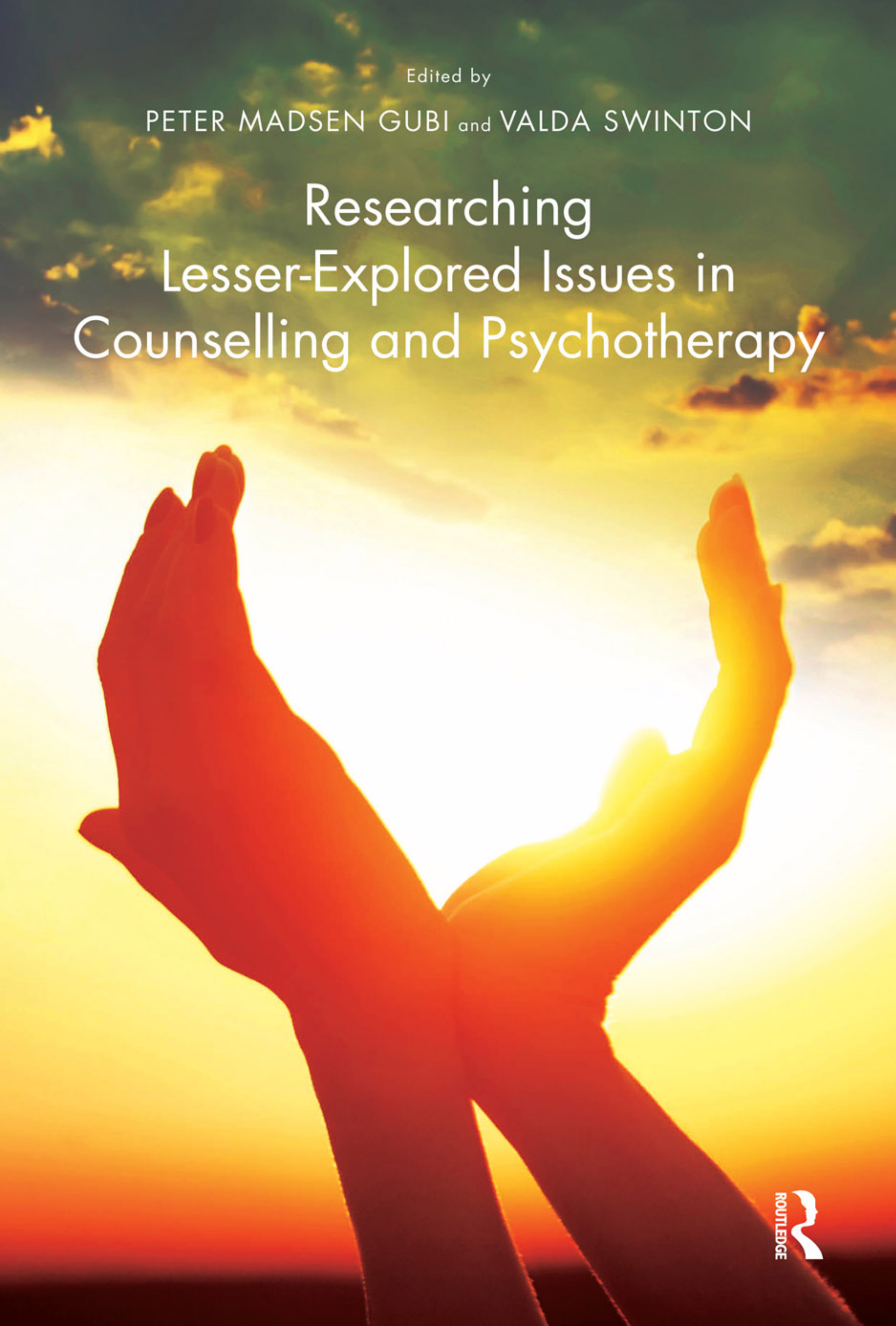
Edited by

PETER MADSEN GUBI and VALDA SWINTON

Researching Lesser-Explored Issues in Counselling and Psychotherapy



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Introduction

Peter Madsen Gubi and Valda Swinton

This book disseminates some interesting research into lesser-explored issues in counselling and psychotherapy. Each chapter is motivated by the personal experience of the chapter authors, and comes from a place of passion within the researchers. It is aimed at informing counsellors and psychotherapists about aspects of human experiencing that are not written about much (if at all) in the counselling and psychotherapy related literature. Each of the chapters comes from research that has been undertaken for a Masters degree in Clinical Counselling at the University of Chester. They are all qualitative pieces of distinction standard. They were undertaken to satisfy the deeply held questions and curiosities that arose from the researchers' experiencing. It is from this place of questioning and curiosity that the best research is motivated and formulated. Each chapter is written by those whom some might consider to be "unseasoned researchers", who are, first and foremost, practitioners, and who, because of that, bring a fresh perspective to the topic that each has studied. Theirs are voices that have something very worthwhile to contribute to professional dialogue. The format of this book, rather than that of the academic journals, allows a fuller expression of their voices, and those of their participants, to be heard, and it is a privilege to host such a range of voices and experiences in this book.

Counselling and psychotherapy training has not always contained elements of research training, or the need to engage significantly with empirical research. Since the development of graduate and postgraduate level training programmes, there is now a requirement to undertake research. In addition, there is now a need for evidence-based practice, and for counsellors and psychotherapists to have the skills to evaluate services to attract the necessary funding. So, students on counselling and psychotherapy training programmes have now to grapple with research methods on their training journey. However, there is often resistance, because research provokes anxiety within many. It is often seen as the domain of the academics, rather than that of practitioners. As one student remarked, "What I am interested in is what happens in the counselling room, the practice with clients, not wasting time learning research methods!" Yet, doing research does inform practice, as the researches presented in this book testify, but training in research has to engage the student's curiosity, their need to know and understand, and to discover. In so doing, their findings will become relevant to their own practice and to that of other practitioners. Research is not just about jargon and