CHAPTER 6

RESEARCH METHODOLOGIES

6.1 Introduction

Chapter 1 explains that this research followed a pluralistic approach towards the study of the experience of breast cancer and its recurrence. The literature review showed that most studies done on the psychological experience of breast cancer and its recurrence, used mainly a quantitative approach. These studies seemed to provide limited answers towards the question of how women experience breast cancer. It was thus important to conduct this study using a wide theoretical lens, including those theories already discussed in previous chapters; keeping the physical aspects of the disease and its treatments in mind; but always remembering that each patient also experiences her illness from her own individual frame of reference. This could only be attempted by using both quantitative and qualitative techniques. Using both quantitative and qualitative approaches may be compared to showing the other side of the coin to gain a more complete picture.

The research instruments were chosen within the framework provided by the different theories. For the quantitative approach, the General Health Questionnaire (GHQ) was used as a measure of health status of the patients. As discussed in Chapter 6, it gives an indication of non-psychotic psychiatric disturbance and was described by Goldberg and Williams (1991). This is a questionnaire that falls within coping and stress theories such as that of Lazarus (1966) discussed in Chapter 4. The Hospital Anxiety and Depression Scale (HAD) developed by Zigmond and Snaith (1983) was used to

measure levels of anxiety and depression. Anxiety and depression also fall within the framework of coping theories, as both are expressions of how well an individual is coping within a stressful situation such as having breast cancer.

Still within the general framework of coping, is the way in which an individual perceives control within a specific situation. The questionnaire used to measure this is the Multidimensional Health Locus of Control Scale (MHLC), developed by Wallston, B.S., Wallston, K.A., Kaplan and Maides (1976). The theories related more specifically to control, are social learning theory as described by Rotter (1966), and discussions on self-regulatory behaviour (Bandura, 1977). These theories have been discussed in more detail in Chapter 3. One possible way of taking control may be to use an alternative form of treatment. To test whether patients considered this possibility a semi-structured interview was conducted with them, based on information provided by BACKUP, an organization that aims to provide relevant information to women with breast cancer.

Background to the use of alternative treatments has been discussed in Chapter 3. To describe findings of the qualitative research interviews, an interactional model described by Swart and Wiehahn (1979) was used. This descriptive method and the interactional theory (Carkhuff & Berenson, 1967; Swart & Wiehahn, 1979; Hychner, 1991) were described in Chapter 5. The theories discussed and the instruments used formed parts of a picture as complete as possible about the psychological experience of breast cancer.

To illustrate this point further a short discussion of the different research approaches and the methodology of this study follows.

6.2 Therapeutic research as complementary to quantitative research

There are certain limitations in doing only a quantitative investigation in psychological research projects. The first of these limitations as named by Slife and Gantt (1999) is empiricism. The assumption is that only the empirical or observable may be seen as reliable information. For example, in this study that would implicate that the behaviour of those patients who did not use alternative forms of treatment after their recurrence, still trust conventional treatments. Although their behaviour certainly confirmed this conclusion based on structured interview data, many patients would say that they still go to hospital because they do not trust alternative treatments either. Some patients expressed grave concern that they were afraid that previous treatment had failed and that they realized that their chances of long term cure was very limited. This additional knowledge could not be accommodated by empirical research methods. From a therapeutic perspective, however, this is very important information on how patients deal with the experience of cancer. One might even go as far as claiming that the empirical research may lead to the wrong interpretations of results.

The second limitation of quantitative research is the fact that everything is measured. There are things in human experience that cannot be quantified. Trying to classify emotional experience into quantifiable scales, for example, by asking: "On a scale of one to ten, how stressful did you experience the diagnosis of a recurrence of your breast cancer?" limits the amount of knowledge we gain. Quantification oversimplifies and limits information. Quantifiable information can be analysed by statistical means, but loses the depth that is needed in psychological research.

Slife and Gannt (1999) described the third limitation of traditional research as the assumption that scientific knowledge should be universally applicable, fixed and

unchangeable across time and space. Again this is not applicable to psychological phenomena. For example, the emotional experience of a diagnosis of cancer changes with time and varies according to circumstance. In order to find practical implications on how to deal with these situations one cannot ignore the fact that most psychological phenomena are individual experiences and do not only vary between individuals, but also within the same individual.

