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Getting Back to My Life: Exploring Adaptation to Change Through the Experiences of Breast Cancer Survivors

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GETTING BACK TO MY LIFE:
EXPLORING ADAPTATION TO CHANGE THROUGH THE EXPERIENCES OF BREAST CANCER SURVIVORS

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A DISSERTATION

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This is to certify that the dissertation entitled:

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Dr. Tish Knobf, Committee Member date

Dr. John Adams, External Reader date

Dedication

To have practical value, the results of this study should still be recognizable by breast cancer survivors as "their" experience. To achieve this, I used respondents' quotes to illustrate the category descriptions and blend their voices with my analysis of the transition process. The quotes summarize spoken and written words that belong to each of the respondents. I am grateful for the trust the respondents placed in me to interpret and incorporate their words into this study. Without their willingness to take the time to relate their stories to me this study could not have taken place.

Without the support of my wife Joyce, a breast cancer survivor herself, the writing of this study would not have occurred. While her contribution is not visible in these pages, her encouragement behind the scenes was instrumental to my completing it.

I would like to dedicate this study to Joyce and all the women who participated.

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Abstract

The *holding environment* concept, developed by Donald Winnicott, has been used to represent the type of support that encourages adaptive change during psychosocial transitions. The leadership and change literature posited that the holding environment had the ability to shape the trajectory of the transition, yet did not test this empirically. The psychosocial breast cancer literature empirically researched support during and after treatments ended, but did not incorporate the holding environment concept. This presented the opportunity to inform both the leadership and breast cancer fields by studying holding environments in the breast cancer setting. This study had a twofold purpose: 1) to explore empirically the adaptation process using the context of the breast cancer psychosocial transition, and 2) to consider if the holding environment concept, as it is used in the leadership literature, is supported by the results of this study. Grounded theory methodology was used to interpret interviews, diaries, and observation data gathered from breast cancer survivors during the after treatment transition period. This study presented the grounded theory categories in two organizing frameworks, a transition phase diagram and a person-environment situating diagram. The results suggested that the leadership adaptive change literature should integrate an understanding of *coping* and *searching* into organizational change interventions. In addition, incorporating the social interaction represented by *situating* would enrich any attempts to intervene in adaptive change, including the psychosocial breast cancer literature. The electronic version of this dissertation is at Ohiolink ETD Center http://www.ohiolink.edu/etd

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Chapter I: Introduction

Sitting in the breast surgeon's examining room, Joyce and I listened as the breast surgeon revealed that she was "very concerned about the Joyce's imaging results." With those words everything in our lives – except Joyce's health—seemed to "fall away." Things that seemed urgent and critical only days before became suddenly trivial and meaningless. In 2006, my wife Joyce—a conscientious follower of breast cancer screening recommendations—had her annual mammogram. The radiologist asked Joyce to stay for an ultrasound and to schedule an appointment with a breast surgeon to discuss the imaging results, leading to the unanticipated conversation above.

At first there was little time to even consider other matters. After a second breast surgeon opinion, followed by a core biopsy, a breast MRI, a nuclear lymph node scan, an excisional biopsy (a.k.a. lumpectomy), a sentinel lymph node biopsy, a CAT scan, a nuclear bone scan, a PET scan, a pathology study of each biopsy, and an additional opinion from an oncologist, Joyce was diagnosed with advanced stage breast cancer and recommended for a modified radical mastectomy, followed by chemotherapy, radiation, and adjunctive hormone reduction therapy. Within three weeks of her mammogram Joyce went from initial diagnosis to surgery and eight months later she completed her local and adjuvant chemotherapy treatments. In the scheme of things her treatments were a relatively quick process. Adapting to being a breast cancer survivor, on the other hand, is an ongoing process.

Throughout the ordeal, Joyce and I not only had to navigate the process, making many decisions along the way, but were also forced to deal with a world turned upside down. On the one hand we felt lost since we had never experienced anything like this before, yet, somehow we also felt as if we knew what to do and what resources we needed. This paradox

made our experience feel like a roller coaster ride. At the end of the local and adjuvant chemotherapy treatments we were left with an existential question. Now what?

Overview

Throughout the journey we interacted with healthcare professionals, friends and family, the breast cancer culture, and information sources that were mostly helpful, yet at times inappropriate or insensitive. I soon realized that concepts like *psychosocial transitions*, *holding environments*, *transformational leadership*, and *transformative learning* —which I had studied in relationship to leadership and organizational change—seemed to apply to our breast cancer experience.