statistical calculations, written in a way that is really hard to understand (although clearly some is). As this book demonstrates, qualitative research is akin to sitting in front of a client (participant), hearing the client's (participant's) experience and then trying to make sense of what the client (participant) is saying about their experience. There are technical and academic regulations to overcome, which add validity and ethical efficacy, but the hope always is that on the journey the keenness about a research topic and the enthusiasm to find out more is enhanced by the experience of undertaking research. The researchers' journeys to find out more about their research topics can be the means of discovering more about people, and about how to better respond to the issues that are encountered in the therapeutic encounter. Ultimately, this enriches the disciplines of counselling and psychotherapy generally, as well as the researcher's own practice. The more knowledge that is available through research that can challenge accepted ways of seeing the world, the greater the impact on the "givens" of how things have always been done, and this changes professional "norms" of what is considered best practice.

As counselling and psychotherapy trainees or as established practitioners, researchers bring something of value to the endeavour of research. Their wealth of life experience and their work with their clients can form the backdrop to finding their research topic. What is it that they have experienced in their own life and development that they would like to delve into more deeply? Or, in working with clients, what has sparked their interest to find out more? This connection to the research topic can ensure that the experience is a positive one, something that they will feel able to continue to pursue, even when the going gets tough—and it does get tough. Research is not easy, but it is a creative process. In this process, having an "idea" is a place to begin the process of how the topic can be made into a researchable question. Then the process of refining begins, so that the research idea can become more concrete. There are times when the research process can be a very lonely endeavour as researchers try to meet all the demands of carrying out an ethically and academically rigorous research project with many hurdles to overcome: will the project gain ethical approval? Will any participants come forward? Then, in qualitative research, there is often interviewing, transcribing, analysing, finding themes, and generally making sense of the data. There is the pressure of doing justice to the material with which they have been entrusted.

So, within this edition is the finished product at the end of journey—minus the blood, sweat, and tears. In this book, the researchers try to do justice to the voices of their participants and contribute to the evidence base of the professions of counselling and psychotherapy.