The last limitation described by Slife and Gannt (1999) is naturalism. This assumption assumes that psychological phenomena are determined by certain laws. It implicitly assumes a cause-effect relationship that excludes the possibility of free will. Within the therapeutic research procedure the possibility of some control and choice within the individual is accepted. In the cancer field the manifestation of this control is clearly illustrated with some patients taking control and managing their illness, while others just give up the responsibility of their health and allow others to take full responsibility. A practical example of this is where a patient herself did not know what medication to take, but her husband knew exactly what pills to give to her at what time.

Quantitative studies are not programmed to deal with individual differences between patients. However, when one needs to intervene it is usually at an individual level. Examples of primary concerns of patients that quantitative research did not adequately address are: fear of being dependent on others and a burden to their families and fear that they might experience pain. Furthermore, none of these studies described how this "fear" or "worry" affected the women in their daily lives. For example, were those who underwent a mastectomy overconcerned with the occurrence of a lump in the other breast, did they check for it more often than the situation warranted, or not?

Given the limitations of traditional research, qualitative research should aim at providing

an additional perspective to the answers provided by qualitative research methods. Psychotherapy research provides the practical answers to enable clinicians to enhance their psychotherapeutic skills. It bridges the gap between science and practice (Golfried, Borkovec, Clarkin, Johnson, & Parry, 1999; Miranda, & Borkovec, 1999).

In order to add to our understanding of psychological phenomena that could not be provided by quantitative analysis of the data, qualitative approaches of research aim to ask questions in ordinary language, towards which patients may respond in ordinary language. They are not requested to transform their experiences into quantifiable scales. The assumption of universalism does not exist in qualitative research. It is assumed that psychological phenomena may be limited to a specific context. Qualitative research does not ascribe meaning, but strives to understand the meaning a person ascribes to his/her own experience.

6.3 Pluralistic approach of this study

6.3.1 Introduction

The psychological aspects examined in the quantitative analysis are perception of general health, anxiety and depression, locus of control and the use of alternative treatments for cancer. I also examined the psychological impact of the news of recurrence on the partners of those patients whose cancer recurred, by comparing their measures of general health, anxiety and depression and marital relationships with the partners of the comparison group.

I obtained approval for the quantitative study from the Ethical Committee of the South East Kent Health Authority in the United Kingdom. This allowed me to assess patients at the breast care clinic within the first few days after hearing that their cancer had

recurred.

A qualitative investigation was undertaken by conducting therapeutic interviews with patients in South Africa. Approval for this part of the study was obtained from the Ethical Committee at the Academic Hospital in Pretoria. The therapeutic interviews conducted were interpreted using the structure of interactional psychology as described by Swart and Wiehahn (1979).

6.3.2   Quantitative approach

Three groups were used for this part of the study. The first group of patients consisted of patients whose breast cancer recurred, the second group were breast cancer patients whose disease had been in remission for at least a period of one year. The third group was husbands of these patients. After a description of the groups, a discussion of the method of statistical analysis follows as well as a description of the quantitative measures used.

The hypotheses for the quantitative approach were the following:

(i)   Patients with recurrent disease would have lower perceptions of their general health   than the comparison group.

(ii)   Patients who experienced a recurrence of their breast cancer would be more anxious and depressed than a comparable group of breast cancer patients whose illness was in remission.

(iii)   Patients' first reaction to recurrence of cancer would relate to their expectation of whether they have been cured from their initial cancer or not. Those who

expected it to recur would experience it as less of an emotional shock than those who believed themselves cured.

(iv) The partners of recurrence patients would have lower measures of general health, would be more anxious and depressed and would experience more discord in their relationships with their partners.

(v) Patients with recurrent cancer would be more inclined to make use of alternative treatments than patients whose disease was in remission. Those patients with a high internal locus of control would be more inclined to use complementary treatments than those who were higher on the other types of locus of control.

6.3.2.1 Groups

Patients with recurrence (N=51)

This group included all patients diagnosed as having a first recurrence of their cancer at the William Harvey Hospital in Ashford, Kent, from September 1992 to May 1994. Recurrence included local recurrence in the breast or distant metastases. Patients with breast cancer, who developed a new cancer located in the other breast or any other area of the body such as the liver or lungs, were also included.

The consultant surgeon or breast care nurse asked eligible patients for their consent to take part in the study. Only patients judged by the consultant surgeon as having a prognosis of at least one year, were seen.

Patients were introduced to the researcher, who explained the procedure. The first set of questionnaires were administered at the breast clinic or on the ward if women had had an operation and had to stay in hospital for a few days. In those cases where the

patients could not be approached directly at the hospital, the researcher contacted them at home by telephone, explained the research procedure and sent the first set of questionnaires by post.

