jordens, C., & Sayers, E. (2002). Survivorship and discourses of identity. *Psycho-Oncology, 11*, 170-178.

Low, C. A., Stanton, A. L., Thompson, N., Kwan, L., & Ganz, P. A. (2006). Contextual life stress and coping stratagies as predictors of adjustment to breast cancer survivorship. *Annals of Behavioural Medicine, 32*(3), 235-244.

Lyddon, W. J. (1998). Social construction in counselling psychology: A commentary and critique. *Counselling Psychology Quarterly, 11*(2), 215-222.

McKinley, E. D. (2000). Under toad days: Surviving the uncertainty of cancer recurrence. *Annals of Internal Medicine*, 479-480.

Mols, F., Vingerhoets, A. J., & Coeburgh, J. W. (2009). Well-being, posttraumatic growth and benefit finding in long-term breast cancer survivors. *Psychology and Health*, *24*(5), 583-595.

Mrdjenovich, A. J., & Moore, B. A. (2004). The professional identity of counselling psychologists in health care: a review and call for research. *Counselling Psychology Quarterly, 17*(1), 69-79.

Neimeyer, R. A. (1998). Social constructionism in the counselling context. *Counselling Psychology Quarterly, 11*(2), 135-149.

NICE. (2004). *Supportive & Palliative Care Guidelines.* Retrieved Dec 1, 2011, from http://www.nice.org.uk

Nietzstche, F. (1888). *Twilight of the idols.* (W. Kaufmann, W. & R. J. Hollingdale, R. J. Trans.). London: Penguin Classics

Nicholas, D. R. (2013). On being a psycho-oncologist: A counselling psychology perspective. The Counselling Psychologist. *41*(2) 186-215

Park, C., Zlateva, I., & blank, T. O. (2009). Self-identity after cancer: 'Survivor', 'victim', 'patient', and 'person with cancer'. *Journal General Internal Medicine*, s430-s435.

Parker, I. (1992). *Discourse dynamics: a critical analysis for social and individual psychology.* London: Routledge.

Paton, F. (1999). A psychotherapeutic framework for addressing medical problems in counselling psychology. *European Journal of Psychotherapy, 2*(3), 345-356.

Pomerantz, A. (1986). Extreme case formulations: A way of legitimizing claims. *Human Studies, 9*, 219-229.

Porter, L. S., Belyea, M., Mishel, M., Gil, K. M., & Germino, R. N. (2006). Predicting negative mood state and personal growth in african american and white long-term breast cancer survivors. *Annals of Behavioural Medicine, 31*(3), 195-204.

Potter, J. (1996). Discourse analysis and constructivist approaches: theoretical background. In J. T. Richardson (Ed.), *Handbook of Qualitative Research Methods for Psychology and the Social Sciences* (pp. 125-140). Leicester: BPS.

Radley, A.& Billig, M. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health and Illness, 18*(2), 220-240.

Ransom, S., Sheldon, K. M., & Jacobsen, P. B. (2008). Actual change and inaccurate recall contribute to posttraumatic growth following radiotherapy. *Journal of Consulting and Clinical Psychology. 76*(5) 811-819

Ridley, D. (2008). *The Literature Review: A Step-by-Step Guide.* London: Sage.

Riggs, D. W. (2005). Locating control: Psychology and the cultural production of 'healthy subject positions'. *Culture, Health & Sexuality*, *7*(2), 87-100.

Rogers, C. (1964) Toward a modern approach to values: The valuing process in the mature person. *Journal of Abnormal and Social Psychology. 68*(2) 160-167.

Ruini, C. & Vescovelli, F. (2013). The role of gratitude in breast cancer: it's relationships with posttraumatic growth, psychological well-being and distress. *Journal of Happiness Studies.* 14, 263-274.

Schegloff, E. A. (1997). 'Whose text? Whose context?'. *Discourse and Society, 8*, 165-87.

Sears, S. R., Stanton, A. L., & Danoff-Burg, S. (2003). The yellow brick road and the emerald city: benefit finding, positive reappraisal coping, and posttraumatic growth in women with early stage breast cancer. *Health Psychology*, *22*(5), 487-497.