Research choices

All of the research presented in these chapters use interpretative phenomenological analysis (IPA) as the research methodology for analysing the data. Rather than spend verbiage in each chapter explaining the methodology, a brief summary of the main points of IPA is presented here. The aim of IPA is to explore, in detail, participants' views of the topic that is under investigation (Smith et al., 2009). It is a phenomenological approach, in that it is concerned with personal perception rather than with the formation of objective statement. It is a method that seeks an insider's perspective, but which takes account of the fact that the researcher's own perceptions are needed to make sense of the other's world through a process of interpretative activity. Therefore, it is the researcher's role to comment on, and to make sense of, the participant's activity and opinion. IPA is a *bricolage* of established approach and methodology, in that it brings together a phenomenological approach and a symbolic interactionism approach, while using research instruments and methods of analysis that are commonly found in discourse analysis and thematic analysis. The philosophical paradigm on which IPA is based is that it is not necessary to go beyond the verbal statement to understand underlying cognitions or to predict the relational dimension between verbal statement and behaviour. Instead, IPA attempts to value the perception and meaning that is attributed to an object, event, or experience, while recognising that meaning can only be obtained through a process of interpretative activity. It is a dynamic process that is complicated by the researcher's own conceptions. The method of analysis is creative, not prescriptive. It relies on a method of making sense of the data through the coding of themes and subordinate themes, and the seeking of connections. It is important that the researcher's bias does not distort the selective process of the categorisation of themes. Initial themes can be governed by the prompts that are used at the interviewing stage. However, at the transcribing stage, it is important for the richness of the data to determine the emerging themes and categorisation, and for the researcher to be led by that process rather than dictate it. Once a superordinate list of themes has emerged, the researcher is then required to be selective towards the emerging subordinate themes, with the selectivity dependent on the parameters of the research and the relevance of emerging subordinate themes to the research topic. At the writing-up stage of the research, the shared themes, patterns, connections, and tensions are translated and woven into a narrative account that details the interesting and essential things about the participants' responses and the researcher's interpretative analysis of them. These data can be presented in a variety of ways (e.g., diagrammatically to detail the relationships and/or conflicts between emerging themes, or as a narrative that comprises the respondents' comments that are interpretatively analysed). However, at this stage of weaving the tapestry that is the narrative, it is important for the unique nature of each participant's experience to emerge, and, throughout, the participants' voices are heard in the rich data.

Ethical awareness

As each research project was undertaken within the Division of Counselling and Psychotherapy at the University of Chester, it was subject to the rigorous procedure of ethical approval by the university's Research Ethics Committee. Every effort was made to protect the participants from harm, to seek their consent at various stages of the research, to protect their right to withdraw without prejudice, to support them if anything emotional was stirred up within them because of the research process, to maintain the confidentiality of their identities, and to maintain the security of their data.

The structure of each chapter

Each chapter has been edited and formatted in such a way as to offer a cohesive and homogeneous presentation that enables each to set the scene for the research, to establish the research project in published literature that has been searched for, and accessed, through various academic search-engines, to introduce the participants and the questions asked of them in semi-structured interviews, to present the findings, to enable a reflexive and critical discussion of the findings in the light of the published literature, and, finally, to conclude.

Introducing each chapter

In Chapter One, Susan Shortt explores the experiences of four young, single women who were diagnosed with breast cancer, and examines the impact of this on their sexuality during and post treatment. The chapter focuses on the impact on their sexuality and includes areas such as body image, dating and relationships, and fertility. It widens awareness of the issues faced by this particular group.

In Chapter Two, Amanda Sives examines the impact of pregnancy loss and involuntary childlessness among a specific group of women who delayed childbirth, whether through choice or circumstance. The chapter highlights the devastating impact of pregnancy loss for childless women of advanced maternal age, the isolation and loneliness of their pain, and the struggle to rewrite a future that involves childlessness. Based on the lived experience of six women, the chapter concludes with recommendations for greater psychological support and a deeper understanding for this often silenced group of women.

In Chapter Three, Caroline Fletcher considers the lived experience of counsellors who grew up, and continue to live, without siblings, and looks at the significance that they attach to the experience of being an "only child". The chapter examines ideas of identity, relationships, and loss, and captures some of the complexity and richness of individual lives—something that seems to be missing from the generalisations and stereotypes associated with "only children".

In Chapter Four, Tracey Clare explores adults' experiences of parental rejection in childhood and the impact of personal development during counsellor training on processing unresolved feelings. Commonalities of experience are teased out and examined against the backdrop of the academic literature. Personal development is found to play an intrinsic role in the processing of participants' experience.

In Chapter Five, Eileen Doyle examines the notion of emotional labour and its particular impact on teachers. Because teaching involves a high degree of emotional labour, teachers are at significant risk from the adverse effects it can have on their emotional wellbeing. Recently, there has been a drive to provide counselling for pupils in UK schools, which is in contrast with the lack of similar support available to teachers.

In Chapter Six, Mair Sides considers the experiences of trainee counsellors in clinical placement working with clients perceived to be inappropriately referred to them. The impact of this work on their professional development is recognised, along with the wider implications for training.

