

A QUALITATIVE STUDY OF THE EXPERIENCE OF SELF-HYPNOSIS OR JOHREI IN METASTATIC BREAST CANCER USING INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Bryan M. Bennett, Tannis M. Laidlaw, Prabudha Dwivedi, Akira Naito, John H. Gruzelier

Imperial College and Goldsmiths College, London

Abstract

In this paper we explore the meaning and experience of living with breast cancer that had returned after conventional treatment. We focus on the process of learning and applying a specific psychological intervention to aid with the coping process. Of sixteen women who were randomized to self-hypnosis training, Johrei training or a control wait-list group, eight agreed to be interviewed. Interviews were recorded, transcribed and then analysed using interpretative phenomenological analysis. The major themes that conceptualized living with the return of breast cancer were self-identity, self-blame, social isolation and feelings of being constrained. The themes relating to psychological intervention were gaining a sense of control and empowerment, normalizing and re-attribution, and a powerful military metaphor for dealing with the actual cancer. Copyright © 2006 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key words: breast cancer, interpretative phenomenological analysis, Johrei, self-hypnosis

Introduction

Being diagnosed with breast cancer is a traumatic event for any woman. Degner, Hack, O'Neil and Kristjanson (2003:170) describe it as a 'pivotal life event'. Indeed, it is a time when a woman is faced with many philosophical and metaphysical questions, as well as with difficult choices. During this search for meaning and answers to questions, the fear that the disease may return or spread may also lead to additional anxiety and distress. For some it does return.

Researchers and clinicians have manipulated various psychosocial variables with some degree of success, improving areas such as quality of life, coping, psychological and spiritual well-being and physical functioning in patients with cancer, specifically breast cancer (van Weert, Hoekstra-Weebers, Grol, Otter, Arendzen, Postema and van der Schans, 2004; Baider, Andritsch, Uziely, Goldzweig, Ever-Hadani, Hofman, Krenn and Samonigg, 2003; Marchioro, Azzarello, Checchin, Perale, Segati, Sampognora, Rosetti, Franchin, Pappagallo and Vinante, 1996; Lin and Bauer-Wu, 2003).

Here we examine with qualitative methods the relatively under researched issue of women's response to the return of breast cancer and subsequent treatment. This accompanies a quantitative study (Laidlaw, Bennett, Dwivedi, Naito and Gruzelier, 2005). The literature is fairly comprehensive regarding how women diagnosed with breast cancer cope with the initial diagnosis and the disease. Using qualitative methodologies research-

ers have elicited the meanings that women subscribe to in coping with their disease (Jensen, Back-Petterson and Segesten, 2000; Landmark, Standmark and Wahl, 2001; Richer and Ezer, 2002). Studies point to the fact that women find meaning in their disease through at least eight categories. The categories include: challenge, enemy, punishment, weakness, relief, strategy, irreparable loss and value. They are based on the work of Lipowski (1970) and coping strategies. Lipowski identified eight areas that have been the focus of much of the research in the area of coping with cancer (Barkwell, 1991; Fife, 1994; Degner, 2003). Lipowski (1970) further states that three factors are considered when a meaning is applied to illness and disease. These are intrapersonal, disease-related and environmental factors, and in combination determine the subjective meaning and the coping strategies the individual employs. Lipowski postulated that the way in which we experience and give meaning to our illness or disease influences recovery. This gives rise to the opportunity that by changing the way we give meaning to illness, we may be able to influence recovery.

However, the meanings, experiences and the reality of living with the return of breast cancer lack the same depth of knowledge. Moreover, the experience of applying a psychological intervention in metastatic breast cancer from a qualitative dimension requires further attention.

In this paper we explore the phenomenological aspect of learning and applying a psychological intervention and the perceived difference made in coping with the return of the disease. Two psychological interventions were used in this study, namely self-hypnosis and Johrei which is a Japanese non-touch healing method aimed at spiritual purification of body and mind. Initial scientific laboratory trials in students facing the stress of examinations have shown that both interventions provided benefits psychologically (Laidlaw, Naito, Dwivedi, Enzor, Brincat and Gruzelier, 2003) and immunologically (Naito, Laidlaw, Henderson, Farahani, Dwivedi and Gruzelier, 2003), with a particularly strong immunological result. In fact to our knowledge, the increase in the number of natural killer cells, which characterized the Johrei group during exam stress, has not been reported before; the typical achievement through psychological intervention has been maintenance of pre-stress levels reflecting the buffering of the stress induced reduction in the number of natural killer cells.