Seligman, M. E. (2002). Positive psychology, positive prevention and positive therapy. In C. R. Snyder, & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 3-7). New York: Oxford University Press.

Seymour-Smith, S., & Wetherell, M. (2006). 'What he hasn't told you...': Investigating the micro-politics of gendered support in heterosexual couples' co-constructed accounts of illness. *Feminism & Psychology, 16*(105), 105-127.

Sheikh, A. L. (2008). Posttraumatic growth in trauma survivors: Implications for practice. *Counselling Psychology Quarterly*, *21*(1), 85-97.

Silva, S. M., Crespo, C., & Canavarro, M. C., (2012). Pathways for psychological adjustment in breast cancer: a longitudinal study on coping strategies and posttraumatic growth. Psychology and Health. *27*(11), 1323-1341

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research.* London: Sage.

Sontag, S. (1979). *Illness as metaphor.* London: Allen Lane.

Stanton, A. L., Bower, J. E., & Low, C. A. (2006). Posttraumatic Growth After Cancer. . In L. G. Calhoun, & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research & practice* (pp. 138-175). Mahwah, NJ, US: Lawrence Erlbaum Associates.

Stanton, A. L., Ganz, P. A., Rowland, J. H., Meyerowitz, B. E., Krupnick, J. L., & Sears, S. R. (2005). Promoting adjustment after treatment for cancer. *Cancer* (11 Suppl), 2608-2613.

Stephens, C., Carryer, J., & Budge, C. (2004). To have or to take: discourse, positioning, and narrative identity in women's accounts of HRT. *Health, 8*(3), 329-350.

Stubbe, M., Lane, C., Hilder, J., Vine, E., Vine, B., Marra, M., Holmes, J., & Weatherall, A. (2003). Multiple discourse analyses of a workplace interaction. *Discourse Studies, 5*, 351-388.

Sulik, G. (2011). *PInk Ribbon Blues: How Breast Cancer Culture undermines Women's Health.* Oxford: Oxford University Press.

Sumalla, E. C., Ochoa, C., & Blanco, I. (2009). Posttraumatic growth in cancer: Reality or illusion? *Clinical Psychology Review, 29*, 24-33.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory. *Journal of Trauma and Stress, 9*, 455-471.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1-15.

Thorne, S., Pateerson, B., & Russell, C. (2003). The structure of everyday self-care decision making in chronic illness. *Qualitative Health Research, 13*(10), 1337-1352.

Tomich, P. L., & Helgeson, V. S. (2002). Five years later: A cross sectional comparison of breast cancer survivors with healthy women. *Psycho-Oncology*, 11, 154-169.

Tomich, P. L., & Helgeson, V. S. (2004). Is finding something good in the bad always good? Benefit finding among women with breast cancer. *Health Psychology*, *23*(1), 16-23.

Tritter, J. Q., & Calnan, M. (2002). Cancer as chronic illness? reconsidering categorisation and exploring experience. *European Journal of Cancer Care, 11*, 161-165.

Van Dijk, T. (2001). Critical discourse analysis. In D. Schiffrin, D. Tannen, & H. E. Hamilton (Eds.), *The handbook of discourse analysis* (pp. 352-370). Oxford: Blackwell.

Ware, J., Kosinski, M., & Dewey, J. (2000). How to score version 2 of the SF-36 Health Survey. Lincoln, R.I: Quality Metric Incorporated.

Weiss, T. (2002). Posttraumatic growth in women with breast cancer and their husbands: an intersubjective validation study. *Journal of Psychosocial Oncology*, *20*(2), 65-80.

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society, 9*(3), 387-412.

Wilkinson, S. (2000). Feminist traditions in health psychology: Breast cancer research. Journal of Health Psychology. *5*(3), 359-372

Wilkinson, S., & Kitzinger, C. (2000). Thinking differently about thinking positive: A discursive approach to cancer patients' talk. *Social Science and Medicine, 50*(6), 797-811.

Willig, C. (1999). *Applied Discourse Analysis: Social and Psychological Interventions.* Buckingham: Open University Press.

