

An exploration of holistic life coaching for breast cancer survivors

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Abstract

This study is an exploration of holistic life coaching for breast cancer survivors using a phenomenological mixed methods approach involving action research and semi-structured interviews. The aim of the research is to explore the possible introduction of coaching interventions to the breast cancer care pathway. Current survivorship issues are addressed in the National Cancer Survivorship Initiative (NCSI), (DOH, 2010). However, coaching interventions are not currently included in the survivorship pathway. Some limitations to the study were identified but all the participants reported that the coaching was a valuable experience.

Key Words: Holistic, coaching, breast cancer survivors, National Cancer Survivorship Initiative, Personal Construct Theory.

Introduction

According to statistics published by Cancer Research UK (2009) 45,500 women were diagnosed with breast cancer in 2006. The incidence of this disease has doubled over the last 25 years. The National Health Service (NHS) screen 10,000 women every year and save 1,400 lives annually. In the 1970's 5 out of every 10 women diagnosed survived beyond 5 years, in 2009, that figure improved to 8 out of every 10 but it is still the second most common cause of cancer death in women in the United Kingdom. In 2010 the 5 year survival of breast cancer patients is 86% (DOH National Cancer Survivorship Initiative, 2010). There are also 400 men a year now diagnosed with breast cancer.

In the 1970s the overriding emphasis on medical intervention gave the public a view of medicine that was centred on putting things right (Williamson, 1978). Such a mechanical approach led to a downgrading of personal responsibility that was paralleled by the low priority assigned to preventative medicine by the NHS itself. This resulted in a medical model of healthcare that objectifies human experience bracketing out holistic influences on physical health and concentrating only on medical diagnosis, treatment and cure.

Charalambous *et al.* (2008) remind us that Cartesian thought clearly divided mind and body. It is this fundamental premise that provides the foundation upon which the medical model of health care in the NHS is based (Thompson & Hammer 2007, Connolly *et al.* 2009, Scott 2010). In holistic care pathways the aim is to treat the body and mind together as one and overcome the Cartesian mental-physical split.

The challenge for coaches in this context is that the current care pathway for breast cancer patients in the public sector is still firmly embedded in the medical model and does not include coaching interventions. Macmillan Cancer Support has been working hard with other partners in recent years to address issues relating to psychosocial support for breast cancer survivors. This has led in part to the publication of the National Cancer Survivorship Initiative (NCSI) (DOH, 2010), which calls for every cancer survivor to be treated holistically and have a personalised assessment and care

plan. However, all reference to emotional support for cancer survivors in the NCSI points towards informal support via Cancer Support Groups (CSG's) or the employment of clinical psychologists and counsellors.

Although conventional medical treatment is recognised as essential in the fight against cancer (Cancer Research UK, 2009), it is hoped that this study can contribute to the already recognised view (DOH NCIS, 2010) that cancer patients recover more fully with a return to their previous quality of life, through a more holistic approach. The study proposes the introduction of coaching interventions to cancer care pathways that may empower breast cancer survivors to set goals and take control of their lives again. This may have a positive effect on their future health.

Through discussion with breast cancer patients, relatives and friends, anecdotal evidence has been discovered to suggest that the most difficult time for breast cancer patients is not when they are diagnosed, or even when they are undergoing treatment, but when the active treatment is all over and they have to face getting on with their lives. One of my friends said to me recently:

You know that trick where a magician pulls the table cloth away so quickly that everything on the table remains in place? Well that's how it feels when you finish your treatment.

Another friend who was still undergoing treatment told me:

This bit's OK. I feel like I'm fighting it. The bit I dread is when the treatment is all over and they say I'm fine. What the hell am I going to do then? How can I just go back to normal?

The anecdotal evidence regarding the difficulties breast cancer survivors experience following the completion of treatment is supported by research. Ambler *et al.* (1999) quote studies from as far back as 32 years ago (Maguire, 1985., Hughson *et al.*, 1986., Dean, 1987., Shields & Rousseau, 2004) all of which draw attention to persistent and serious levels of distress which continue to disrupt the everyday lives of breast cancer survivors long after treatment has been successfully completed.

There is now increasing evidence that health is influenced not just by what we eat or how much exercise we take, and not just by our own bodies' internal protective mechanisms, but by our attitudes, our expectations, our hopes, our moods, our personalities and our temperaments (Abedi, 2007; Azar, 2001; Kiecolt-Glaser *et al.*, 2002; Lerner, 2009; Nick, 2007; Reilly & Harrison, 2002; Wayne, 2001). McDonald (2005) agrees that there is a widespread belief that a positive attitude is linked to recovery and cure, giving further credence to the belief that our physical health can be affected by our mental health and our willingness to take responsibility for ourselves. Broderick (1990) in Kegan (1982) also alludes to the possibility of an unwitting fourth order demand that suggests that cancer patients who display "fighting spirit" live longer and better.

Methodology

This is a qualitative phenomenological research study. The study's structure is formed around a hybrid of action research and hermeneutic phenomenology with an interpretive, constructivist stance. The first part of the study is based on the delivery of a coaching intervention to three breast cancer survivors. Part two hinges on semi-structured interviews with each respondent. The semi-structured nature of the interviews will not restrict phenomenological accounts being told as the respondents will still be allowed the freedom to tell their stories within the semi-structured framework. The epistemological position of interpretivism requires the study to grasp the subjective meaning of the respondents' experience whilst asserting the ontological constructivist position that

social phenomena are continually being acted out through life experience and therefore constantly changing.

The study begins with the action research approach. An intervention (four individual life coaching sessions for each of three cancer survivors) was designed and delivered. Personal Construct Theory (PCT) (Kelly, 1963) was used in the coaching with a view to helping the participants make positive changes in their lives. The intervention was evaluated using Goal Attainment Forms (CORE, 1998). Rather than revisiting the intervention as would normally be the case in action research, phenomenological semi-structured interviews were then conducted. This was because I was interested in the experience and meaning of the respondents in relation to their cancer experience and the coaching rather than the review and improvement of the intervention. The interview transcripts were thematically analysed using Interpretative Phenomenological Analysis (IPA) (Smith & Osborne, 2008).