Self-hypnosis has been well researched, disclosing benefits for mood and putative benefits for immune function (Kiecolt-Glaser, Glaser, Strain, Stout, Tarr, Holliday and Speicher, 1986; Gruzelier et al., 2001a; Gruzelier, Smith, Nagy and Henderson, 2001b; see Gruzelier, 2002a, 2002b for review).

In this study, the self-hypnosis intervention focused upon two aspects of psychoneuroimmunological research; the use of creative visualization of immune-enhancing imagery (Kiecolt-Glaser, Glaser, Strain, Stout, Tarr, Holliday and Speicher, 1986; Gruzelier, Clow, Evans, Lazar and Walker, 1998; Naito et al., 2003), and stress control (Kiecolt-Glaser, Glaser, Shuttleworth, Dyer, Ogrocki and Speicher, 1987; Laidlaw, 1994; Laidlaw, 1999; Laidlaw and Willett, 2002; Laidlaw et al., 2003). The importance of visualization has been demonstrated, by showing that the effects on immunology and health were superior in students whose hypnosis included visualization compared with those in whom the visualization component had been replaced by further deep relaxation imagery (Gruzelier et al., 2001a).

Johrei, the second intervention, is a Japanese non-touch, **laying-on-of-hands method**. It can be classified as a type of subtle energy medicine under the **complementary medicine rubric** (Clarke, 2000). **During a Johrei session, the participant visualizes a universal healing light coming from an imaginary source and transmitting, or channel-**

ling, this to the recipient through the palm of a gently outstretched hand. Johrei is based on the concept that 'one can heal oneself by healing others', for the participant acts as both 'channeller' and receiver. Johrei has its own philosophical background, with the name of Johrei literally meaning 'purification of the spirit'. Through uplifting the participant's spiritual awareness a Johrei session aims to give unique skills for coping with illness psychologically as well as providing a relaxing experience. The experience of Johrei is one of a self-contained time to be quiet, mindful and kindly, concentrating on the recipients' benefit as well as one's own.

Methodology

Participants and recruitment

Patients from this study participated in a larger quantitative study (see Laidlaw et al., 2005). All the women had been diagnosed with metastatic breast cancer, and had been attending regular outpatient clinics at Charing Cross Hospital, London. All were given written information about the study and asked to sign a consent form before the study began. About 100 women were initially approached with 37 agreeing to participate in the original quantitative study. At the time of asking people to participate in the qualitative study involving semi-structured interviews, 8 people agreed to be interviewed: 4 from self-hypnosis, 2 from Johrei and 2 from the control group (both of whom subsequently trained in self-hypnosis). No one refused for other than health reasons. The response rate was low due to the severity of the disease. This study was approved by the local Research Ethics Committee of Chelsea and Westminster NHS Trust.

Training in psychological intervention

All participants were randomly assigned to one of three conditions: self-hypnosis, Johrei or wait-list control. After three months controls were randomized to one of the intervention techniques.

In the self-hypnosis training group, 4 weekly training group sessions were held initially over a month, with CDs or tapes provided for home practice. Each session was devoted to learning a new skill, and culminated in a hypnosis script that was to be reinforced by home practice over the coming week. Any missed sessions were made up individually. After this initial training period, group meetings were held once a month. These meetings were partially support group in format, but always included a new hypnosis experience; some of these scripts were included in new CDs. Participants were encouraged to practise the self-hypnosis on a daily basis and they were able to choose which hypnosis they wanted to work on.

The training of Johrei also consisted of four training sessions, examining the core principles needed to practise Johrei techniques such as 'healing oneself by healing others'. An introduction to Johrei philosophy emphasized the importance of awareness of spiritual well-being, harmony and balance, aesthetics and appreciation of the natural environment, especially natural farming practices. In essence, the practitioner, also known as the 'Channeller', imagines light entering through their body and being concentrated through an outstretched hand towards the recipient. The practitioner, without touching the recipient, slowly moves their hand from the head down to the kidney area, front and back. The procedure takes approximately 15 minutes. The participants were requested to practise Johrei daily with a partner, however, at the end of training self-Johrei was introduced as a supplement so that participants could still practise even if a partner was not available.

In both interventions, adherence to daily practice was high, with all participants indicating that they did practise on a daily basis during the initial four week training period. It was noted though, that after this training period adherence fell significantly. Participants explained that they would practise the intervention whenever they felt the need.

Interviews

Each of the interviews took place at either Charing Cross Hospital or the participant's home, whichever was the more convenient. Researcher (TL), the only female investigator, conducted all of the interviews primarily because of gender and sensitivity to the nature of the disease under investigation. The interviews all took place after a three-month training period of either Johrei or self-hypnosis. All the interviews were tape-recorded with the participants' consent, and afterwards transcribed. The interviews were semi-structured and allowed them to talk freely about any aspect of cancer and the psychological intervention that they were trained in. Each interview lasted between forty and ninety minutes.