Finally, in Chapter Seven, Gary Tebble examines the nature of school-based counselling in Wales. He investigates the assertion that talking alone is enough when engaging a young person in school-based counselling, and demonstrates the helpfulness of creative and symbolic methods and their impact on the therapeutic relationship.

Who this book is for

This book is written to disseminate research to counsellors and psychotherapists, those who are qualified and those who are in training. However, the insights that the researches provide are applicable, and will be of interest, to anyone who is interested in understanding people better, and those who are involved in people-work where the accompaniment of those in emotional difficulty is paramount (e.g., social workers, pastoral care workers, chaplains, clergy, clinical and counselling psychologists, nurses, prison wardens/ warders, etc.).

This book is dedicated to each of our mothers:
Iceline (Icy) Henry and Joyce Isabel Gubi, whom we each
greatly miss, and to whom we each owe so much.

CHAPTER ONE

Sexuality after breast cancer: voices of young, single women

Susan Shortt

Introduction

My interest in the stories of young, single women treated for breast cancer originates in my personal experience of being a member of this group. Eight years ago, I was diagnosed, in my thirties, with breast cancer, and embarked on an intensive and lengthy treatment path. The experience has undoubtedly had an impact on my identity in many ways, some extremely positive and growth-promoting, "a wake-up call" (Gorman, 2011), but some much more painful and difficult. A breast cancer diagnosis as a young woman was described by one child-free woman as changing the entire trajectory of her life (Gould et al., 2006); this resonates.

At a counselling course residential, I found myself exploring, in front of the group, my narrative of before, during, and after treatment, in response to an invitation to consider influences on our sexuality. I had not talked through the chronology of my journey in this way before, and having this witnessed by my peers felt very powerful, affirming, and hugely emotional. It also caused me to reflect upon how this area had been one of the hardest aspects of my diagnosis, and one that is seldom talked about, both in clinical settings and among friends. The ending of a relationship during my treatment, and the subsequent search for a new partner, brought to the fore a raft of issues, both physical and psychological, for which I was completely unprepared. There was a sense of my having to rewrite the narrative of my life to accommodate this "off-time" event (Wurm et al., 2008), and I began to become interested in how major illness interrupts the predictable course of life and forces us to write a new story (Frank, 1995; Neimeyer et al., 2002).

I volunteer for Breast Cancer Care's (BCC) "Someone Like Me" service, offering support to women following diagnosis. Hearing other young women's stories and struggles in relation to their sexuality also fuelled my desire to explore this area. At young women's events, optional sessions on sexuality and intimacy are popular, and people appear relieved to have found a forum to share their concerns. However, along with much of the information literature I have come across, it is often the case that sessions such as these very much refer to "you and your partner", leaving single women isolated. So, the strands of my research topic took shape, to encompass a breast cancer diagnosis along with being younger, being single, and examining the impact on sexuality. I acknowledged that in embarking on this research, as well as wanting to bring the experiences of this group to a wider audience, it might prove to be an important part of my own personal journey.

As I began to look for existing research, I discovered little about this topic that is focused on this group. This made it feel all the more important, and I wanted in some small way to begin to redress the balance. There are distinct issues faced by young single women who have experienced breast cancer (Gluhoski et al., 1998)—for example, in the area of dating. I wanted to enable some of these women to have their voices heard, and, by doing so, broaden awareness among the counselling community of this group, and give a flavour of their experiences. I was also keen to contribute to the "pedagogy of suffering" (Frank, 1995, p. 145); this posits that someone who suffers has something to teach, and, therefore, has something to give, thus restoring agency to the ill person and giving their story parity with professional expertise. As Adams et al. (2011) note, a quarter of all cancers in adults under forty-five are breast cancers and it is the most common type of cancer for this group. It is, therefore, likely that counsellors may encounter younger women who have faced this diagnosis.

What the literature says

Each year, around 55,000 people in the UK are diagnosed with breast cancer (Breast Cancer Care, 2013). There are around 9,800 cases each year in women under fifty, and very few of these occur in women in their teens or early twenties. Breast cancer is the most common cancer in women aged under forty, and, in women aged 35–39 in the UK, around 1,300 cases of breast cancer are diagnosed each year (Cancer Research UK, 2014). These statistics position a breast cancer diagnosis in a young woman as an unexpected and relatively rare event.