Of the 51 patients who were approached, 40 patients participated. Three patients died without completing the first assessment, 2 patients refused, 2 were excluded because they had a history of depression prior to their initial diagnosis of breast cancer and 2 had incomplete or spoilt questionnaires. One patient was excluded because she did not believe the cancer had recurred, in spite of being told by both the consultant surgeon and the breast care nurse. Another patient went to Mexico for alternative treatment and was admitted to the psychiatric unit of the hospital shortly after her return.

Comparison group (N=94)

The comparison group was breast cancer patients, whose illness had been in remission for at least one year. They were of similar age, type of original cancer, stage of cancer and time of first diagnosis as the recurrence group.

The researcher at the breast clinic approached them when they came in for follow-up visits. She explained the purpose of the research and the procedure, asked for their consent to take part and gave them the first set of questionnaires to be filled in at home and returned by post in a pre-stamped envelope.

Of the 94 patients who were invited to participate, only one patient refused to take part, 18 did not return their questionnaires and 8 returned incomplete and spoilt questionnaires. Therefore, the statistical analysis on this group was performed on 67 patients.

The demographic data of the two groups are shown in Table 1.

Table 1: Demographic characteristics

	Recurrence (N=40)	Comparison (N=68)
AGE		
Mean	62 years	58 years
Range	35-85 years	27-80 years
MARITAL STATUS		
Married	26	39
Widowed	9	19
Divorced	2	1
Separated	2	3
Single	1	4
Live together	0	2

There was not a significant difference in age between the groups. The mean number of days since initial diagnosis of cancer for the recurrence patients were 1843 days and for the comparison patients 1831 days (about five years). The majority of women in both groups were married or widowed with few being single, separated or living together.

The groups were also comparable in terms of treatment for first diagnosis, adjuvant treatment, histological type of tumour, and menopausal state as can be seen in Table 2. However, the Mann Whitney test showed that the two groups differed significantly in number of lymph nodes involved at first diagnosis (p=0.01).

Table 2: Physiological characteristics

	Recurrence	Comparison
Primary treatment		
Mastectomy	23	27
Wide excision	16	36
Tamoxifen only	1	5
Adjuvant treatment		
Chemotherapy	6	6
Radiotherapy	3	1
Endocrine	16	27
No treatment	11	30
Radio and chemo	1	2
Radio and endocrine	1	1
Radio, chemo, endocrine	1	1
Missing	1	0
Menopausal state		
Over 50	29	56
Under 50	11	12
Histological type of tumour		
Infiltrating carcinoma	34	58
Other	1	5
Not recorded	5	5
Number of nodes affected		
0	18	49
1-3	12	14
4-15	6	3
Not recorded	4	2
Tumour size in centimetres		
<2	7	22
2-5	23	40
>5	5	2
Not recorded	5	4

The different types of recurrence are shown in Table 3. Most women experienced local recurrence.

Table 3: Type of recurrence

Liver metastases	1
Brain metastases	1
Bone metastases	10
New primary	7
Local recurrence	14
Lymph nodes	6
Lung	1

Partner groups

(Recurrence N=9) (Comparison N=18)

The researcher asked patients who gave their consent to take part in the study to hand over sets of questionnaires to their partners. Although the patients themselves were very co-operative and willing to take part in the study, it was evident that it would be difficult to obtain sufficient numbers of partners to take part in the study. Upon request to hand over questionnaires to partners, patients replied with comments such as: "*My husband is much too old to fill in questionnaires*"; another said: "*My husband is too ill too fill in questionnaires*" or "*too busy*" and another said that her husband would get his secretary to fill in the questionnaires. In those cases where the partners accompanied the patients to the out patient clinic, the researcher asked them personally for consent to enter the study.

As indicated in Table 4, the majority (65%), of the recurrence patients was married at the time of assessment. The comparison patients were similar, with 57% married. Thirty-nine of the comparison patients and 25 of the recurrence patients completed the marital relationship scale (GRIMS).

Table 4: Marital status of the patients

	Recurrence	Comparison
Single	1	4
Married	26	39
Divorced	2	1
Separated	2	3
Widowed	9	19
Live together	0	2

Nine husbands of patients with recurrent cancer took part in the study and 18 husbands of comparison patients. All these husbands had been married for at least five years and most of them had very long marriages, with a median duration of marriage of 35 years. Both the average age of the husbands and the median age were 59 years.

See Table 5 for a distribution of husbands' ages.