The intention was to talk about, and explore as much as possible, the individual and personal meaning of the cancer returning, and their perception of the process of the psychological intervention on the cancer and the individual. At the end of the interview each participant was asked whether there was anything that they would like to talk about that they thought relevant to the study that the interviewer had not already asked. This ensured that we recorded very personal and meaningful data relevant to each participant.

While the interview schedule was flexible the following key areas were explored:

1. How do participants experience being a 'returned cancer' patient; and what kind of impact has this had on various aspects of normal living?
2. How have participants experienced their intervention and has this changed over time?
3. How does practising the intervention relate to their health?

Because of the nature of questioning, researcher TL debriefed all the participants to ensure that no issues were remaining after the interview process.

Data analysis

The way in which the transcripts were analysed was adopted from Smith, Jarman and Osborn (1999). This method, interpretative phenomenological analysis (IPA), aims to capture the meaning to the participant of the phenomena under investigation. It is a method of analysis that is increasingly being used in health psychology and allows the researcher to gain unique insights into the world of the participant. It allows data to be extracted that might otherwise be difficult to obtain, or missed using standardized quantitative research questionnaires. Although other qualitative methodologies could have been employed in this study, IPA was thought to be an excellent methodology compatible with the therapeutic paradigm employed. Furthermore, given the nature of the disease and therapeutic relationship with each participant, using IPA allowed the individual to express and develop meaning to their view of the world in which they live and dealing with their disease.

Each transcript was read several times to be familiar with the content. Recurrent themes were coded within and between transcripts. A list of themes was produced by one of the researchers (BB). This list was then given to the other researchers to produce a table

of 'master themes'. These master themes were constantly checked back with the original transcripts to ensure that they were still explanatory of the original interview data.

Reliability and validity

Internal coherence and presentation of evidence are two important criteria to assess the reliability and validity of qualitative research (Smith, 1996). Therefore in order to satisfy these conditions each theme presented within the paper will be supported by original discourse from participants.

Results

The meaning and experience of returning breast cancer

The experience of living with cancer that had returned had a significant impact on many aspects of the women interviewed. Of particular interest were four emerging themes, which relate to the conceptualization of what it means to have breast cancer again. The themes that emerged related to:

- internal negative reactions (self-identity, constrained emotionally and socially);
- internal behaviour (self-blame, attribution of physical symptoms, empowerment, control, normalizing, constrained physically);
- external behaviour (social isolation, normalizing);
- social perceptions (social isolation).

All of the themes could be placed within one or two of these four concepts depending on the context of the discourse. All themes emerged as a general pattern throughout the interviews. Interestingly, some of these themes do emerge for women receiving a first diagnosis of breast cancer; however, there were some subtle differences in some of the categories. In the transcript extracts which follow, the names used are pseudonyms. Unless stated otherwise each of the comments refers to the return of breast cancer and not the initial onset of the disease.

'Self-identity'

The women had changed with the diagnosis that the cancer had returned or spread. They were aware from that moment of diagnosis that they were different from other women. It was noteworthy that the perception of 'self' changed before there were any surgical or medical procedures that may change the physical 'self', and that this change was apparent at the first diagnosis of breast cancer.

When participant Lynne was diagnosed with breast cancer she said:

I was kind of in a daze and my mother was going through ovarian cancer at the time, so that was occupying a large portion of my mind . . . and I remember though . . . standing on the tube station [underground station] and looking around at other people and thinking . . . um, I'm different from you . . . (Lynne)

Furthermore, when thinking about the surgical interventions available when a diagnosis of breast cancer returning is made, the issue of perceived gender for that person arises.

I thought they would say, 'well we would [perform surgical procedures] for some people', they'd say 'well look you're not really a girl, you're a half-thing'. (Pat)

Accordingly, important for this participant, following the diagnosis that the cancer had returned, was not only the question of her gender, but also her perception of how others would see her, particularly the medical profession. These two excerpts demonstrate the internal forces of negative self-interpretation of body image and negative values of worth. On a more positive note, some of the participants recognized that the given diagnosis, and perceiving themselves as 'different' from others and their 'old self', could be used to their advantage.

My friends are very nice and they make exceptions for you. You know if you say you don't want to do something, they say 'oh well just let it go, she must be tired, doesn't feel very well'. So I get out of things I don't want to do, whereas it would be difficult normally . . . it makes you a little celebrity because you're ill. (Catherine)

'Self-blame'

On diagnosis of breast cancer returning nearly all of the women felt somehow responsible for their own misfortune. Interestingly none blamed any other issues such as genetics or environmental factors. They found meaning in that they had somehow brought the cancer on, either by thought or as punishment for something they had done in the past.