I wondered, how would each of us adapt, in our own ways, to the changes breast cancer brought to our lives? Did my knowledge, perhaps assumptions is a better term, about leadership and change provide any pragmatic ideas that could be applied to the challenges we faced? Which of the various transition models best fit our experience? How could and/or should I best support my wife, while I myself was going through a transition too? How do we begin to understand such a complex and multidimensional process? These ponderings led to expansion into a research topic.

Problem and Purpose

The transition from receiving a breast cancer diagnosis to living as a survivor[1] involves existential, physical, emotional, social, and psychological issues (IOM, 2004;

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[1] Use of the term "survivor" is fraught with definitional problems, especially in a study focused on psychosocial transitions. There are definitions used by researchers that divide survivorship into phases (for example Mullen, and Welch-McCaffrey), while the National Coalition of Cancer Survivors (NCCS) considers someone a survivor beginning with diagnosis and includes family and caregivers as survivors too (Hewitt, Greenfield, & Stovall, 2006). Add to this the individual's own sense of when they consider themselves to be a survivor (or even if they use the term) and it becomes apparent that it is ambiguous.

Knobf, 2007; Rustøen & Begnum, 2000; S. L. Shapiro et al., 2001; Tomich, Helgeson, & Vache, 2005). These can be challenging, especially when taken in the context of the many decisions that someone with breast cancer needs to make. There is evidence that quality of life (QOL) continues to be disrupted after treatments, and while new knowledge is emerging there are relatively few definitive studies (Helgeson, Snyder, & Seltman, 2004; Knobf, 2007; Thewes, Butow, Girgis, & Pendlebury, 2004; Vivar & McQueen, 2005). Disagreement is found in the breast cancer literature concerning after treatment psychosocial issues (Thewes et al., 2004; Vivar & McQueen, 2005). For example, there are extremes in findings about elevated anxiety levels, ranging from few respondents (Deshields et al., 2005) to most respondents (Holland, 1989) reporting symptoms.

Some breast cancer studies suggest that the bulk of the adaptation comes after treatments and that psychosocial needs are unmet (Lethborg, Kissane, Burns, & Snyder, 2000; Vivar & McQueen, 2005). Appropriately, much of the research focuses on prediction, detection, and intervention to prevent disruption in psychosocial functioning (Brennan, 2001; Maguire, 1995). It is, however, difficult to discern what can be considered "established knowledge" (Glanz, Croyle, Chollette, & Pinn, 2003; Macvean, White, & Sanson-Fisher, 2008; Rustøen & Begnum, 2000).

The lack of clarity makes it difficult for health care providers to know if, when, and where to intervene after treatments end. Without a clear understanding of the transition process it is a daunting task to intervene empathetically, pragmatically, and efficiently. To use Lewin's (1951/1997) metaphor, the individual's life space needs to be re-frozen after treatments. Certainly, resilient individuals are quite capable of achieving this on their own. However, not everyone can and in either case the process is not easy.

This is not unlike the dilemma faced by leaders who have organizational goals to achieve through change initiatives. They ask their members to first endure a difficult process of change. Then, when the dust settles, they must reestablish the organization's life space around work tasks. This is where the similarity between the two psychosocial transitions lie, adapting so that the life space can be reestablished in a state of equilibrium. One of the most intriguing aspects of facilitating the adaptation process is grounded in a developmental perspective, the *holding environment*. The holding environment is made up of social interactions that support or retard the individual's adaptation to impingements. The holding environment concept is developmental because it contributes to an individual's maturation, growth, and adaptation (discussed in more depth below).

Glanz and Lerman (1992) see using a developmental perspective to better understand the adaptation experience as useful. There is also a call to better understand the psychosocial transition *process* as it applies to changes *within* the individual cancer survivor (Brennan, 2001; Kornblith, 1998). Framing the psychosocial breast cancer experience using the holding environment concept model would provide additional insights. This focus is similar to adult development transition models—which have proven useful in understanding leadership and organizational change—where the focus includes the adaptation process, not just the current state, endpoint, or coping behavior.

These models suggest that the change needs to be adapted to if equilibrium is to be maintained or reestablished, or for transformation to occur. In the leadership literature, Heifetz and Linsky (2002) suggested that there is a zone within which adaptive change is most likely (the productive range of distress, p. 108). Heifetz and Linsky saw the holding environment as key to containing anxiety. Conceptualizing an adequate holding environment

as a container is one way to visualize support intended to keep one inside this zone where adaptation is least disruptive (Heifetz & Linsky, 2002).

Deliberating on the above ideas suggested some overarching themes for this study. Who and/or what helped them maintain or regain equilibrium? How and what is it that adapts in our life space? Is the holding environment concept useful in understanding adaptive change? Does the leadership literature help us understand the psychosocial breast cancer transition in any way? Does the psychosocial breast cancer transition inform our understanding of leading change in any way? These themes are considered in more detail in Chapter II.