Explanation of terms

It was felt important to carefully define coaching in such a way as not to alarm or alienate potential volunteers. As cancer survivors are currently offered counselling it was also important to make the difference between the two very clear. It was decided to adapt one of the best known definitions of coaching and define coaching thus: coaching is unlocking a person's potential to maximise their own quality of life. It is helping them to learn rather than teaching them (Gallwey, 1986)

Gallwey's original definition related to life as a 'performance'. In the context of this study this was considered inappropriate and was therefore rejected. It was replaced with 'quality of life'.

A clear definition of counselling was difficult to find. After much deliberation it was decided to use Rogers (2008, p.17) as a reference, defining counselling as:

...a helping relationship that is likely to revolve around a short term engagement following a particular crisis. It is based on the powerful comfort of non-judgemental listening in the moment and means talking through it extensively, without either counsellor or client feeling any obligation to take action.

For the purposes of this study a coach was defined as (Rogers, 2008, p.7): someone whose sole aim is to work with the client to achieve all of the client's potential – as defined by the client.

Coaching

Three volunteers were asked to participate in 4 x 1.5 hour monthly coaching sessions over a 4 month period. Before the initial coaching session each participant was asked to complete the 'Wheel of Life' adapted from Whitworth *et al.* (2007). Goal setting as an important coaching tool is well documented (Cox *et al.*, 2010; Law *et al.*, 2007; Whitmore, 2002; Stober & Grant, 2006; Rogers, 2008). A Goal Attainment Form (GAF) from Core System Group (CORE, 1998) was adapted for this purpose. The GAF was used to guide Donald, Paula and Janet to appropriate and achievable goal setting and also provided a tool to evaluate the intervention.

George Kelly's Personal Construct Theory (PCT) (Kelly, 1963) was used extensively in the coaching intervention. PCT is born of constructivism. Constructivism is based on the premise that learners build personal interpretation of the world based on experiences and interactions. PCT takes this a step further suggesting that a person has the freedom to choose the interpretation he wishes to construe of the world in terms of his experience of it. Bannister and Fransella (1986) refer to the postulate of the theory being about the events we face today being subject to as great a variety of

constructions as our wits will enable us to contrive. Kelly (1963) refers to this freedom of choice as constructive alternativism and is what Karakowsky and McBey (1999) express as the ability to choose to change what one does and how one sees things.

The use of PCT was incorporated into the coaching in an attempt to instigate positive change where appropriate. The aim was to help Donald, Paula and Janet to understand that life doesn't have to be the way they currently perceive it and that if they want to change, they have the potential within themselves to develop and make the choices that will enable them to achieve their goals in order to make those changes. Therefore during the coaching process when areas of stagnation were encountered which hampered making choices and fostering change, the use of PCT was key to assist Donald, Paula and Janet to realise that change was possible.

Interviews

Semi-structured phenomenological interviews were employed to gather data about the participants' experiences, feelings and meaning regarding their cancer journey and the coaching they had received. The interviews in this case were described as 'discussions' in the volunteer information to make them seem less formal. Donald, Paula and Janet were asked for their permission to record the final interviews. The coaching and the final interviews were all held at Primrose Hospice in Bromsgrove where the Cancer Support Group met every month. This provided a comfortable, familiar and relaxed environment for all our interactions. Data was gathered in an informal way in what Mason (2002, p.62) refers to as 'the interactional exchange of dialogue'.

Transcription and thematic analysis

Interpretative Phenomenological Analysis (IPA) was adopted to facilitate an in depth thematic analysis of, and engagement with, individual accounts of the breast cancer experience and the coaching intervention. Wilde & Murray (2009), state that there is no objectively finite sample size for an IPA study. Indeed, their study had only three participants as does this one. Although there are general guidelines available as to how to proceed with a thematic analysis using IPA (Smith & Eatough, 2007., Smith & Osborn, 2008) the method is essentially prescriptionless. According to Bryman (2008) thematic analysis is a mechanism for thinking about the meaning of the data and more importantly, for reducing the vast amount of data into its significant and relevant parts. It provides a method of interpreting data and understanding the significance of it in terms of the lives of the research subjects. Finding similarities between themes and linking them together leads to a clearer picture of the meaning of the data. In this way the meaning of long interview statements can be reduced to a few meaningful themes.

Findings

The coaching intervention

At the end of each coaching session Donald, Paula and Janet were asked to complete Side 2 of the GAF to record the following: firstly, if the coaching had had a positive outcome for them, and if so how helpful it had been, secondly, if they still had unresolved issues, and if so how hindering they were, thirdly, how satisfied they were with the coaching, and finally, if they would recommend coaching to other breast cancer survivors. The results have been combined in one table (Figure 1.). The table is colour coded in red, amber and green as a visual reference to demonstrate the success of the coaching intervention, red being an indication of areas of significant concern, amber indicating moderate concern and green meaning that the issue had been successfully addressed. It can be seen at a glance that the majority colour is green denoting more successfully addressed issues than not.

The evidence from the Goal Attainment Forms is very encouraging and demonstrates the coaching as a successful intervention in varying degrees for all three participants.

	P O		How helpful			U I		How hindering			How satisfied			Reccommendation					
	Y	N	S	M	E	Y	N	S	M	E	V	S	MF	D	V	YD	YTS	NDTS	ND
Donald																			
1	X				X	X		X				X					X		
2	X			X		X		X				X					X		
3	X				X		X					X					X		
4	X				X		X					X					X		
Paula																			
1	X			X		X				X		X					X		
2	X				X	X		X				X					X		
3	X				X		X					X				X			
4	X				X		X					X				X			
Janet																			
1	X				X	X				X	X					X			
2	X				X	X			X			X				X			
3	X				X		X					X				X			
4	X				X		X					X				X			

Figure 1

Key:

1, 2, 3, 4, = Coaching session number

PO = Positive outcome, Y = Yes, N = No.

How helpful/How hindering, S = slightly, M = moderately, E = extremely

U I = Unresolved issues, Y = Yes, N = No

How satisfied, V = very, S = slightly, MF = mixed feelings, D = dissatisfied, V = very dissatisfied

Recommendation, YD = yes definitely, YTS = Yes think so, NDTS = No don't think so, ND = No definitely.