Table 5: Age of husbands

Age	Recurrence	Comparison
30-40	1	1
41-50	0	1
51-60	5	6
61-70	2	4
71-80	1	4
TOTAL	9	18

6.3.2.2 Statistical analysis

The Statistical Package for the Social Sciences (SPSS) (Frude 1987; Norusis 1991) was used to analyse the data and mainly non-parametric procedures as described by Siegel (1988), were applied.

6.3.2.3 Quantitative methods

6.3.2.3.1 Introduction

Recurrence was defined as local recurrence or distant metastasis, or both, with histological or radiological confirmation and timed from the month when clinical symptoms began. The consultant surgeon confirmed the presence of recurrent disease. Either the surgeon or the breast cancer nurse explained the purpose of the study and obtained consent from the patient to take part. They were told that the researcher who would provide more details about the study would contact them. Although the

researcher was often present on the day that the news of recurrence had been given some patients were too distressed to be approached. They were contacted by telephone or visited on the ward within three weeks after the news had been conveyed. During the telephone call or visit the full research procedure was explained and permission obtained to visit them at home within three months to conduct an interview on the psychological impact of recurrent cancer and the use of alternative treatments. They were asked to fill in the first set of questionnaires that were handed over to them in the ward or sent by post in the case of those who were contacted by telephone.

Interviews were done three months after the news of having cancer had been broken and another set of questionnaires was handed over at the same occasion. Two more sets of questionnaires were sent six months later and again after an interval of one year.

The recurrence patients completed the questionnaires four times during the following time intervals.

First assessment   -   Within three weeks of being diagnosed with recurrence

Second assessment -   Three months later

Third assessment   -   Six months later

Fourth assessment   -   One year later

Members of the comparison group were recruited concurrently with the recruitment of the recurrence patients and they filled the questionnaires in twice.

First assessment   -   Within a week of giving consent to take part in the study

Second assessment -   One year later

6.3.2.3.2 Semi-structured Interviews

Thirty three of the forty recurrence patients were available for interviews three months after the first assessment. The reasons for failure to interview were either because the patient was too ill or had died before the interview could be arranged. One patient, who consented to take part in the study, subsequently refused to be interviewed.

The thirty three recurrence patients who were interviewed were also asked questions about the use of alternative treatments for breast cancer. The comparison patients were sent a questionnaire containing the same questions regarding their use of alternative treatments. A list of the treatments is presented in Chapter 5. This list was obtained from the British Association of Cancer United Patients (BACKUP), Clement-Jones (1985).

The questions relating to expectations and impact of recurrence, were the following:

What do you think caused your cancer to recur?

Did you expect that your cancer would recur?

Did you experience the recurrence as a great shock emotionally?

6.3.2.3.3 Questionnaires

(i) The Hospital Anxiety and Depression Scale (HAD)

The HAD was used to measure levels of anxiety and depression. It is a self-assessment scale that was developed by Zigmond and Snaith (1983) as a reliable instrument for detecting states of depression and anxiety in a hospital outpatient clinic. These researchers compared the validity and reliability of the scale against psychiatric ratings of patients by using Spearman correlations. The results were $r = 0.70$ for depression and

r = .74 for anxiety. Both those figures are significant (P< 0.001), which means that both measures are valid and reliable indications of anxiety and depression. The HAD was developed as a screening instrument in busy hospital settings to identify those patients with emotional disorders who are in need of emotional support (Aylard, Gooding, McKenna, Snaith, 1987).

Patients find the scale easy to complete and it only takes a few minutes. It provides two separate measures of anxiety and depression. For each construct a score below 8 is in the normal range, 8-10 is "borderline" and above 10 indicates a probable disorder of anxiety or depression.

Moorey and Greer (1989) used the HAD in their research projects that involved the development of a cognitive approach towards psychological therapy with cancer patients. They pointed out that the HAD has the advantage of not containing any somatic items which means it gives an indication of anxiety and depression independent of somatic symptoms such as tiredness which might be caused by, for example, chemotherapy received by cancer patients.

A comparison was made between the two groups in levels of anxiety and depression to determine the psychological impact of the news of recurrence within three weeks after the patients had been told. The groups were compared again a year later to determine if possible differences in anxiety and depression persisted after a year of "living" with recurrence. A score of 10 and higher was used to indicate "caseness".

Moorey, Greer, Watson, Gorman, Rowden, Tunmore, Robertson and Bliss (1991) as well as Hopwood, Howell and Maguire (1991) confirmed the factor stability of the Hospital Anxiety and Depression scale and showed again that it is a useful instrument in determining emotional disturbance in cancer patients.