Willig, C. (2008). *Introducing qualitative methods in psychology: Adventures in theory and method* (2nd ed.). Buckingham: Open University Press.

Willig, C. (2009). Unlike a rock, a tree, a horse or an angel...' Reflections on the struggle with meaning through writing during the process of cancer diagnosis. *Journal of Health Psychology, 14*(2), 181-189.

Willig, C. (2011). Cancer diagnosis as discursive capture: Phenomenological repercussions of being positioned within dominant constructions of cancer. *Social Science and Medicine, 73*, 897-903.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology.* UK: Open University Press.

Wooffitt, R. (2005). *Conversation analysis and discourse analysis: A comparative and critical introduction.* London: Sage.

Yalom, I. (1980). *Existential psychotherapy.* US: Basic Books.

Zoellner, T., & Maercker. (2006). Posttraumatic growth in clinical psychology -A critical review and introduction of a two component model. *Clinical Psychology Review, 26*, 626-653.

10   Appendices

Appendix A: Poster invites and Research pack

POSTER INVITES

Have you experienced Breast Cancer?

Would you be willing to take part in some research?

I am a Counselling Psychology doctoral student at London Metropolitan University, I'm interested in talking to women who have had breast cancer to find out how they feel about life afterwards.

To take part, you would need to have completed your treatment (e.g. radiotherapy/chemotherapy) more than 6 months ago and be willing to be interviewed (this would take about one hour of your time).

For more information please contact
Jennie on

INFORMATION SHEET

Introduction

You are invited to take part in a research study about how women who have experienced breast cancer feel about life afterwards. Before you decide, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information before you decide whether you would like to take part. It might also be useful for you to discuss it with your friends or family. If you would like more information please do not hesitate to get in touch.

Why is this research being done?

- As previously mentioned, this research aims to understand how women who have experienced breast cancer feel about life afterwards.

- The research is being conducted as part of a Professional Doctorate in Counselling Psychology at London Metropolitan University (see below).

Who is conducting the research?

- This research forms part of an accredited post-graduate qualification in Counselling Psychology. The primary researcher is a post-graduate student who has experience in conducting research. In addition, the study is fully supervised and all of the discussion topics and methods have been approved for use.

- The research complies fully with the guidelines set out by the British Psychological Society (BPS) and has been approved by the London Metropolitan University research ethics committee.

What will happen if I decide to take part?

- If you are willing to take part, please call Jennie, who will be pleased to make arrangements for the interview.

- You will need to give your consent by signing the forms provided, keeping one yourself and bringing the other to the interview.

- The interview will take place in your own home or at a local venue if you would prefer this, at a mutually convenient day and time.

- The interview will last for approximately one hour.

- The interview will be audio-taped and then a written transcript will be produced.

What happens if I decide not to take part?

- It is your choice whether you take part in the research and whether you choose to continue once started.

What will happen to all of the information that I give?

- The interview transcripts will not have any names attached to them, so anything you say will be anonymous. In addition any spoken names or other identifying markers will be changed. The taped interview will not be heard by anyone other than the researcher and research supervisor so that no one will be able to identify you.

- Initially the information (both audio recordings and transcripts) will be stored securely at the home of the researcher and only the researcher and supervisor will have access to it. Both will be kept in a secure place for a period of no longer than 5 years.

- A report will be produced at the end of the work, but again no information will be included which could identify who took part. Some quotes from the transcripts will be included in the analysis section of the report to show how the researcher has interpreted what has been talked about.

What if I change my mind about taking part in the research after I attend the interview?

- You have the right to withdraw your consent to be part of this research at any time up until September 2013. If you decide to withdraw from the research project please make contact with the researcher who will then erase your interview audio recording and destroy the written transcript.

Where can I get more information about this research?

- If you would like more information, you can either contact myself (Jennie) or alternatively you can contact my research supervisor. Here are our contact details:

Researcher:

Jennie Hitchins jenniehitchins@xxxxxxxxxxx   Tel: xxxxx xxxxxx

Project supervisor:

Dr Anna Butcher   Anna.Butcher@xxxxxxxxxxxxxxxx Tel: xxx xxxx xxxx

London Metropolitan University
Department of Psychology
London Metropolitan University
Tower Building
166-220 Holloway Road
London
N7 8DB

Participant Consent Form.