I tried to look after myself a bit better but I still felt I was indestructible, and that I could work 20 hours a day and be fine, and go out lots, and I didn't really take on board . . . so I blame myself a little because I really didn't look after myself that much. (Amanda)

Amanda demonstrates a willingness to accept the cause of her breast cancer returning as being her responsibility because of her busy lifestyle and, on reflection, that she did not take care of herself as much as she should have when initially diagnosed with breast cancer. Another participant also expressed this theme of self-blame when talking about the breast cancer returning and spreading:

. . . the first time around, it's total, it's nothing to do with me, something that has happened. This time it's much more to do with me, what I'm doing and what I should be doing. (Catherine)

Catherine is willing to accept that the first time she developed breast cancer was due to something out of her control, however, when it returned it was very much something to do with her own behaviour.

I didn't want to tell anyone, I intended not telling anyone. I also said it was my fault, and I really did, because when I was small I bashed into this little girl I didn't like, and I really bashed her bosom. (Pat)

Here Pat attributes the cause of her breast cancer returning to this incident. The participants frantically search their past experiences, even from early childhood, to try and find some justification for the breast cancer returning. Pat also raises another important theme that emerged throughout the interviews, that of 'social isolation'.

'Social isolation'

Throughout many of the interviews 'social isolation' was discussed by each of the participants. Interestingly this was sometimes a conscientious decision made by the participant. On occasions where the social isolation was used as an avoidant behavioural coping

strategy, it was often done in order to protect from identifying with any form of cancer. The social isolation may also have been a form of not only protecting the 'self', but also protecting family members and friends. These women, who had previously had a diagnosis of breast cancer, would have experienced various forms of social isolation in the first episode of the disease. However when the cancer returned the social isolation experienced here may actually be a form of control. The social isolation that emerged reflected both physical and emotional isolation.

. . . um, I suppose talking a lot to friends . . . um, but also covering up, quite a lot, particularly with my parents and so on . . . I realized that the only way to cope was to carry on as normal, as far as possible. (Anne)

In this example Anne realized that the only way she felt able to cope was not to tell some people about her diagnosis. She perhaps felt that she had an obligation to protect her parents. This led to an enforced emotional isolation where social support from her parents was the sacrifice for their protection. However, sometimes even when there was some form of disclosure, social isolation still occurred, with the result being the same as non-disclosure and a lack of social support.

I am more willing to talk about it . . . I wasn't when it first happened. I couldn't cope with all the questions of concern and all the denial . . . and so I did, I told many more friends, and again I lost some of them. (Elizabeth)

Elizabeth's experience helps us to understand some of the internal conflict that a person has to deal with when considering whether they should disclose their diagnosis of the breast cancer returning. When considering whether or not to disclose a diagnosis, it is clear that the individual does think about the consequences of social isolation.

I thought no one would speak to me . . . that they would catch it or I was some kind of leper, and I couldn't get over it. (Pat)

One person . . . who I didn't really see for ten years . . . got in touch in November last year . . . but when I was rushed to hospital in May he was called, and since then . . . when I want to talk to him it's like a sixth sense and he avoids me completely. (Amanda)

Pat identifies how social isolation affected her. It is very interesting that she compares herself to a leper. Unfortunately this comparison was not developed further in the interview.

'Constrained'

A theme that was identified in all of the interviews was the experience of feeling constrained. This theme was expressed not only in terms of physical but also emotional constraint. Moreover these experiences were projected through time. Participants expressed feeling constrained in the present, and perceived the future to be the same.

I try to live in the present . . . but when I was diagnosed I had so little hope – do you know I wouldn't even buy a pair of socks. I thought I'm not going to wear them out, I'll do with the one's I have. (Mary)

I mean at one point I really wanted to move house and each time I started feeling better I kept on hitting this bloody brick wall – no you can't, you can't, and I think I haven't quite figured out how to deal with that one yet. (Elizabeth)

I can't leave, I'm tied to Charing Cross. You know . . . you can't say I'm going – I'm going to live in Suffolk. You think what hospital am I going to be with there? So you're chained to your bloody disease in a way. (Catherine)

The feeling of being constrained and restricted because of the cancer returning was clearly expressed where the dimensions of time and place in their world were almost non-existent. Regarding the meaning and experience of breast cancer returning to these participants, these can be classified into internal and external directed attitudes and behaviour. Internally directed themes concentrated first on self-identity, which encompassed concerns about altered perceptions of self, and perceived as both different and compromised, particularly regarding gender and femininity. This second diagnosis was not always seen as a disadvantage, similarly to the first diagnosis, but also having the potential gains of the conventional illness role. More pervasive was the negative attribution of blame for the condition, where in some way they felt responsible for their own affliction. Social isolation and withdrawal were also expressed, often as a form of coping and protection. However, withdrawal also had negative consequences through emotional isolation and anxiety about losing friends and social support, through disclosure of the second cancer diagnosis.