(ii) The General Health Questionnaire (GHQ)

The GHQ was used as a measure of health status of the patients. It gives an indication of non-psychotic psychiatric disturbance and was described by Goldberg and Williams (1991). The scaled version of the GHQ-60, called the GHQ-28 was used in this study. It was developed on the basis of the results of a principal components analysis of the sixty-item version of the GHQ and is particularly useful for research purposes. It measures the following: Somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. It also gives a total score as an indication of general health.

Morris and Goldberg (1989); Goldberg and Hillier (1979) and Rand, Badger and Coggins (1988) confirmed the validity of the GHQ-28 as an effective screening instrument for psychiatric disorders. Griffiths, Meyers and Talbot (1993) validated the GHQ-28 against the Clinical Interview Schedule (CIS) and found an optimum sensitivity 0.81 and specificity of 0.82 when using a cut-off score of 3/4 (0011 scoring method).

The GHQ-28 was validated for use with patients with breast cancer by Hughson, Cooper and Mc Ardle (1995) who found the scale to be valid (r = .73) when compared with observer ratings. They suggested a threshold score of 10 for clinical morbidity. Threshold scores for the subscales were determined as: anxiety and insomnia 6/7; severe depression 2/3; somatic symptoms 6/7; and social dysfunction 7/8.

(iii) The Multidimensional Health Locus of Control Scale (MHLC)

As measurement of locus of control, the Multidimensional Health Locus of Control Scale (MHLC) developed by Wallston BS, Wallston KA, Kaplan and Maides (1976) was used. The scale reflected three dimensions of health locus of control beliefs as explained by Wallston KA, Wallston BS and Vellis (1978) as: Internality (IHLC); powerful others

(PHLC) and chance (CHLC) externality. The scale determines whether individuals perceive that they have control over their health (internal); whether others have control over their illness (powerful others) or whether the occurrence and course of their illness is determined by chance (chance).

Levenson (1974) also questioned the conceptualisation of locus of control as a unidimensional construct and argued that the understanding and prediction of locus of control could be further improved by studying fate and chance expectations separately from external control by powerful others. She attempted to develop a conceptually cleaner instrument than Wallston's I-E scale.

Since its construction, the Multidimensional Health Locus of Control Scale (MHLC) had been widely used and Wallston KA, Wallston BS, Vellis, (1978) commented that the MHLC Scale predominate in the literature as the preferred means of assessing control in health-related settings.

(iv) The Golombok Rust Inventory of Marital State (GRIMS)

The Golombok Rust Inventory of Marital State (GRIMS) developed by Rust, Bennun, Crowe and Golombok (1988) is a questionnaire which measures the overall quality of the relationship between a married man and women or a couple who are living together. It can be used to assess the impact of psychological or medical factors on a relationship. The authors tested the validity and reliability of the instrument against observer ratings and found the scale to be both valid, with a correlation coefficient of .77, and reliable, with a split-half reliability of 0.91 for men and 0.87 for women.

6.4   Qualitative approach

A useful approach to psychotherapy and more specifically psychotherapeutic research,
is descriptive interactional analysis, slightly adapted as described by Swart and Wiehahn
(1979, p. 51). This approach was used for the analysis of the therapeutic interviews.
They proposed the following five steps in order to arrive at a good understanding of the
client's interactional style. When the interactional analyses were interpreted for patients
with cancer, these five factors were taken into account:

1. *How does the patient talk to the therapist?*

The therapist determines whether a client's speech is coherent, logical or whether there
is the possibility of a thought disorder. Does the individual express herself clearly? What
emotions, such as aggressiveness, ambivalence, anxiety, depression, or sympathy are
expressed?   Notice should also be taken of non-verbal cues that may confirm or
contradict the verbal communication.

In Swart and Wiehahn (1979) the emphasis is on psychotherapy. In this study the
analysis is used as a method of research. Thus, the way in which the patient talks to the
researcher is described. It must also be noted, because of the nature of the open-ended
research interview as required for the qualitative approach, the interview takes on many
characteristics of what is usually described as therapy. For this reason, ethical
considerations   came into play and all patients gave their consent for the publication of
the content of the interviews.

2. *How does the patient talk about her problem?*

Is there blaming, anger, denial, intellectualization or vagueness on behalf of the person?
In this study,   the "problem" is more the description of the patient's experience of

having breast cancer and formulated as: "How did she speak about her experience of having breast cancer" ? It may, however, also include general problems or any other problems related to the issue of cancer, e.g. the way her family reacts towards her cancer.