If you would like to take part in this research project, please fill in and sign these consent forms, keeping one copy for yourself.

Before you sign please read and tick the following statements:

☐   I have read the information sheet provided.

☐   I have had the opportunity to ask any questions I have.

☐   I understand I have the right to withdraw my participation at any time prior to the research being written up.

☐   I agree to the resulting data being used both in oral and written forms, for the purposes of distributing the research in a range of settings.

☐   I give permission for my interview to be audio recorded.

☐   I agree to take part in this research.

SIGNATURE OF PARTICIPANT

_____

Name (PLEASE PRINT):

_____

Date

_____

Tel no:

When is the best time to contact you? ....

Demographics form

It would be really helpful if you could answer the following questions.

1. Your age: _____ years old

2. Ethnic origin:

Ethnic Origin does not mean nationality but is normally defined in relation to a people or culture with which a person's forebearers are most strongly identified.

Please tick **one** of the following that you most strongly identify with:-

☐ White
   (e.g. British, Irish, or any other white background)

☐ Mixed
   (e.g. White and Black Caribbean, White and
   Black African, White and Asian, or any other
   mixed race background)

☐ Asian or Asian British
   (e.g. Indian, Pakistani, Bangladeshi, or any other
   Asian Background

☐ Black or Black British
   (e.g. Caribbean, African, or any other black
   background)

☐ Other ethnic group
   (e.g. Chinese or any other ethnic group)

3. When was your breast cancer diagnosed? _____/_____ (month/year)

4. Please tick the treatment type you received.

☐ Chemotherapy
☐ Radiotherapy
☐ Hormone therapy
(tablets such as tamoxifen or anastrozole).

5. Please tick which of these types of surgery you had.

☐ Mastectomy
☐ Lumpectomy
☐ Reconstructive surgery

Appendix B: Final Interview Schedule

1. How would you describe yourself before you had breast cancer?

- How about other people? How would they describe you?

2. I wonder if you could tell me about the time you were diagnosed?

- How did you find out that you had breast cancer?

3. Can you tell me about the treatment that you had for your breast cancer?

- E.g. chemo/radiotherapy?
- E.g. surgical intervention?
- How would you describe going through the treatment?

4. What was life like when treatment ended?

- What was that time like for you?
- What do you think it was like for those around you?

5. How would you say life has been since you finished treatment?

- Was it how you thought it would be?
- Are there any examples you can give?
- Do you think other people would say the same?

6. Some people say that after we experience a trauma like BC it is possible to experience some benefits or positive outcomes from the experience. Some people say the opposite; that they've felt no different, or they've felt worse. What do you think about this?

- Can you tell me why you think that is the case?

7. Is there anything you'd like to say about life after breast cancer that we haven't talked about?

8. What was it like to take part in the research?

Appendix C: Distress Protocol and Debrief sheet

I would like to take this opportunity to remind you once again of the following:

- Anything you have talked about will be made anonymous. The written transcripts of the interviews will not have any names attached to them and the names of any people or places you have mentioned will be changed. The taped interview will not be heard by anyone other than the researcher and research supervisor so that no one will be able to identify you.
- If you should decide that you want to withdraw your participation please make contact with me (Jennie) and I will then erase your interview audio recording and destroy the written transcript.
- If you would like to know about the findings of the research please let either myself (Jennie) or my research supervisor (Anna) know and we will be happy to send you a copy in due course.

Our contact details:

Jennie Hitchins   Researcher   xxxxx xxxxxx

Dr Anna Butcher   Project supervisor: xxx xxxxxxxx

Department of Psychology
London Metropolitan University
Tower Building
166-220 Holloway Road
London
N7 8DB

Sometimes talking about past experiences of cancer can bring about some distress. We have included the names and contact details of some organisations, providing information and support for all stages of the cancer journey, that you might want to make contact with if you feel this might be helpful to you.