Very few published studies on younger women's experiences of breast cancer conducted in the UK exist; notable exceptions are Corney and colleagues (2014), and Adams and colleagues' (2011) synthesis of the work of others. Corney's work is primarily concerned with fertility issues, although it did also consider partnership issues. Many studies have a medical slant, and aim to provide information to healthcare professionals about how they might best support patients (e.g., Ganz, 2008; Gould et al., 2006; Kissane et al., 2004; Takahashi, 2014; Thewes et al., 2004). Some research is written in medicalised language (e.g., Cardoso et al., 2012). Gould and colleagues' study was large by qualitative standards, and included sixty-five young women in ten focus groups. While its emphasis was very much on support and information needs, this did draw out some of the themes that are pertinent to younger women, including the unexpected side-effects of treatments on sexuality.

There is an abundance of quantitative studies, (e.g., Avis et al., 2004; Burwell et al., 2006; Fallbjork et al., 2013; Fobair et al., 2006; Meyerowitz et al., 1999). Avis and colleages, in their study of over 200 women, do include some open-ended questions, and note that responses to these were particularly informative, acknowledging that purely quantitative studies obscure the diversity of experiences. Far less has been written about the qualitative lived experience. Adams and co-authors (2011), in their meta-ethnography found just seventeen qualitative studies, conducted over a twenty-year period, that focused on the experiences, needs, and concerns of younger women with breast cancer. Coyne and Borbasi's (2006) study is noteworthy from a methodological perspective, with its emphasis on enabling women to tell the story of their journey without the rigidity of set questions, adopting a feminist approach to the encounter. Their aim was to give health professionals a greater understanding, and their ethos resonates with mine. This quote from a participant in a further study by Coyne and Borbasi (2009) gives a flavour of the impact of a breast cancer diagnosis at a young age:

> . . . in one fell swoop I was told everything that was feminine about me was gone, I was losing my breast, I possibly couldn't have children. . . . all of a sudden choices for the life I had planned were being taken away from me. (p. 10)

Young women can feel marginalised and isolated as they do not conform to the "normal" older profile of a woman with breast cancer (Dunn & Steginga, 2000), and, as a distinct population, they are an under-researched group in terms of specific key issues and concerns they face (Adams et al., 2011).

A recent review of twenty-eight large scale, quantitative studies conducted over a fifteen-year period among women under fifty-one or premenopausal at diagnosis found that, compared to older women diagnosed and the normal population, younger women experienced some reduction in their quality of life, with a greater impact on emotional wellbeing than physical functioning. Main anxieties were around fear of recurrence and what might happen in the future. Depressive symptoms were relatively common, and menopausal symptoms, such as hot flushes, lack of libido, and vaginal dryness were a source of concern for many, as were fertility issues (Howard-Anderson et al., 2012). While this review provides some useful pointers as to areas that might cause difficulty, it does not address the lived experience of these women and a more qualitative approach is required to uncover this.

A comprehensive review of qualitative research among younger women identified feeling "out of sync" as the issue that "permeates all others"; breast cancer is a disruption to the normal life course (Adams et al., 2011). There are clear links here with theories about "assumptive worlds" (Parkes, 2009): each person has an internal model that they assume to be true; it contains everything we take for granted, and when an event occurs to disrupt this, we become lost. Reproduction, body image, fear, and sexual activity are also identified as key issues in Adams and colleagues' review. From this, the authors construct an interesting conceptual model suggesting how women experience and respond. They propose three processes, used in varying combinations. The first is balancing: for instance, balancing the immediate priority of treatment with learning to adjust to sudden menopause, or weighing up desire for a child against future health concerns. Next comes normalising; this might be by having reconstruction to regain a sense of normality, or, for some, by normalising an "imperfect" body. Last, changing is identified as a process, often part of a wish to find a new "normal", and this can comprise both negative and positive elements. For example, infertility might force a change in plans for a family. On a more positive note, cancer might be perceived as a turning point and lead to better self-care or new activities. As with all "meta" research, the authors are distanced from the original data and findings are generalised, but this study does provide a rare and useful insight into issues specific to younger women and draw these together into a model that illustrates the complexity and fluidity of response to diagnosis. Its validity is demonstrated, for example, in the work of Kirkman and colleagues (2014), whose participants describe balancing the need to stay alive with their desire to have a child.