Opinions

During the interviews the respondents were asked several specific questions. These questions related to whether or not the medical model was still predominant in cancer care in the NHS, whether breast cancer should be addressed in a more holistic way, if so, what the best way of doing this was, whether coaching should be added to the breast cancer care pathway and whether they agreed with the view of the study that the end of active treatment was the most difficult time.

The Medical Model of healthcare and the NHS's obsession with cure was mentioned in particular by Paula who raised the issue on two occasions in her interview. She said that:

...it's a matter of six weeks from your mammogram to your surgery. It's a totally wonderful service but still so, just...railroaded, pushed so quickly. You can't fault it but it really feels overwhelming, that's the word... Totally overwhelming.

Later on she says:

You know, you've got to look after the cancer and really.....you've just got to hope that people have got good support at home.....and if they haven't hope they don't fall through the cracks.

The meaning Paula ascribed to this part of her experience led to a strong inference that the NHS is still obsessed with cure having failed to address any aspect of her diagnosis other than the medical one. This suggests that the NHS's obsession with cure may still have a strong hold in cancer care today.

All the respondents were asked if they thought it was important to address cancer in a more holistic way by addressing both the emotional and psychological impact of a breast cancer diagnosis. The two women responded by saying:

Oh it's very important. Yeah...very important.

I'd say it's more important than the actual cancer itself sometimes cos it's really devastating.

Donald thought that it was only important for women saying:

I think it's very important but I would say the question is aimed more towards women than men.

Donald's view was based on his assumption that all women were devastated and psychologically damaged in some way by the disfigurement of surgery. This opinion was based on his experience of talking to women in the breast cancer support group. His assumption that men were not similarly affected by a mastectomy was again based on his own experience, having been adversely unaffected by his own physical appearance.

When all three were asked for their opinion of the best way to provide this support they all agreed that counselling was important but that a coaching intervention would be equally important and may be more effective for some people than counselling. Again, Paula expressed this when she said:

...it (coaching) has really worked for me, better than counselling. Better than mentoring because it's up to me in the end.

Janet and Donald also expressed their opinions that both counselling and coaching should be offered to cancer patients. In doing so, Janet also demonstrated a clear understanding of the foundations of a coaching intervention saying:

Well counselling is about giving advice really. But you've shown me how to reach the goals I've wanted to in the way of tackling issues that I've had...

All three respondents identified coaching as a useful adjunct to the cancer care pathway in order to address both the emotional and psychological impact of a breast cancer diagnosis.

All three respondents felt the end of active treatment was very difficult, to different degrees, but was not necessarily the worst time. Whilst Donald described a feeling of being "cast aside" and "abandoned" by the NHS when he was told that there was no reason to see him again for some time, and did therefore acknowledge this stage as very difficult, he nonetheless describes the chemotherapy as the worst time for him.

Paula described the end of her active treatment as “disconcerting”. She experienced her treatment as being part of a club. By categorising it in that way, Paula expressed the reassurance she received by both belonging to that club and also by witnessing other people in the club who were much worse off than her. The reaction of her family made it very difficult for Paula to acknowledge that she was ill and watching people worse off than her validated the belief that this was so. Paula said:

I keep trying to tell myself there's nothing wrong with me really, and there isn't, and there wasn't when I went in. Um...and so it's good in one way, it makes you feel positive when you see so many people so much more worse off than you. And then that stops.

When the treatment was over, the withdrawal of the support system that reinforced her belief that she wasn't ill at all was devastating for Paula. She became very low and fatigued saying that she had lost her “cushion” and her “comfort”. She reported that when she expressed her fatigue people responded by saying, “Well, what's wrong with you?”

Although Paula expressed that she was “disconcerted” at the end of active treatment the description of her experience and the meaning she ascribed to it appear to denote a much more serious effect on her than the choice of the word implies. This validates the belief of the study that the end of active treatment may be particularly difficult for some people. Significantly, Paula was the only one who was at the end of her treatment during the coaching intervention. Donald was a five year survivor and Janet a nine year survivor.

Janet reported feeling both relieved and afraid at the end of her active treatment. Relieved because there were “no more doctors and hospital appointments” and afraid because:

...they'd always kept an eye on me and then suddenly I was going to be left...what if it did come back?...you know.

This lack of closure and uncertainty at the end of active treatment is what has led to the recent recommendations in the National Cancer Survivorship Initiative (DOH, 2010)

Themes

The themes that emerged from the respondents' descriptions of their experience of breast cancer are as follows:

- Loss of control.
- Cancer made respondents more receptive to address other issues.
- Personal responsibility and a positive attitude are important to aid recovery.
- Change.
- Physical health, mind and mood are related to diagnosis.

Each one will be discussed in turn.

Loss of control

Loss of control is an issue with which all three respondents had difficulty and which is widely reported as a common difficulty relating to the psychosocial adjustment of people diagnosed with breast cancer (Fulton, 1990; Gray *et al.*, 1991; Lowery *et al.*, 1993; Morgan 2008). Donald, Paula and Janet all perceived the loss of control differently and dealt with it in different ways. Donald acknowledged the loss of control by saying:

There were certain parts of it that I did find difficult – when you're not in control of the situation, which is when the tiredness comes from the chemotherapy.

For Donald this was purely a loss of control in the activities of daily living. When he was debilitated by chemotherapy fatigue he was unable to physically do what he wanted to. He took a very pragmatic approach when this happened by simply giving in to it until it passed:

In the end you just have to give in to it and sit down or lie down until that feeling passes you by. And when that's gone you can get on with what you're doing with your life on that particular day.

For Janet, the loss of control issue was all about her physical appearance and in particular her hair loss at the time.

Yes, (it was a loss of control).....I never felt like an attractive woman anyway and I just felt I was going to look absolutely dreadful and that was my worst thing but I couldn't do anything about it.

The opportunity to address this with Janet was not possible because the hair loss issue was no longer relevant when I met her and she chose not to raise the ongoing issue of having to come to terms with the loss of her body image in the coaching intervention, only mentioning it in the interview. A continuing coaching intervention may have been helpful to address this with Janet at this stage. Alternatively, one could infer that her new found confidence and her understanding of Personal Construct Theory will enable her to attribute new meaning to her perception of herself as disfigured in order to achieve a more positive orientation.