Breast Cancer Care   0845 092 0800   www.breastcancercare.org.uk

Macmillan Cancer Support   0808 808 00 00   www.macmillan.org.uk

Cancer Counselling London   07570 968428   www.cancercounsellinglondon.org.uk

British Association for   01455 883300   www.bacp.co.uk
Counselling and Psychotherapy

British Psychological Society   www.bps.org.uk

Appendix D: Transcription notation

Transcription notation.

Underlined text	Added emphasis placed upon word(s)
[ ]	Indicates overlap in speech
(.)	Audible pause in speech (untimed)
(other information)	Laughter, or explanation of non-verbal events referred to within the interview.
' '	Reporting speech of others, or use of active voicing
° quieter speech°	Encloses audibly quieter speech (not due to distance from microphone)
(xxx)	Signifies inaudible speech

Appendix E: Example of analysis: Interview 1 with Ali

Discourses Positions Context	L. No	Speaker		Fine grain features & effects
	198	Ali	To live, so in the middle of all this, it was an amazing success story, but you're still	Amazing – ecf. Middle – Hemmed in?
War metaphor	199		trying to juggle the fall out in your life aren't you?	Cancer as trauma/nuclear war
	200	Jennie	Mm, mm. What was it like getting the balance between living an 'amazing success story'	Paraphrased
War metaphor	201		and dealing with the 'fall out'?	
	202	Ali	It was quite hard really, even, because you've got a lot of side effects you're dealing	Quite, lot –ecf maximises
Fortune	203		with. I'm lucky, I didn't have to take all the hideous hormone treatments some	Fortune repairs 'hideous' – ecf. maximises
biomedical				
	204		people have to live on for five years, but I had an arm that wasn't working brilliantly	Ecf Brilliantly – repair
	205		um, I think it took a good year to recover energy levels to any proper extent	1 year vs five - repair
	206	Jennie	so just the physical post-treatment	Expected effects – minimises? Or enough alone?
	207	Ali	[yes	
	208	Jennie	[side of things, yeah, in its own right	
	209	Ali	Yeah absolutely. Um mentally, quite a bit of that getting used to that not freaking	Extreme anx - freaking out
	210		out every day was it going to come back?	Every – ecf

Discourse Positions Context	L. No	Speaker		Fine grain features & effects
	211	Jennie	mm	
Think positive Fortune Biomedical	212 213	Ali	But I was quite lucky, the success story bit there could be my mantra 'they've fixed me once they could do, fix me again	Ecf -quite Mantra –allays fear Body as machine -fix Agency – passive patient
	214	Jennie	Mm	
Biomedical	215	Ali	You know they're clever people	Drs power 'they'
	216	Jennie	Mm	
Biomedical Warfare Biomedical	217 218 219 220	Ali	But, which was also really important with the triple negative thing, there weren't any other strings to the bow, we'd used every bit of treatment we'd got um(.) so that's one of the only buggers about being triple negative really (.) erm (.) yeah so, it was a difficult to balance all of that, and people do this, they always say, don't they	High risk – triple neg Used every bit – high risk Only – ecf People do – socially held, Always – ecf commonplace
Moral imp'	221		with all cancer don't they, 'Oh positive thinking'	Don't they – we all know this All –ecf generalises Active voicing
	222	Jennie	mm	
	223	Ali	And when you're bouncing back from all of that, you can't live every day like you're	All of that -treatment 3rd person bouncing – fall
PTG	224		having a party, and live life to the full', you've got a young family to look after	Two positions: ordinary extraordinary life
Warfare Stoical Moral imp'	225 226		there's very practical things, you just have to bite the bullet and get on with don't You?	Bite bullet -war Don't you ?– common Knowledge