3. What is the nature of the relationships of the patient ?

Aspects to note here, would be, for example, whether the patient is cold, neutral, warm, distanced or controlled. At this stage of the descriptive analysis, it is also important to listen to the manner in which the person talked about her other relationships? How do the relationships help maintain the behaviour in the here-and-now situation? The analysis of the way the client interacts in the relationship with the therapist leads to further understanding of a patient's interactional patterns. Labuschagne (1997) described this interaction as the most important source of information of a client's interactional patterns, because that is the reality of the here-and-now that the therapist has in front of her.

For the purposes of the research, I took note of the way the patient spoke about her important (or not so) others, e.g. her relationship with her husband, children, extended family or friends.

Secondly, the relationship between myself and the patient, during the interview, was analysed, that is, how did she relate towards me, what effect did she have on me and vice versa; how did she come across as a person?

4. What does the patient achieve with her behaviour and symptom?

This aspect of the analysis created some form of ambivalence and difficulty for me. When I was confronted with a person with terminal illness, an emotional reaction on my

part had to be overcome. The emotional reaction was related to my rejection of the possibility that a person in a state of fighting cancer, or even dying, could possibly be in the position of "achieving" something with her behaviour or symptoms. Although I accept that all behaviour, as defined by interactional theory have effects and reciprocal effects (for that reason also my own aversion to the analyses of this part of patient behaviour), I had difficulty in formulating these as "achievements", or manipulations. The concept of manipulation is defined here in a therapeutic sense: the withdrawn, shocked person, or the one who radiates a message of: "don't come closer, leave me alone" sends messages which can be defined as manipulations and/or achievements.

Symptoms usually have a function and often have an effect on other people. If the effect that it has on other people benefits the client the symptom will probably continue. For example, sick role behaviour may often have the effect of eliciting sympathy from others, or it may have be used to get attention from others or may lead to becoming too depended . If the significant others change their behaviour by for example not being overly sympathetic or not giving too much attention, the individual will probably become more assertive and less dependent on others.

When listening to the magnetic tape recordings of the interviews in order to overcome my own possible rejection of the ideas stated above, the promoter assisted me in defining this part of the interactional analysis. He stated: *"You have to recognize, because of your own vulnerability as therapist and researcher you are vulnerable within the relationship with a patient with a terminal illness. You have to recognize your own humane feelings, in order to become part of an exceptionally sensitive context. This means that conducting research in this manner, your ethics should include openness towards your own mind. You have to be aware of your way of interacting with the patient, your manner of communication, your attitudes as well as an openness to*

convey what you have done, to report it in your research as clearly as possible. In this way, your research becomes a responsible event". (Personal communication, Professor Beyers, 2000, Head of Psychology Department, University of Pretoria).

Finally, the emphasis is on the researcher's, that is, my attitude. As Swart and Wiehahn (1979, p. 29) put it: *"In this evaluation, the therapist will place himself in a direct open relationship towards the patient, without bias or prejudice. Only by moving out of his own frame of reference will the therapist be open and free to evaluate the patient".*

5. In what context is the therapist in the relationship with the patient?

It is essential to describe the context as it may influence or determine how a person behaves. The context of home versus hospital may influence how a person talks and functions. Thus, context is an important influential factor in the final consideration of the interactional analysis.

The context applicable to this study was that of a patient diagnosed with breast cancer interacting with a psychologist within a hospital environment. The role of the psychologist was to create a safe relationship wherein the patient was free to explore the result of her diagnosis on her interaction with herself and others. The research was adapted to the context of the individual, where her specific needs were respected. Although there may be similarities and even "stages" some cancer patients go through, the researcher was guided by the context that the patient creates within the relationship and not by a preconceived idea of how the interview should progress.

This initial interview was thus interpreted using the interactional model as underlying theory. The interview itself was not used as an attempt to apply any interventions but it

showed   possible aims for ensuing therapy with those patients. Although the therapy was outside the scope of this study, it was a natural progression from these interviews. This illustrates how research and therapy practice may become part of a process and not two total separate entities. This underscores the systemic or circular approach that is the basic paradigm towards this study.

6.5   Conclusion

In this chapter, an attempt is made to combine qualitative and quantitative measures to obtain a broad perspective on the way patients and their partners react emotionally to the news that the cancer had started again. The research results will be presented in the next chapter.