Until recently, research examining the impact of a breast cancer diagnosis on sexuality mainly took place within the context of a positivist–realist paradigm, and was focused on the physical aspects of women's experience and satisfaction or dysfunction in their sexual relationships (Emilee et al., 2010). However, women do not equate how often they have sex with sexual satisfaction. "Their sexuality is much more complex, involving issues of self-esteem, identity, body image, and role functioning" (Wilmoth, 2001, p. 279). Wilmoth's study asked women to define what sexuality meant to them, and the impact breast cancer had on this part of their lives. While her participants were mostly over forty-five, the resulting themes of missing parts, loss of womanhood, loss of bleeding, and loss of sexual sensation would appear pertinent to younger women, too. These combine to form an "altered sexual self". The supportiveness of partners, and the degree to which women took control of finding out information relevant to their treatment appeared important in how women adapted. Wilmoth proposed three processes: *taking in* the diagnosis and changes to the body, *taking hold* of the losses, and coming to terms with them, and those who had managed to do this moved on to *taking on* the role of breast cancer survivor and gaining some control over treatment side-effects. Her study explores menopause in some depth, which is not relevant to all participants in this study. Wilmoth's grounded theory model conveys well a sense of movement and agency for the women. It does, however, feel a little prescribed, but could be considered as a useful framework of elements and processes that could be experienced, and valuably highlights the sense of loss experienced.

Prior to Wilmoth's study, a dissertation by Turner (1999) also pioneered a more women-centred approach in inviting women to explore the impact of their diagnosis on sexuality, using their own definitions. This provided vivid quotes of their lived experiences and chimed with my aims to "get under the skin" of what a breast cancer diagnosis meant for my participants. It did not, however, focus specifically on younger women, no participants were single, and just one was childless. It does provide an early example of challenging a narrow definition of sexuality, and her model of a "reconstructed sexual self" is sociological, considering a wide range of influences. In considering sexuality in this way, it does lose its connection to individual women's stories at times.

Few studies have focused on younger women in relation to body image (Rosenberg et al., 2013), and those that do tend to look at short term rather than longer term impacts, and are quantitative (e.g., Fobair et al., 2006; Rosenberg et al., 2013). Fallbjork and colleagues (2013) did follow up women almost three years post-surgery, and illustrate the difficulties in matching such a nuanced and personal subject with a quantitative methodology. They discovered a decrease in feelings of sexual attractiveness and comfort over time, and spent much of the discussion speculating as to why this was the case; a sensitive piece of qualitative research might have revealed some answers.

Some research indicates that breast conserving surgery (lumpectomy) has less impact on body image than mastectomy, with or without reconstruction (Kissane et al., 2004; Rosenberg et al., 2013). A review by Emilee and colleagues (2010) notes that overall results are mixed as to the impact of differing types of surgery on sexuality (of which body image is a part). Varying methodologies and samples make robust comparisons difficult, and I would argue there are multiple variables that come into play: for instance, body image prior to diagnosis, and reaction of partner. It has been suggested that greater than the impact of type of surgery on sexuality is that of the chemotherapy and hormonal treatments that many women undergo (Klaeson et al., 2011). Chemotherapy is associated with increased risk of sexual difficulties (Avis et al., 2004), and for younger women the combination of sudden menopause and associated symptoms such as vaginal dryness, loss of sexual function, and loss of fertility can be particularly devastating (Ganz et al., 1998). Archibald and co-authors (2006) qualitative study, while narrow in its focus on sexual functioning following chemically induced menopause, does give some insights into the lived experience, missed by quantitative studies. For example, one single young woman is quoted wondering how any young man will handle her lack of sex drive and a body that she now perceives as old.

Chemotherapy-induced hair loss can also be extremely distressing and pose a threat to body image (Power & Condon, 2008). This is borne out by Thomas-MacLean's (2004) research on embodiment; a participant speaks of hair loss being so visible, and, as such, in some ways harder to cope with than breast loss, and a participant in Hefferon's (2008) thesis echoes this, describing her hair loss as worse than losing her breast.t helps them r

Larder (2010) notes in a BCC qualitative study on body image that for many of her respondents, while there was a degree of adjustment, the effects of breast surgery stayed with them and, as a result, they never became fully accepting of their body image. One, ten years post diagnosis, talks of learning to accept her mastectomy, but still hating it and feeling it looks ridiculous. An interesting counterpoint to studies suggesting ongoing difficulties with body image can be found in the research of Dunn and Steginga (2000), who asked participants to choose from a list of words those which best reflected their breast cancer experience. "Unattractive" was chosen by only three out of twenty-one women.