The meaning and experience of the psychological intervention

Regarding the initial reaction, on the whole, all were pleased irrespective of the intervention they received. There was also a clear message of approval that neither involved any pharmacological products:

I wanted to do it, especially because it didn't involve any chemicals . . . I tried to come with an open mind as possible. I am excited about learning new things. (Elizabeth, self-hypnosis)

Well, I was very pleased, I was very pleased that Charing Cross was doing a study, it wasn't just chemotherapy, I just thought how wonderful that at least it has come into a hospital environment, it's being taken seriously. (Catherine, Johrei)

These two particular interventions do not have serious side-effects. Following the first diagnosis all of the women had undergone chemotherapy, surgery, or other pharmacological treatments with some unpleasant side-effects. They faced these a second time when the cancer had returned. It is understandable that their initial reactions to these interventions, with no negative side-effects, were very positive.

Regarding how they made sense of the intervention and their breast cancer following training, all spoke about how the intervention helped them, relating this to real life events about living with breast cancer.

Sense of control and empowerment

A sense of control and empowerment were the two biggest themes that emerged from the interviews. Participants mentioned these at least twice throughout their interview.

It has given me time to stop and think of it, not just at a biological level, you know, doctors doing this chemotherapy . . . approaching cancer in a different way. I'm more in control, telling my body what it's got to do. (Catherine, Johrei)

I did find it beneficial which surprised me . . . it was just kind of relaxation and meditation but I felt good about it anyway . . . it seems to get into my inner self . . . me as an individual. I think because I believe it connects you to yourself, it is very personal and does solve

problems, and it gives you, I suppose, that little space where you can go. (Mary, self-hypnosis)

. . . the first thing I noticed after any session, whether it be with you, and it was better once we had tapes and things, was that after a session I felt revitalized. Although I might have felt terribly tired beforehand, I felt quite strong and able to go home and do all sorts of things . . . I just got on with my life. (Alice, self-hypnosis)

The participants expressed the belief that the intervention they practised helped them, not only to function better but to take control. This seems to be very important to these women who having had breast cancer before were now being diagnosed with it again. Instead of handing control to another person they felt as though they were active agents in their own 'treatment'. Furthermore, they were able to conceptualize that their life was not ended because of this second diagnosis.

Normalizing and attribution

Throughout the interviews another emerging theme was that of 'normalizing' and re-attributing physical sensations. 'Normalizing' has been identified as an important theme in ovarian cancer. Ekman and colleagues (2004) conducted a qualitative study and identified that women with ovarian cancer rated normality as one of the central themes described in their discourse.

After completing a course of self-hypnosis or Johrei many of the participants found that they were able to change the way in which they attributed the cause of some physical sensations. They reported through the interviews that they were better able to deal with pain, anxiety and interrupted sleep by rephrasing the cause, thus gaining a better understanding of the processes underlying their illness.

Well my coping skills at the moment are basically treating myself as normal . . . I want to surround myself with 'normality'. (Lynne, self-hypnosis)

I mean at first I put every little ache or twinge or pain at the cancer door, and then you have to stand back and say, hang on, that's got nothing to do with it – that's a toothache! . . . now I sleep for four hours and that's quite good. Apart from the fact that I know that the hot flushes are down to the Tamoxifen, I would say that probably as you get older you don't sleep, you don't go to bed and sleep right through. (Alice, self-hypnosis)

I try not to dwell on cancer, I try not to think about it too much. In the beginning I tend to think if you sneeze, well it's cancer, if you twist your ankle, oh it's cancer . . . and that goes on for a while, and then you realize that the cancer is in one part of your body and the rest of your body is carrying on doing the things it normally does, and so I don't dwell on cancer. (Mary, self-hypnosis)

I wonder if there might have been a connection, I was doing so well in the first term, the autumn term, and then I stopped doing the Johrei regularly and my health deteriorated, and I thought that was quite interesting. (Amanda, Johrei)

These examples show that the individuals concerned are not in denial or simply 'forgetting' about the fact that they have breast cancer and that it had returned, but that they appraised the phenomena and made attributions based on evidence, and not solely on emotion, or catastrophizing. They illustrate the theme of being 'normal'. They also reflect the emotions that breast cancer patients may feel with respect to being treated as normal, and the fact that they wanted to continue doing 'normal' everyday activities.

'Something in the tool bag!'