What is missing is an empirically based understanding of how the holding environment contributes (if at all) to adaptation after breast cancer treatments end. It is possible that current leadership and change theories may hold part of the answer; however, many of them are theoretical not empirical. That is why a grounded theory study that starts with an exploration of the breast cancer survivor's lived experience and discovers the key dimensions that the holding environment plays in the adaptation process, then compares and contrasts that data with existing theories is needed. Two audiences will benefit from this study, those interested in a better understanding of the psychosocial breast cancer transition after treatment, and those interested in how change agents can effectively create or maintain a holding environment.

This study had a twofold purpose: 1) to explore empirically the adaptation process using the context of the breast cancer psychosocial transition, and 2) to consider if the holding environment concept, as it is used in the leadership literature, is supported by the results of this study. This study specifically focused on the transition period after any initial

local and/or adjuvant chemotherapy treatments end. Local treatments focus on the tumor itself; these include surgical removal and radiation aimed at the tumor site. Adjuvant treatments are systemic in nature; these include anti-cancer drugs, commonly known as chemotherapy, hormone therapy, and targeted therapy.

Additionally, based on the review that follows in the Chapter II, this study was sensitive to potential connections between the individual's life space, assumptive world, developmental learning, and critical reflection. The intention was to produce pragmatic knowledge that can be applied by scholars researching interventions for breast cancer survivors, and to add to the knowledge base that considers holding environments critical for adaptation to change.

Framework

This study is an interpretive qualitative design in nature. Interviews and field notes from observations were analyzed using "constructed" grounded theory methods, as defined by Charmaz (2006), to discover and understand the dimensions of those key events and/or relationships (as defined by the respondent) that shaped the transition. Secondary sources of data were sought out to the interview and observation data; this included talking to partners of breast cancer survivors, health care professionals, reading some on-line posting, and reading diaries and blogs of several respondents. This study explored the respondent's perception of her transition from the end of initial local and adjuvant treatments to the current time. This is clearly retrospective self-report data; there was no attempt made to connect it to some objective quality of life measure.

Respondents were breast cancer survivors, who had finished or nearly so with both their local and adjuvant treatments. The rationale for recruiting respondents at this point in

their journey is twofold. First, respondents had experienced much of the total beast cancer health care system by that time and were able to comment on interactions with a variety of individuals. Second, respondents had also faced existential and survivor issues, which they drew upon when answering questions. Initial respondents were recruited using convenience techniques (word of mouth and networking). Additional respondents were determined according to theoretical sampling techniques (Charmaz, 2006; Dey, 1999; Goulding, 2002). Attempts were made to include ethnoculturally diverse respondents, however those who volunteered for interviews were mostly white (see also Chapter III, Methods and Chapter V, Discussion).

Positioning

My background in social/organizational psychology and organizational consulting influenced my curiosity about this topic. In my consulting practice I have worked closely with organizations experiencing major change. The ability of the holding environment to contain anxiety in groups experiencing change is a key component of this work (Kahn, 1995). Improving the quality of the holding environment is a philosophical touchstone for my work with clients.

I find that Edgar Schein's (1988) process consultation method fits this philosophy quite well. According to Schein's definition, "Process Consultation is the creation of a relationship with the client that permits the client to perceive, understand, and act on the process events that occur in the client's internal and external environment in order to improve the situation as defined by the client" (1999a, p. 20). This is similar to "giving the work back" (Heifetz & Linsky, 2002, p. 123) to the client and creating a holding environment, through building the consulting relationship. Not only is this respectful of the client, a value

that is important to me personally, it also helps to create a proactive client who is involved in deciding what *they* should do (Schein, 1999a). This interactive co-discovery extends to my research as well.

My background and training also affects the theoretical perspective I bring to my research. I believe that there is often more data to explore beyond the "presenting" data (Schein, 1988, 1999a, 2003), and that the interactive elements of an interview provide important data too (Ellis, Kiesinger, & Tillmann-Healy, 1997). To understand an individual's behavior and meaning making I also need to know and incorporate something about the cultural and identity groups of which they are a part. I believe an individual's perspective changes based on many factors including but not limited to context, the individual's goal(s) in the situation, and changes in internal and external systemic forces (Charon & Cahill, 2001; Lewin, 1951/1997). An additional factor to consider is my effect on the process.