Paula expressed the meaning of her loss of control in the description of what happened at diagnosis when everything went so fast. But for Paula there was also an associated loss of control of her position in the family and the loss of the support of her husband. Morgan (2008) states that some of the characteristics of negative marital support during illness include physical avoidance of the patient, avoidance of open communication and a minimisation of the illness and its consequences. The latter statement in particular echoes the story Paula tells. Whilst this was happening to Paula she reacted by engaging in what Morgan describes as maladaptive behaviours; hiding her concerns, denying her worries and yielding to her husband in order to avoid disagreements. In trying to be what she describes as 'strong', Paula merely contributed further to the loss she was experiencing by adopting these maladaptive behaviours that only served to isolate her even further.

The issue of loss is a complicated one. The inference is that loss, in all its guises, needs to be addressed at every stage of the cancer journey. This cannot be achieved if the treatment is based on the Medical Model. A more holistic approach is necessary.

Heightened receptivity to address other issues

The study respondents all experienced this to some degree. For the two women the heightened receptivity was related to the willingness to address deep psychological, personal and emotional difficulties but for Donald, it was once again related to a physical issue.

Donald describes his cancer diagnosis as:

...a wake-up call for me, not just in terms of being overweight but in terms of the stuff I was eating and the sort of lifestyle I was living.

The wake-up call Donald describes made him realise that he could no longer put off addressing the lifestyle issues he had been aware of for some time, but had not had the motivation to do anything about. This decision constitutes Donald's acknowledgment of a heightened receptivity to address other issues in his life that might otherwise have been left unresolved.

When asked whether she felt a heightened receptivity to addressing other issues Janet said "no". However, she went on to say:

...but it's enabled me.had I not gone to the breast cancer group meeting....I don't think I would have had the life coaching.....I'd have just plodded along as I have been, brushing it under the carpet and carried on until the next time came along and something else knocked me down, you know.

Janet did not acknowledge that it was directly the cancer that resulted in a heightened receptivity to address her difficult issues, but described a pathway that indirectly led her to do so. It could therefore be concluded that it was the cancer that led to her addressing her issues, albeit via a slightly circuitous route.

Paula was the most vociferous in the expression of her heightened receptivity to address her complex issues as a result of the cancer. She expresses certainty that her issues would have remained unresolved if it were not for the cancer saying:

I'd have left it. It would have remained unresolved. I think it's made me question, the cancer has made me question my life.

The inference is that the coaching intervention was the tool that enabled her to address her issues, without which Paula would still have questioned her life but would not have had the skills to take action. It was the skilled questioning and guidance provided through the coaching intervention that helped her to identify her goals and empowered her to take action.

Taking personal responsibility

Donald stood out above the women in his positive attitude towards fighting his cancer and taking personal responsibility to improve his position, and even that of others. From the outset Donald decided to fight saying:

I thought right, you know, I'm not going to let this beat me and I need to have the best positive attitude I can.

Donald also recognised the value of taking action to participate in his own treatment by visiting a holistic therapist, by completely changing his diet, and determining to lose weight saying that at the end of his treatment he "felt the best I've felt for a long time." He took his own responsibility seriously, even to the extent of working to increase awareness of breast cancer in men. He featured in magazine articles, educational DVDs and television programmes, spreading the word that men too could get breast cancer.

Participation is defined by Catrine et al. (2010) as "being involved in a life situation". One could say that Donald had fully participated in his treatment and recovery from breast cancer. Taking ownership in this way is important for patients and according to Larsson *et al.* (2007) contributes to increased motivation to improve their own condition, better treatment results and greater satisfaction with received care.

Janet too describes taking some personal responsibility by visiting a homeopath. For her it was more related to her depressive illness than the cancer but it demonstrates a willingness to take some ownership of her condition that is of overall benefit.

Janet does not display the same fighting spirit as Donald but has contributed in her own way to taking some responsibility to improve her situation. Like Donald, she has taken responsibility for improving the lot of others by suing the NHS for a misdiagnosis that delayed her eventual correct diagnosis and subsequent treatment. In doing so Janet felt that she was acting on behalf of other patients who may benefit in the future from her actions. She described how taking legal action against the NHS also helped her deal with the chemotherapy “it helped me really because it gave me something else to focus on”. Considered in these terms Janet’s fight with the NHS could be compared with Donald’s fight against the cancer. They both took on a battle of considerable proportions and both won. Both found the fight helpful in addressing their fears and gave them less time to sit and feel sorry for themselves. Ironically Janet was able to overcome her lack of assertiveness in order to take on the might of the NHS. When asked about it she said that it was simply a case of right and wrong and that she didn’t identify with it personally, she was doing it for others.

When analysing Paula’s transcript, no reference to taking responsibility or fighting spirit could be found. The absence of fighting spirit and the lack of personal responsibility in Paula’s story was felt to be the more significant for its absence. She described herself as having very little energy or motivation to take any responsibility for anything in her life and even admitted to feelings of not wanting to be alive:

It’s (the coaching) made me realise that I’ve got to do something but I didn’t realise what the actual.....(long pause)....I didn’t think I wanted to live much actually, before I had the cancer and then I realised ‘oh yeah, I do’.

The realisation that she wanted to live was the key to unlocking the door for Paula, the coaching was the tool for opening the door a crack and now Paula has to take the responsibility to keep opening the door wider and wider.

Change

The pathology of change has been the focus of study of many (Knowles *et al.*, 2005; Rogers, 1951; Stevens, 1995; Rogers, 2008; Sugarman, 2001; Fransella, 2005; Stober & Grant, 2006; Dryden, 2007; Palmer & Whybrow, 2007). The most simplistic statement comes from Sugarman (2001, p.2) who says that “to live is to change”. Change takes many forms but is usually associated with some form of loss (Rogers, 2008), which is what makes it so difficult.

In Janet’s case there was a strong desire to make changes and she started doing so immediately after the first coaching session. However, there was a much more significant change in Janet’s cancer experience that she revealed in the semi-structured interview. It was the loss of the cancer itself. During the interview Janet said of her cancer:

When I was diagnosed and going through the treatment it was wonderful because of all the attention from so many people. I got cards and flowers. In my very darkest days I wanted it to come back and that’s absolutely awful but I had so much love shown to me and I just wanted it back again.