The actual meaning ascribed to the experience of psychological interventions shows the integration of the experience and the meaning of the intervention for the metastatic cancer.

... the fact that I had the secret weapon that I could use. I could do something. (Pat, Johrei)

I don't know whether I can quantify whether it has done me any good medically, mentally it's something else on my shelf that I can make use of, and I know that it has not done me any harm. (Alice, self-hypnosis)

It's a tool that I've got in my bag that's always there ... and I can dip back into it, and hopefully that's what I'd really like to do. (Lynne, self-hypnosis)

These examples illustrate the meaning that each of the participants has given to the intervention with a use of terms suggesting that they perceive the intervention to be somewhat powerful, something that can fix things, and something that can be used to destroy bad things. There were no apparent differences between each intervention group's discourse and meaning.

Regarding the meaning and experience of the intervention, these can be classified similarly as the experience of dealing with the breast cancer returning. From a behavioural context these women were enthusiastic to learn and practise. This in turn influenced adherence, reflecting the fact that most practised on a daily basis during the study period, and many stated that they continued to practise long after the training and follow-up period. Internally directed attitudes of having a sense of control and empowerment meant that participants were able to perceive taking control of their lives again. This was further enhanced by the ability to reattribute physical sensations enabling a better, and more normal, quality of life. Importantly, none of the participants reported any negative effects of either self-hypnosis or Johrei.

Discussion

This study adds insight and information to those already published in the area of breast cancer and psychological interventions for breast cancer. Here the participants were patients with breast cancer that had returned or spread after a course of conventional therapy. Results support much of the previous research findings for first time diagnosed breast cancer patients, and extend understanding to the impact of the return of breast cancer. However, because of the small sample size results should be viewed with some caution.

The two main areas explored were the themes associated with a diagnosis of breast cancer returning, and with what it means to use the psychological intervention. The themes that emerged about diagnosis were:

- self-identity;
- blaming oneself for the cancer;
- feeling that others were isolating them or that they felt isolated from others; and
- feeling physically and emotionally constrained and also constrained in time.

The themes that emerged in relation to the psychological intervention were:

- gaining a sense of control or feeling empowered;
- normalizing the condition and re-attributing physical symptoms not related to the diagnosis; and
- having the use of a new tool or weapon.

Although some smaller themes did emerge (e.g. coping with death, anxiety and being reflective), they were not universal, were raised by one individual, and were not regarded

as a major emerging theme. All found a positive meaning in the psychological intervention and reported that they coped better as a result of practising it.

Reflecting back on Lipowski's eight categories only three were described in our study: punishment, weakness and strategy. Both punishment and weakness were reflected in the internal negative reactions and internal negative behaviour. The theme of strategy was reflected in what we have defined as external behaviour, where the second diagnosis of breast cancer was used to the advantage of the participant for their gain.

More recently, Luker, Leinster, Owens and Beaver (1996) described some of the meanings of illness for women with breast cancer. They suggested that the most popular choice of meaning was challenge, meaning that these individuals viewed the illness as a challenge using adaptive coping strategies, similar to goal-orientated behaviour. They further suggested that this particular approach promotes positive feelings about disease and illness. However, perceiving illness as a challenge can also be maladaptive. When a woman is diagnosed with breast cancer for the first time, adopting this meaning may be useful. It may well help them to keep a positive attitude and to maintain a quality of life similar to that before the diagnosis. What happens though when they were told that the cancer has spread, or that it has returned? When this occurs there may be a sense of self-responsibility (Lupton, 1994) and there is a natural tendency to blame oneself. This was a pattern that emerged in our participants. It is no surprise then that the category of challenge did not emerge as a theme throughout our study. Albeit in a small sample, we have demonstrated that here is a perceived difference between those women receiving a first diagnosis of breast cancer and those receiving a diagnosis that the cancer has returned or spread.

Furthermore, Lupton (1994) describes the dominant discourse surrounding cancer as hope. However, in the experiences of our participants, although there is an element of hope the main discourse is more active and more aggressive than a description of hope. This difference in the dominant discourse may be due to the fact that our participants were patients with metastatic breast cancer and not patients receiving their first diagnosis of breast cancer. This makes sense if we consider 'hope' as a fairly passive attribute. After receiving the first diagnosis and 'hope' not keeping the cancer away, a more aggressive and active attribute might be adopted when the cancer is diagnosed as having returned.