Even using rigorous attempts to "bracket," "position," or use "participant check-in" (qualitative research techniques that reduce subjective bias introduced by the researcher), the resulting grounded theory produced by this study was ultimately "constructed." It is not a discovered "objective" reality, but an "interpretive" rendering of the breast cancer transition (see Charmaz, 2006). This subject is at the heart of several methodological debates within grounded theory circles and will be touched upon lightly in the research design chapter. The relevance of this theoretical perspective to my position is twofold; my worldview is that a researcher has an affect on their research, which must be accounted for, and that transparency in the research process is vital to establishing credibility with the reader.

The genesis of this particular study was in my own experiences and observations of providing a holding environment during my wife's breast cancer transition from diagnosis to survivor. I am therefore an insider, yet that dividing line is not as clear-cut as it seems. First, in each interaction I had, the "who and what" I represented to the respondent(s) was dynamic and ever shifting (Charon & Cahill, 2001; Naples, 1997). Second, I brought multiple selves to the field (Reinharz, 1997). There are those selves that related to my being a researcher. There are selves that I brought as an individual (i.e. husband, white male, etc.). Then there were the aforementioned situationally created selves that emerged in my interactions with respondents and during data analysis. Being an insider, while especially relevant in this study, is only one of many selves that had an impact.

I was transparent and thoughtful about my insider status, and adjusted appropriately. I did not write nor pretend that I'm a *tabula rasa* that was merely recording and organizing data objectively. I am more than just "the author" in regard to this study and it would have been irresponsible—to the readers and respondents—for me to pretend otherwise. For the reader I have stated above how I came to conduct this study. For respondents I was clear about the study's purpose and my background. During the analysis I wrote notes about my coding including reflection on how I came to code the way I did and I scrutinized my choices. I also sought out feedback from colleagues on the early coding.

Assumptions, Foreshadowing, and Limitations

There is a primary assumption in this study that there are phenomena—the adaptation process and the provision of a holding environment during the breast cancer psychosocial transition—that can be studied empirically. Also assumed is that respondents, through the telling of stories, will make meaning of their adaptation experience during that transition, and

that the dimensions of those experiences can be discerned through analysis with constructed grounded theory methodology. Those stories however will use narrative forms—metaphor, idioms, language, symbols—that are culturally learned and socially interactive within the context of the interview, and do not represent an objective reality, but instead a respondent/researcher socially created reality.

Terms that have a "directionality" to them were avoided in the initial and follow up questions, so that respondents were not guided to present any particular type of story. There is also an implicit assumption that someone who is coping or under stress is having a "bad experience," so those terms were avoided unless the respondent used those terms. This study analyzed mostly retrospective self-report data and there is no expectation that the results mirror clinical assessments of the respondent's current or past psychological state. This study is not intended to assess or evaluate therapeutic interventions, although they were part of the data gathered about the respondent's perception.

Concepts of loss, grieving, and recovery may overshadow other dimensions, and may focus on psychopathological issues that do not apply to all respondents (Bonanno, 2004), and this study took that into consideration. Social and cultural contexts were the primary focus in this study, and it is possible that some of the incongruence in the research literature is due to not taking this into account. Social and cultural influence may play a role in respondents' perceptions and "public" portrayals of their experiences; this study was sensitive to that possibility.

This study was emergent and the focus narrowed to follow categories of interest. There were categories that are part of the respondent's narrative that were not explored further or reported on in this study. Some potential respondents chose not to participate,

these non-respondents may have provided unique data, however, no attempt was made to ascertain that.

Because grounded theory's methods are designed to summarize the main themes in the data into abstract categories, it is not well suited to discovery of non-dominant voices. Every reasonable attempt was made to allow all voices to surface, both during interviews and analysis; however, saturation was achieved in the field much earlier with the dominant voice(s). Therefore, it is speculated that some voices were not heard or uncovered in the data, and that limitation must be acknowledged. By starting within a context of adaptation/adult development and focusing on the provision of a holding environment, this study also privileges that perspective over other perspectives through which the breast cancer psychosocial transition might be viewed.

While my academic background in organizational psychology and leadership studies brings a unique perspective to the study of psychosocial breast cancer issues, it also brings with it limitations. All academic disciplines have their own cultural bias and preferred perspectives. I may not even be aware of those I have internalized. The same can be said about my past vocation of organizational development, and leadership training and development. One way this was offset was through reflection on the assumptions I made during this study.

My insider status - as the husband of a survivor - has the potential to provide me with insights into the process. However, my own experiences could have caused me to have selective hearing and blinded me to alternative meanings. To overcome this other researchers provided feedback at several key points during the coding of data. Additionally,

respondent feedback and check-in was used to ensure that the respondents feel that the grounded theory captures their experiences.