Discourse Positions Context	L. No	Speaker		Fine grain features & effects
	227	Jennie	mm	
Disappointed vs lucky/spoilt	228	Ali	So some days life can feel a bit disappointing I suppose (…) and then other days I just	A bit – ecf, I suppose – owns, but contestable
fortune	229		feel very spoilt and very lucky, so it swings from one to the other really	Very –ecf. swings
Think positive	230		So it definitely does, that 'stay positive' thing does help. Keeping buoyant, but it	variation
Active voicing
Think pos has a time
Social pressure	231		doesn't help in the <u>afterlife</u> when you're not having a positive '<u>whoopee</u>, shall I go	afterlife-synonymous with death?
'When you're not having' – Signifies expectation
Active voicing.
Celebratory life
PTG	232		sky diving today?' type thing	
Think pos	279	Jennie	So, it sounds like that was something that kind of carried you along during the treatment	Sounds like –query
Kind of - softens
Sounds like – query
Kind of – softens
	280	Ali	Mm	
	281	Jennie	And helped to, to focus you as you went through the treatment, but it	Think pos as focussing

Discourse Positons Context	L. No	Speaker		Fine grain features & effects
	282		sounds as if when the treatment stopped that was the difficult point, at which, I	I don't know – invites
PTG	283		don't know, it's kind of sounding like there was an unspoken 'now get on with life'	Unspoken – but felt pressure
	284		kind of (.)	Softens question
	285	Ali	<u>Yes</u>	Definite answer, emphasised.
	286	Jennie	is that, am I hearing that right?	Query understanding
Career loss	287	Ali	Yes, yeah. And I lost my job as a result of it	Loss
	243	Jennie	Gosh, so that	Effect
	244	Ali	they took my medical away for <u>five years</u>	They – powerful others
	245	Jennie	Right	
Biomedical	246	Ali	because of the likelihood, with it having gone to my lymph, the stats of it coming	Stats – medical/science
	247		back as a brain tumour were quite high, and so they won't let you back in charge of	They –powerful others
	248		A [plane	risk
				Lack of agency
	249	Jennie	[Mm	
	250	Ali	If you're likely to have a fit from a brain tumour and that sort of thing (inhales	Inhalation – difficulty saying
War metaphor	251		sharply) so the fallout from <u>that</u> has been <u>massive</u> and er (.) <u>very</u> traumatic for	Fallout- nuclear, ecf- massive, Very –ecf maximises
	252		quite some time for me er (.) but in the long run I can see it's meant I've had a	Reframes
PTG	253		wonderful time with my <u>children</u>, when they're little, when they're behaving	Ecf- wonderful
				When – expected time for mothers to be at home?
	254		obviously, other days, the little bastards, <u>and I look up at the sky and go 'arrgh!'</u>	Active voicing
	255		laughs) so that's what upsets me about this 'get on with life', it's get on with	Repairs with laugh/humour

Discourse Positions Contexts	L. No	Speaker		Fine grain features & effects
	256		A completely different life	Completely - ecf
	257	Jennie	Mmhmm	
punished	258	Ali	(.) so that decision about 'do I go back to work , or do I <u>treasure</u> time with my family	
	259		Because I've been ill' all got taken away from me, erm and that's just what	Loss of agency
	260		happened. Get on with it.	Stoic
	261	Jennie	So it sounds like um actually kind of, moving forward, that the cancer had affected a	Cancer causes neg cons
	262		number of areas of life so um physical health had been affected because of the side effects,	inc social
	263		work life had been affected, knock on into family life	Cumulative cons
	264	Ali	Mm	
	265	Jennie	um there's a lot there isn't there?	Acknowledges magnitude
	266	Ali	Mm	Accepts acknowledgement
	267	Jennie	What do you think, um how would you, how would you describe yourself after the	
	268		treatment had finished? (.) I know you've sort of talked earlier about there was a	
	269		person, a 'you' that was before the cancer, a 'you' breast cancer, and another after the	
	270		cancer. What do you think the differences are?	
Loss of status	271	Ali	°Just a home bug now°	Homebug. Just ecf -min
				Quietly spoken – hard to say
	273	Jennie	Yeah?	Acknowledging difficulty
	274	Ali	Mm, Yeah still incredibly busy (laughs). I'm trying to think did it knock my	Repair – still busy. Not
				Wasting time/opportunity
	275		confidence? the (xxxxxxxx) I think it does a bit, you lose your confidence in yourself	3rd person – generalises