To our knowledge this is the first research to look at the meanings given to experiencing self-hypnosis or Johrei intervention for metastatic breast cancer. Although other studies have examined the experience of living with cancer, this study adds further insight into the dynamic process of learning and applying these two interventions, particularly in women who have metastatic breast cancer. The experience of learning and using either self-hypnosis or Johrei appeared to be a positive one for these participants. Irrespective of the type of intervention we investigated, the self-hypnosis or Johrei participants gave positive meanings to the process. Similar constructs are found where the onset of breast cancer has been studied; however, perhaps the crucial difference between these and women with returning breast cancer is the way in which they cope. This would have consequences for the type of care offered to these individuals.

Although the two interventions are similar, they do have stark differences in procedural mechanics. For example, in self-hypnosis participants are engaged in focussed attention and are asked to use visualization techniques. In the practice of Johrei, the participant acts as both channeller and receiver, engaging in both active and passive roles, and in both these roles, engaging in less active visualization than self-hypnosis. Furthermore, it has been observed that EEG power following these two interventions shows

opposite changes in anterior brain asymmetry, with increased left hemisphere power following a course of self-hypnosis (and relaxation) and increased right hemisphere power following training in Johrei (Gruzelier et al., in preparation). This is in keeping with more inward focussed attention with hypnosis and more outward directed diffuse attention and mindfulness with Johrei. Notwithstanding these differences, participants from both self-hypnosis and Johrei described their experience as powerful, almost to the point of using a military metaphor.

The study does have some limitations that should be carefully considered when concluding. The sample size was very small. Women with metastasis are often very ill, especially when undergoing active treatment such as radiotherapy or chemotherapy. Therefore participating in an interview that covers some personal and emotional areas of one's life may have been too much for some. Obviously, this then leads to a highly selected sample. Overall, the interview covers a vast area and this is reflected in the analysis. Future research should focus on specific areas, especially changes in coping strategies, rather than covering so much in one interview.

In summary, and acknowledging the limitations of the study, we reported the meanings ascribed to living with a second diagnosis of breast cancer with regard to internally and externally directed positive and negative attitudes and behaviour for participants in this study. Furthermore, and importantly, the meanings of learning and applying a non-pharmaceutical intervention were reported as internally directed positive attitudes which may have enhanced coping and the general quality of life of these women. Future studies in this area should look specifically at the differences between first time diagnosed cancer patients and those where the cancer has returned. Identifying areas where there are differences between coping strategies employed in these two groups may lead to better health care provision, and improvements in understanding the needs of individuals with a return diagnosis of breast cancer.

References

- Baider L, Andritsch E, Uziely B, Goldzweig G, Ever-Hadani P, Hofman G, Krenn G, Samonigg H (2003) Effects of age on coping and psychological distress in women diagnosed with breast cancer: review of literature and analysis of two different geographical settings. *Critical Reviews in Oncology/Haematology* 46: 5–16.
- Barkwell DP (1991) Ascribed meaning: a critical factor in coping and pain attenuation in patients with cancer-related pain. *Journal of Palliative Care* 7, 5.
- Clarke P (2000) *New Japanese Religions*. Richmond Surrey: Curzon Press.
- Degner LF, Hack T, O'Neil J, Kristjanson LJ (2003) A new approach to eliciting meaning in the context of breast cancer. *Cancer Nursing* 26(3): 169–78.
- Ekman I, Bergbom I, Ekman T, Berthold H, Mahsneh SM (2004) Maintaining normality and support are central issues when receiving chemotherapy for ovarian cancer. *Cancer Nursing* 27(3): 117–82.
- Fife BL (1994) The conceptualisation of meaning in illness. *Social Science & Medicine* 38: 309–16.
- Fox PA, Henderson DC, Barton SE, Champion AJ, Rollin MSH, Catalan J, McCormack SMG, Gruzelier J (1999) Immunological markers of frequently recurrent genital herpes simplex virus and their response to hypnotherapy: a pilot study. *International Journal of STD & AIDS* 10(11): 730–4.
- Gruzelier JH (2002a) The role of psychological intervention in modulating aspects of immune function in relation to health and well being. *International Review of Neurobiology* 52: 383–417.