During coaching Janet demonstrated unhealthy needs to please others during her life in the belief that it would make them like her. The meaning she made of her cancer experience allowed her

to believe that people really did like her. They were demonstrating it very clearly through their caring actions. This change gave Janet a wonderful feeling and she didn't want it to end. This meant continuing to be ill. When faced with recovery, Janet found the loss associated with that change more difficult to cope with than anything else.

Palmer & Whybrow (2007) state that people must have the motivation to change and that the triumvirate of being "ready, willing and able" is an essential precursor to successful change. When the coaching opportunity arose, Janet had reached the stage where she was sufficiently motivated to make significant changes in her life. The changes she made were therefore successful. She reported that the coaching "*opened up new doors and I feel that I'm not a bad person*".

For Paula change was not so easy. According to Dryden (2007) there is no clear strategy relating to change, it depends on the person and what is at stake for him or her if he or she were to contemplate changing in some radical way. When considering Paula's difficulties the inference is that the ultimate change facing Paula is potentially the break up of her marriage. Paula was not ready to make that change but had taken small steps towards it by venturing out alone in a social context by going to concerts. She vowed she was going to do this more often in the future saying that the coaching:

...has led toa kind of sea change. If you actually talk him (her husband) into doing something it's so expensive...and so you don't do it and so....but now I think I'm going to do it myself.

Paula also made other small changes. In relation to her cancer Paula was still expected by others to do the same things that she'd always done but in the end Paula was physically unable to comply with their wishes. She started saying "no, you're asking too much of me can you please just slow down". Taking account of Paula's recent history and the story she told me of not wanting to live at one point, the inference is that it was not a lack of assertiveness or self-esteem that made her always compliant with the wishes of others, but more a symptom of the fatigue and depression she was clearly experiencing. She simply couldn't be bothered to argue with anyone over anything. From Paula's point of view the deterioration in her family relationships, the death of her closest friend and her cancer diagnosis were all changes that she could not have predicted, could not have prevented, did not cause, couldn't control and couldn't avoid. Depression was predictable.

The relationship of physical health, mind and mood with cancer diagnosis

Donald believed that his physical health may have had a bearing on his cancer diagnosis:

Erm...I think it could be.....from the research my wife and I have done, the more overweight you are, the more oestrogen you produce and when I have a cancer that is oestrogen based you have to sit back and think 'hey, is that because I'm overweight?

Donald adds that if you take into account that he has a sedentary lifestyle, was eating badly and taking no exercise then he may be partly to blame for his cancer:

...so if you add all those things together, you could say that I'm partly to blame for it.

In the semi-structured interviews neither Janet nor Paula recognised their emotional health as a significant factor in their cancer diagnosis. This was frustrating as both had already acknowledged it to be so during the coaching intervention. Paula even said the following after the tape had been switched off at the end of the interview:

I think there's a definite link with bereavement. Every woman in my radiotherapy group had had some kind of bereavement in the last year.

This was not caught on tape but it was so significant that I immediately wrote it down. Janet had intimated the same thing during coaching saying that she thought low mood, bereavement and depression were connected to cancer. I made a note of these comments in my journal at the end of the session. Their failure to vocalise this in response to the interview question may have been as a result of ambiguity in the question. If this is so then it represents a limitation to this part of the study.

There are many studies making the connection between poor mental health and physical illness (Harvard, 2007; Dowrick, 2006; Safran, 2010; Adams *et al.*, 2008; Sharpley *et al.*, 2007; Morgan, 2008; Lively, 2008; Simon & Lively, 2010) but only two were found suggesting a specific link between traumatic life events and cancer. Low *et al.* (2006, p. 236) say that:

Cancer does not occur in a vacuum, and over the course of a woman's diagnosis and treatments, such life events as death of loved ones, financial difficulties, and divorce continue to unfold.

Low *et al.* go on to say that post treatment recovery is adversely affected by stressful life events and that strategies aimed at exploring the emotions associated with breast cancer may be particularly useful to facilitate goal-directed action relevant to those concerns. Low *et al.*'s study makes no recommendations in terms of what strategies are most useful but this study suggests that goal-directed coaching may be efficacious under such circumstances.

Nick (2007) describes the connection between depression and cancer explaining that depression leads to inefficiencies in the immune system that regulate the inflammatory response. She goes on to say that for cancer patients:

....the incidence of depression correlates conversely with both mean length of survival and serum cytokine level, raising suspicions that pro-inflammatory cytokines are involved in the development of feelings of despair, depression and hopelessness that occur in many cancer patients (p.3).

Low *et al.* (2006) and Nick (2007) are the only two amongst the identified literature to discuss specific links about how the mind may be connected to the diagnosis of cancer. However, what is clear from the other literature is that depression and worry can cause general physical illness. In a Harvard Health Letter (2007) it is stated that worry isn't always experienced as a mental health problem but that it can be experienced as fatigue, headaches, stomach ache and vague pain. Dowrick (2006) says that the interactions between physical and mental illness are complex. Each may lead to the other, both may arise from common antecedents; they may occur separately or make an appearance together.

Conclusion

Paula unwittingly described the archetypal Medical Model of healthcare in explaining an experience of diagnosis and swift treatment of her cancer that lacked any holistic considerations. This mirrors the acknowledged lack of holistic care which has resulted in the publication of the National Cancer Survivorship Initiative (NCSI DOH, 2010) which calls for the development of a cancer care pathway that centres on quality survivorship issues. The NCSI moves the focus from cancer as an acute illness to a greater focus on recovery, health and wellbeing after recovery. Its intention is to support survivors to take an active role in their aftercare. This study proposes the same approach and

identifies coaching as an intervention through which part of the NCSI's proposals can be put into practice. All three respondents agree that a more holistic approach to cancer care would be beneficial and that coaching should be included in that approach, saying that it may be more appropriate and successful for some patients.

Although Paula clearly found diagnosis extremely stressful all three respondents agreed that the end of active treatment was very difficult. Paula's story inferred that the end of active treatment was indeed a very gruelling stage for her and Janet clearly found recovery extremely challenging. These stories lend credibility to the study's claim that the end of active treatment may be the most difficult for some people.