There is a paucity of research specifically examining the experiences of women who are single at some point following their breast cancer diagnosis. More commonly, brief comment is made about this group, as part of a larger sample (e.g., Archibald et al., 2006; Dunn & Steginga, 2000; Gould et al., 2006; Schover, 1991; Thewes et al., 2004), or no mention is given to singles at all (e.g., Cardoso et al., 2012; Cebeci et al., 2010; Emilee et al., 2010).

It is acknowledged that seeking new relationships after breast cancer can be a specific stressor for younger, single women (Schover, 1994). Often cited is a qualitative study by Gluhoski and colleagues (1998) among a sample of unmarried women as part of a study about pregnancy post breast cancer; all women believed they were still fertile. As such, it does not address fertility concerns, but does identify a set of unique stressors for unmarried women: pessimism about future relationships, fears about disclosing illness to partners, negative body image and impaired sexuality, pain of rejection by partners, and a sense of isolation and inadequate support. A sense of anxiety around dating, broaching the subject of cancer, fear of rejection and being found sexually undesirable, and never being able to form a new intimate relationship is echoed in the work of Holmberg and colleagues (2001). Feelings of being a liability to a future partner if the cancer recurs can be another fear (Thewes et al., 2004). An anecdote from a participant (Wilmoth, 2001) felt particularly discouraging. She told a man she was starting to date that she had breast cancer, and then went to the kitchen to pour drinks. When she came back, he had left. This caused her to completely avoid dating and male company. There is not much written about experiences when people did start to date. An early piece of research that does include this is a dissertation by Whitney (1988), from a feminist perspective; she interviewed single lesbian and heterosexual women about the impact of breast cancer on their "sexual scripts". It is notable for its qualitative approach, treating each participant as an individual case study initially, and conveying a rich sense of their varied experiences.

More recently, Corney and colleagues (2014), as part of a study concerning fertility, interviewed young, single women and similarly noted fear of rejection by potential partners, together with dilemmas around having children, and limited options for fertility treatment as some of the key issues they faced. With regard to infertility and loss of choice about having children, women believe that these concerns can sometimes be trivialised by health professionals, who feel that they should be more concerned about survival than loss of fertility (Dunn & Steginga, 2000).

Young single women with breast cancer describe an "utter silence" surrounding understanding of sexual changes in their bodies and how to feel sexual again with a new partner (Gould et al., 2006). There is not much support information specifically tailored to this group. Several years ago, I contributed quotes to a BCC publication entitled *Sexuality, Intimacy and Breast Cancer* (Breast Cancer Care, 2011) but, looking through this and other similar publications, there is generally just a paragraph about being single, with most of the information geared towards those in a relationship. A brief look at other online resources resulted in finding an informative page on the American Cancer Society (2013) website devoted to the single woman and cancer. On the Stanford Medicine website (Brandt, 2013), a doctor states that it is rare to come across anything geared to young, single women, and she blogs about dating tips. Interestingly, as far back as 1991, Schover was suggesting that being young and not in a committed relationship were "risk factors" that the healthcare team should be alert to, suggesting that this group might benefit from brief counselling, hearing about other women who have found new relationships post cancer, and help in planning how to date again and when to disclose their illness.

Of relevance to how women might make sense of their diagnosis, Neimeyer and colleagues (2002), taking a constructivist, narrative approach to their work around meaning reconstruction, write of major losses challenging our understanding of the previously adequate narratives of our life, and of the requirement to develop new ones. They call this "narrative repair" and see the goal not so much as a final truth, but as an account where things can seem meaningful once again. This seems pertinent to young women's accounts of breast cancer.

Frank's (1995) seminal work views illness as resulting in a narrative wreck: "The illness story is wrecked because its present is not what the past was supposed to lead up to, and the future is scarcely thinkable" (p. 55). He goes on to identify three types of illness narrative: restitution, which is based on a return to health, chaos, in which it is imagined life will never get better, and quest, in which the illness is accepted and the person seeks to use it positively. He discusses these in the sociological and political context of the medical profession and wider society. His comment that there is a need for clinical staff to witness the chaos rather than try to drag the patient out of it resonates with the values of person-centred counselling.

Bertero and Wilmoth (2007), in a meta-synthesis of qualitative research on breast cancer treatments affecting the Self, make reference to Frank's quest narrative. They write of a process of redefinition of the Self that includes women reflexively questioning their sense of womanhood in the aftermath of treatment. While this is a valuable