- Gruzelier JH (2002b) A review of the impact of hypnosis, relaxation, guided imagery and individual differences on aspects of immunity and health. *Stress* 5: 147–63.
- Gruzelier JH, Champion A, Fox P, Rollin M, McCormack S, Catalan P, Barton S, Henderson D (2002) Individual differences in personality, immunology and mood in patients undergoing self-hypnosis training for the successful treatment of a chronic viral illness, HSV-2. *Contemporary Hypnosis* 19(4): 149–66.
- Gruzelier J, Clow A, Evans P, Lazar I, Walker L (1998) Mind-body influences on immunity: lateralized control, stress, individual differences predictors, and prophylaxis. *Annals of the New York Academy of Sciences* 851: 487–94.
- Gruzelier JH, Levy J, Williams J, Henderson D (2001a) Self-hypnosis and exam stress: comparing immune and relaxation-related imagery for influences on immunity, health and mood. *Contemporary Hypnosis* 18(2): 73–86.
- Gruzelier JH, Smith F, Nagy A, Henderson D (2001b) Cellular and humoral immunity, mood and exam stress: the influences of self-hypnosis and personality predictors. *International Journal of Psychophysiology* 42(1): 55–71.
- Jensen KP, Back-Pettersen S, Segesten K (2000) The meaning of ‘not giving in’: lived experiences among women with breast cancer. *Cancer Nursing* 23(1): 6–11.
- Kiecolt-Glaser JK, Glaser R, Shuttlesworth EC, Dyer CS, Ogrocki P, Speicher CE (1987) Chronic stress and immunity in family caregivers of Alzheimer’s disease victims. *Psychosomatic Medicine* 49(5): 523–35.
- Kiecolt-Glaser JK, Glaser R, Strain EC, Stout JC, Tarr KL, Holliday JE, Speicher CE (1986) Modulation of cellular immunity in medical students. *Journal of Behavioural Medicine* 9(1): 5–21.
- Laidlaw TM (1994) Hypnosis and breathing training in the treatment of anxiety: three cases. *Australian Journal of Clinical & Experimental Hypnosis* 22(2): 137–45.
- Laidlaw TM (1999) The Interrupt Distraction Procedure: a brief hypnotic intervention for belief change and diminishing distress. *American Journal of Clinical Hypnosis* 42(1): 22–34.
- Laidlaw T, Bennett BM, Dwivedi P, Naito A, Gruzelier J (2005) Quality of life and mood changes in metastatic breast cancer after training in self-hypnosis or Johrei: a short report. *Contemporary Hypnosis* 22: 84–93.
- Laidlaw TM, Naito A, Dwivedi P, Enzor NA, Brincat CE, Gruzelier JH (2003) Mood changes after self-hypnosis and Johrei prior to exams. *Contemporary Hypnosis* 20(1): 25–40.
- Laidlaw TM, Willett MJ (2002) Self-hypnosis tapes for anxious cancer patients: an evaluation using Personalised Emotional Index (PEI) diary data. *Contemporary Hypnosis* 19(1): 25–33.
- Landmark BT, Standmark M, Wahl AK (2001) Living with newly diagnosed breast cancer: the meaning of existential issues. *Cancer Nursing* 24(3): 220–6.
- Lin H, Bauer-Wu SM (2003) Psycho-spiritual well-being in patients with advanced cancer: an integrative review of the literature. *Journal of Advanced Nursing* 44(1): 69–80.
- Lipowski ZJ (1970) Physical illness, the individual and the coping processes. *Psychiatry in Medicine* 1: 91–102.
- Luker KA, Leinster SJ, Owens RG, Beaver K (1996) Preferences for information and decision making in women with breast cancer: a follow-up study. Unpublished report, submitted to the Cancer Relief Macmillan Fund, London.
- Lupton D (1994) *Medicine as Culture*. London: Sage.
- Marchioro G, Azzarello G, Checchin F, Perale M, Segati R, Sampognora E, Rosetti F, Franchin A, Pappagallo GL, Vinante O (1996) The impact of a psychological intervention on quality of life in non-metastatic breast cancer. *European Journal of Cancer* 32A(9): 1612–15.
- Naito A, Laidlaw TM, Henderson DC, Farahani L, Dwivedi P, Gruzelier JH (2003) The impact of self-hypnosis and Johrei on lymphocyte subpopulations at exam time: a controlled study. *Brain Research Bulletin* 62(3): 241–53.
- Richer M, Ezer H (2002) Living in it, living with it, and moving on: dimensions of meaning during chemotherapy. *Oncology Nursing Forum* 29(1): 113–19.

- Smith JA (1996) Semi-structured interviewing and qualitative analysis. In: J Smith, R Harre, LV Langenhove (eds) *Rethinking Methods in Psychology*. London: Sage.
- Smith JA, Jarman M, Osborn M (1999) Doing interpretative phenomenological analysis. In: M Murray, K Chamberlain (eds) *Qualitative Health Psychology: Theories and Methods*. London: Sage.
- van Weert E, Hoekstra-Weebers JE, Grol BMF, Otter R, Arendzen JH, Postema K, van der Schans CP (2004) Physical functioning and quality of life after cancer rehabilitation. *International Journal of Rehabilitation Research* 27(1): 27–35.

Address for Correspondence:

Professor John H. Gruzelier
Department of Psychology
Goldsmiths College
Lewisham Way
New Cross
London SE14 6NW
UK
Email: j.gruzelier@gold.ac.uk