The main themes identified from the interviews were loss of control, cancer made respondents more receptive to address other issues, personal responsibility and a positive attitude are important to aid recovery, change, and physical health, mind and mood are related to diagnosis.

The loss of control issue was difficult for all three respondents. A goal orientated coaching intervention that promoted action to regain some control and which was offered as a routine part of the cancer care programme may have been very helpful at this point. This would also have enabled the respondents to address those other issues in their lives that they were keen to address in an effective model that encouraged personal responsibility and action.

The fact that the respondents all expressed a willingness to address other issues in their lives as a result of their cancer diagnosis is also potentially an indicator that coaching would be efficacious for cancer survivors. These issues may be more successfully addressed through the skilful questioning and guidance to goal achievement of a coach as opposed to the skilful listening skills of a counsellor. Such a coaching intervention could be effective to encourage a positive attitude and the taking of personal responsibility in order to participate in the cancer journey and take back ownership of a life seemingly out of control. This in turn could make the change issue easier to address and render it less debilitating.

All three respondents were offered counselling at some time during their cancer journey which may have been helpful but all three refused the offer. Janet refused because of a previous bad experience. Paula reported being barely aware of the offer and Donald declined because he did not need it. A goal orientated coaching intervention that promoted action to regain some control and which was offered as a routine part of the cancer care programme may have been very helpful.

Donald, Janet and Paula were asked to describe the coaching they had received in three words. Donald said "Interesting, honest and cleansing". Janet replied that she had found the coaching "Life changing, given me food for thought and given me confidence" and Paula chose to employ the words "Positive, empowering and hopeful". They all stated that they thought coaching would be an appropriate adjunct to the breast cancer care pathway. This is demonstrated by the evidence, collated from both the Goal Attainment Forms and the interviews. The findings demonstrate the coaching as a successful intervention in varying degrees for all three participants.

The evidence also suggests that the mind can affect the body and vice versa. Whether this can be said to influence the development of cancer remains a premature claim to make but there does seem to be some foundation to the claims that depression is relevant to cancer progression and recovery. If a coaching intervention can be effective in helping cancer patients with depression, then the inference is that the immune system may be strengthened and become more effective at fighting the disease.

Limitations

In the semi-structured interviews that formed the second part of the study limitations were exposed which have an adverse impact on the overall validity.

At the beginning of the study it was assumed that all the participants would want to discuss difficulties relating to their cancer experience during the coaching intervention but only Paula did so. Accordingly, although the coaching was successful it did not necessarily address what it set out to. It also became obvious that the differences in the stages of recovery for each of the respondents was critically relevant. Paula was just at the end of her treatment and had difficulties that related directly to her cancer such as fatigue, but Donald and Janet were years down the line and didn't feel any compunction to address any cancer related issues. It would have made the study more robust and more valid had all three respondents been at the same stage, just at the end of active treatment.

Future goals

For the breast care nurses and the Breast Cancer Service in Worcestershire it is hopefully the start of an improvement in holistic breast cancer care. I have been invited to present the study to the regional Breast Care Nurses Meeting and have also been invited to a meeting of the National Cancer Equality Initiative at the Department of Health. It is hoped that the results of this study will be promulgated nationally in order to raise the profile for survivorship programmes in accordance with the NCSI (2010).

For life coaches in general (and particularly health professionals with a coaching qualification) it may be that a new specialism of 'health coaching' is just emerging. This could be developed and delivered widely within cancer care pathways and possibly also other serious illness pathways.

Finally, the point was made by both Paula and Janet that they thought that bereavement was in some way related to their cancer diagnosis. This was an unexpected claim that warranted further investigation but no literature was found that provided evidence to consolidate this opinion. As previously stated there have also been claims about depression and childhood abuse being related to cancer diagnosis. These are all potential areas for future research.

Any additional research to identify further links between the mind and the body that may engender further understanding of how people react to a cancer diagnosis and treatment will also be beneficial.

References

- Abedi, A. (2007) Psychoneuroimmunology [Online] *Informational Healing*. Retrieved from: www.informationalhealing.com [Accessed 15 October 2009]
- Adams, T.B., Wharton, C.M., Quilter, L. & Hirsch, T. (2008) The Association Between Mental Health and Acute Infectious Illness Among a National Sample of 18 to 24 Year Old College Students [Online]. *Journal of American College Health*, Vol. 56, No. 6, pp. 657-663. Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].
- Ambler, N., Rumsey, N., Harcourt, D., Fawzia, K., Cawthorne, S. & Barker, J. (1999) [Online]. *Journal of Advanced Nursing*, Vol. 29, Issue 2, pp. 445-453. Retrieved from:

<http://web.ebscohost.com/ehost/delivery?vid=33&hid=8&sid=cb4d1cd1-9161-4783-a>.
[Accessed 1 March 2010].

- Azar, B. (2001) A New Take on Psychoneuroimmunology [Online] *Monitor on Psychology*, Vol. 32, No. 11. Retrieved from: <http://apa.org/monitor/dec01/anewtake.html> [Accessed 8 October 2009]
- Bannister, D., & Fransella, F. (1986) *Inquiring Man: The Psychology of Personal Constructs*. London: Routledge.
- Broderick, M.(1990) Self Cancer and Transformation: A Developmental Critique of the Cancer Prone Personality Literatures. Unpublished qualifying paper, *Harvard Graduate School of Education*. In: Kegan, R. (1982) *The Evolving Self: Problem and Process in Human Development*. Cambridge, MA: Harvard University Press.
- Bryman, A (2008) *Social Research Methods* (3rd ed) Oxford: Oxford University Press.
- Cancer Research UK (2009). *Breast Cancer Statistics – Key Facts* [Online]. Retrieved from: <http://infocancerresearchuk.org/cancerstats/types/breast> [Accessed 24 December 2009]
- Catrine, A., Ekman, I. & Ehnfors, M. (2010) A Comparison of the Concept of Patient Participation and Patients' Descriptions as Related to Healthcare Definitions [Online]. *International Journal of Nursing Terminologies and Classifications*, Vol. 21, No. 1, pp.21-32. Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].
- Charalambrous, A., Papadopoulos, R., & Beadsmore, A. (2008) Ricoeur's Hermeneutic Phenomenology: An Implication for Nursing Research [Online]. *Scandinavian Journal of Caring Science*, Vol. 22, pp. 637-642. Retrieved from: <http://web.ebscohost.com/academicsearchcomplete> [Accessed 11th July 2010].
- Chenail, R.J. (1995) Presenting Qualitative Data. *The Qualitative Report*, Vol. 2, No. 3.
- Connolly, M., Grimshaw, J., Dodd, M., Cawthorne, J., Hulme, T., Everitt, S., Tierney, S. & Deaton, C.(2009) Systems and People Under Pressure: the Discharge process in an Acute Hospital [Online]. *Journal of Clinical Nursing*, Vol. 18, pp. 549-558. Retrieved from <http://web.ebscohost.com/cinahl> [Accessed 26 July 2010].
- Core System Group (1998) *CORE System Management Handbook* [Online]. Retrieved from: <https://web.nhs.net/owa/WebReadyViewBody.aspx?t=att&id=RgAAAADcBoOUs2f> [Accessed 24 January 2010].
- Cox, E. and Jackson, P. (2010) Developmental Coaching, pp. 217-230. In: Cox, E., Bachkirova, T., & Clutterbuck, D.(Eds.)(2010) *The Complete Handbook of Coaching*. London: Sage Publications.
- Cox, E., Bachkirova, T., & Clutterbuck, D. (Eds.)(2010) *The Complete Handbook of Coaching*. London: Sage Publications.
- Dean, C. (1987) Psychiatric Morbidity Following Mastectomy. *Journal of Psychosomatic Research*, vol. 31, pp. 385-392. In: Ambler, Nicholas., Rumsey, Nichola., Harcourt, Diana., Fawzia, Khan., Cawthorne, Simon. & Barker, Jane (1999) [Online]. *Journal of Advanced Nursing*, Vol. 29, Issue 2, pp. 445-453. Retrieved from:

<http://web.ebscohost.com/ehost/delivery?vid=33&hid=8&sid=cb4d1cd1-9161-4783-a>.
[Accessed 1 March 2010].

Department of Health, Macmillan Cancer Support & NHS Improvement (2010) *National Cancer Survivorship Initiative (NCSI) Vision* [Online]. Retrieved from:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111230 [Accessed 19 January 2010]

Dowrick, C. (2006) Chickens and Eggs: Examining the Links Between Mental Health and Chronic Disease [Online]. *International Journal of Psychiatry in Medicine*, Vol. 36, No. 3, pp. 263-267. Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].

Dryden, W (2007) *Dryden's Handbook of Individual Therapy* (5th Ed.) London: Sage

Fransella, F. (ed.) (2005) *The Essential Practitioner's Handbook of Personal Construct Psychology*. pp. 3-13. Chichester: John Wiley & Sons.

Fulton, J. S. (1990) Identifying Meaning in the Cancer Experience for Women with Breast Cancer [Online]. *Doctoral Dissertation, Ohio State University*. Retrieved from:
<http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].

Gallwey, T. (1986) *The Inner Game of Tennis*. London: Pan.

Gray, R. E., Doan, B. D. & Church, K. (1991) Empowerment Issues in Cancer [Online]. *Health Values*, Vol. 15, No. 4, pp. 22-28. Retrieved from: <http://web.ebscohost.com/cinahl>
[Accessed 24 August 2010].

Harvard (2007) Do You Worry Too Much? [Online]. *Harvard Health Letter*, January, pp. 6-7.
Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].

Hughson, A., Cooper, A., McArdle, C. & Smith, D. (1986) Psychological Impact of Adjuvant Chemotherapy in the First Two Years after Mastectomy. *British Medical Journal*, Vol 293, pp. 1268-1271. In: Ambler, N., Rumsey, N., Harcourt, D., Fawzia, K., Cawthorne, S. & Barker, J. 1999) [Online]. *Journal of Advanced Nursing*, Vol. 29, Issue 2, pp. 445-453.
Retrieved from: <http://web.ebscohost.com/ehost/delivery?vid=33&hid=8&sid=cb4d1cd1-9161-4783-a>. [Accessed 1 March 2010].

Karakowsky, L. & McBey, K. (1999) The Lessons of Work: Toward an Understanding of the Implications of the Workplace for Adult Learning and Development, *Journal of Workplace Learning: Employee Counselling Today*, Vol. 11, No. 6, pp. 192-201.

Kegan, R. (1982) *The Evolving Self: Problem and Process in Human Development*. Cambridge, MA: Harvard University Press.

Kelly, G. (1963). *A Theory of Personality, The Psychology of Personal Constructs*. New York: W. W. Norton.

Kiecolt-Glaser, J. K., Robles, T. F., Heffner, K. L., Loving, T. J., & Glaser, R. (2002) Psycho-oncology and Cancer: Psychoneuroimmunology and Cancer. *European Society for Medical Oncology*, pp. 165-169.

- Knowles, M.S., Holton III, E.F. & Swanson, R.A. (2005) (5th ed) *The Adult Learner*. London: Elsevier.
- Larsson, I.E., Sahlsten, M.J.M., Sjostrom, B., Lindencrona, C.S.C. & Plos, K.A. E. (2007) Patient Participation in Nursing Care from a Patient Perspective: a Grounded Theory Study [Online]. *Scandinavian Journal of Caring Science*, Vol. 21, pp. 313-320. Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].
- Law, H., Ireland, S., & Hussain, Z. (2007) *The Psychology of Coaching, Mentoring and Learning*. Chichester: John Wiley & Sons.
- Lerner, M.(2009) *Hedging the Bet Against Cancer* [Online]. Retrieved from: <http://www.wellness.org.za/html/articles/a-hedge.html> [Accessed 8 October 2009]
- Lively, K. (2008) Emotional Segues and the Management of Emotion by Women and Men [Online]. *Social Forces*, Vol. 87, Issue 2, pp. 911-936. Retrieved from: <http://web.ebscohost.com/educationresearchcomplete> [Accessed 21 August 2010].
- Low, C. A., Stanton, A. L., Thompson, N., Kwan, L., & Ganz, P. A. (2006) Contextual Life Stress and Coping Strategies as Predictors of Adjustment to Breast Cancer Survivorship. *Annals of Behavioural Medicine*, Vol. 32, No. 3, pp. 235-244
- Lowery, B. J., Jacobsen B. S. & Ducette, J. (1993) Causal Attribution, Control, and Adjustment to Breast Cancer [Online]. *Journal of Psychosocial Oncology*, Vol. 10, No. 4, pp. 37-53. Retrieved from: <http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].
- Maguire, P. (1985) Psychological Morbidity Associated with Cancer and Cancer Treatment. *Clinics in Oncology*, Vol. 4, No. 3, pp. 559-575. In: Ambler, Nicholas., Rumsey, Nichola., Harcourt, Diana., Fawzia, Khan., Cawthorne, Simon. & Barker, Jane (1999) Specialist Nurse Counsellor Interventions at the Time of Diagnosis of Breast Cancer: Comparing Advocacy with a Conventional Approach [Online]. *Journal of Advanced Nursing*, Vol. 29, Issue 2, pp. 445-453. Retrieved from: <http://web.ebscohost.com/ehost/delivery?vid=33&hid=8&sid=cb4d1cd1-9161-4783-a>. [Accessed 1 March 2010].
- Mason, J. (2002) *Qualitative Researching*. London: Sage.
- McDonald, Pat (2005) Breast Cancer: Strength Through Support [Online]. *Practice Nurse*, Vol. 29, Issue 12, pp. 20-21. Retrieved from: <http://web.ebscohost.com/ehost/delivery?vid=218&hid=8&sid=cb4d1cd1-9161-4783-a>. [Accessed 1 March 2010].
- Morgan, M.A.(2008) Considering the Patient-Partner Relationship in Cancer Care: Coping Strategies for Couples [Online]. *Clinical Journal of Oncology Nursing*, Vol. 13, No. 1, pp. 65-72. Retrieved from: <http://web.ebscohost.com/academicsearchcomplete> [Accessed 24 August 2010].
- Nick, G. (2007) *Sickness Syndrome Causes Depression in Cancer Patients* [Online]. Retrieved from: <http://www.LTPonline.com> [Accessed 8 October 2009]
- Palmer, S. & Whybrow, A. (2007) *Handbook of Coaching Psychology: A Guide for Practitioners*. London: Routledge.

- Reilly, D. & Harrison, T. (2002) Creative Consulting: Psychoneuroimmunology, the Mindbody [Online]. *Student BMJ*, vol. 10, pp 97-106. Retrieved from:
http://archive.student.bmj.com/back_issues/0402/education/97.html [Accessed 8 October 2009]
- Rogers, C. R. (1951) *Client-Centred Therapy*. Boston:Houghton-Mifflin.
- Rogers, J. (2008) *Coaching Skills: A Handbook*. Maidenhead. Open University Press.
- Safran, M. D. (2010) Bridging the Artificial Gap Between Physical and Mental Illness [Online]. *Chronic Disease Notes and Reports*, Vol. 16, No. 1, pp. 26-31. Retrieved from:
<http://web.ebscohost.com/cinahl> [Accessed 24 August 2010].
- Scott, H. (2010) The Medical Model: the Right Approach to Service Provision? [Online]. *Mental Health Practice*, Vol. 13, No. 5, pp. 27-30. Retrieved from <http://web.ebscohost.com/medline> [Accessed 26 July 2010].
- Sharpley, C.F. & Christie, D. R. H. (2006) How I was Then and How I am Now: Current and Retrospective Self-reports of Anxiety and Depression in Australian Women with Breast Cancer [Online]. *Psycho-Oncology*, Vol. 16, pp. 752-762. Retrieved from:
<http://web.ebscohost.com/academicsearchcomplete> [Accessed 24 August 2010].
- Shields, C. G. & Rousseau, S.J. (2004) A Pilot Study of an Intervention for Breast cancer Survivors and their Spouses [Online]. *Family Process*, Vol. 43 No. 1, pp. 95-107. Retrieved from:
<http://web.ebscohost.com/cinahl> [Accessed 6th July 2010].
- Silverman, D. (2006) *Interpreting Qualitative Data* (3rd ed.). Thousand Oaks, California: Sage.
- Simon, R. W. & Lively, K. (2010) Sex, Anger and Depression [Online]. *Social Forces*, Vol. 88, No. 4, pp. 1543-1568. Retrieved from: <http://web.ebscohost.com/educationresearchcomplete> [Accessed 21 August 2010].
- Smith, J. & Eatough, V. (2007) in Lyons, E. & Coyle, A (Eds). *Analysing Qualitative Data in Psychology*. London: Sage
- Smith, J. A. & Osborn, M. (2008) Interpretive Phenomenological Analysis. In Smith, J. A. (ed) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.
- Stevens, R. (1995) *Understanding the Self*. Thousand Oaks, CA: Sage.
- Stober, D.R. and Grant, A. M. (eds.) (2006) *Evidence Based Coaching Handbook*. New Jersey: John Wiley & Sons.
- Sugarman, L.(2001) *Lifespan Development: Frameworks, Accounts & Strategies: Theories, Concepts and Interventions*. London: Routledge.
- Thompson, N. & Hammer, M. (2007) Weaving Gold: Transitioning Nursing Practice from a Medical Model to a Nursing Model [Online]. *Oncology Nursing Forum*, Vol. 34, No. 2, p. 1947-1949. Retrieved from <http://web.ebscohost.com/medline> [Accessed 26 July 2010].

Wayne, M. (2001) *At Play in the Fields of Spiritual Medicine* [Online]. Retrieved from:
<http://www.quantumintegralcenter.com/articles.cfm?mode=display&article=2> [Accessed 8
September 2009].

Whitmore, J. (2002) *Coaching for Performance* (3rd Ed.) London: Nicholas Brealey Publishing.

Whitworth, L., Kimsey-House, K., Kimsey-House, H. & Sandhal, P. (2007) *Co-Active Coaching*.
Mountain View, CA: Davies Black.

Wilde, D. J. & Murray, C. D. (2009) The Evolving Self: Finding a Meaning in Near Death
Experiences using Interpretative Phenomenological Analysis. [Online]. *Mental Health,
Religion and Culture*, Vol. 12, No. 3, pp. 223-239. Retrieved from:
<http://web.ebscohost.com/academicsearchcomplete> [Accessed 6th July 2010].

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