Summary

Chapter II: To structure this study an overview and definition of adaptive change, psychosocial transitions, and holding environment concepts is presented. These concepts focus and provide direction for this study. A brief overview of transition theories and models and transformative learning is presented to provide examples of the scholarly thinking related to similar topic areas. Literature in the leadership and organizational change discipline is reviewed to provide a sense of that literature's perspectives, the foundation for the concepts that frame this study, and the culture of my academic and career background. The field of psychosocial breast cancer research is reviewed along with commentary on selected aspects of that knowledge base. Critical philosophy literature is considered that can inform and improve this study. The chapter concludes with the foreshadowed questions that have their origins in the concepts and literature presented.

Chapter III: Presents the methodology chosen for this study, constructed grounded theory and its theoretical perspective symbolic interactionism. The method is reviewed including data collection and analysis procedures. Procedures to recruit respondents and protect them from harm are covered.

Chapter IV: Results of the study are presented including selected interview quotes to illustrate the various dimensions discovered. Dimensions are presented in organizing categories. A diagram is presented (Transition Phase) that illustrates the connections of the categories graphically.

Chapter V: Interpretation of the results is presented using an additional diagram (Person—Environment Situating). Existing theory is compared and contrasted with this study's results. Discussion of this study's contribution, including implications for future research are put forward.

Chapter II: Conceptualization

Think for a moment about your future. What will you be doing next week? Next year? Five years from now? Who will be there with you? What will you be doing, feeling, seeing, hearing, or tasting? Take a moment, and you can probably even create a persuasive sense of yourself already in that future place. What had to transpire for that future to occur? What had to continue on its current path for that future to occur? What goals do you see yourself achieving in that future? To do that you needed to make some assumptions about how the future will unfold.

Now imagine that those assumptions were disturbed by some positive or negative event, so much so that you could not be sure how the future will transpire, perhaps not even sure how to interpret your past experiences. How would you react? Would you adapt? How would you adapt and reestablish equilibrium? What is it that you adapt, if anything? How does this adaptation progress?

This study focuses on better understanding this adaptation process as it specifically applies to the breast cancer survivor's experience. The core questions of this study emerge from the confluence of my personal experiences with my wife's breast cancer and my scholarly study of leading organizational change. The coming together of these two areas creates an opportunity for each to inform the other, to add to our understanding of the psychosocial breast cancer survivor's transition, and the practice of leading change as well.

The leadership and change literature has investigated the nature of organizational change to a great degree, including the developmental process of adapting to change itself. The psychosocial breast cancer literature, however, has not delved deeply into the processes of adapting to breast cancer (Brennan, 2001; Coward & Kahn, 2005). Therefore, applying

insights from the leadership and change literature adds to psychosocial breast cancer knowledge.

Nonetheless, the theories of psychosocial adaptation found in the leadership and change literature have not been empirically extended to the facilitation of organizational change. In the psychosocial breast cancer literature there is a wealth of knowledge about intervention techniques. Of particular interest is the role that nurse navigators play and how that concept might translate to organizational change facilitation by coaches, mentors, leaders, and consultants. Should the data support respondents finding a type of intervention useful to their adaptation, then connecting that to the leadership and change literature or suggesting ways to explore or test a similar concept in that context would prove useful.

What follows is an overview of concepts that framed this study and are applicable to both leading change and adaptation to breast cancer. These include adaptive change, psychosocial transitions, transition models, holding environments, transformational learning, and critical reflection on assumptions. Those concepts are followed by brief and focused overviews of how the leadership and change literature conceptualized change, the psychosocial breast cancer research, and critical philosophy literature that has implications for this study.

Adaptive Change

Significant change can disrupt a person's life, even when it is positive, creating conditions where that person is faced with a psychosocial transition (Parkes, 1971; Schlossberg, 1981). During the transition, they have the sense of discontinuity in their life space where their assumptive world (see definition below) is challenged, which can cause stress and strain (Adams, Hayes, & Hopson, 1977; Mezirow, 1991b; Parkes, 1971; Spencer

& Adams, 2002). Maintaining equilibrium during this type of transition may require more resilience than they can garner on their own. Heifetz and Linsky (2002) took this further by suggesting that to avoid disequilibrium, people must stay within the "productive range of distress" (p. 108)—a zone where learning and growth takes place—between their threshold of learning (below which is avoidance) and their upper limit of stress tolerance (see Figure 2.1). There is a similar concept, Vygotsky's zone of proximal development, the zone where one[2] learns beyond one's current competence, yet still within one's potential (Horton, 2008; Lisle, 2006; Wennergren & Rönnerman, 2006). I have referred to as the "learning zone" in previous writing (Foster, 2004).

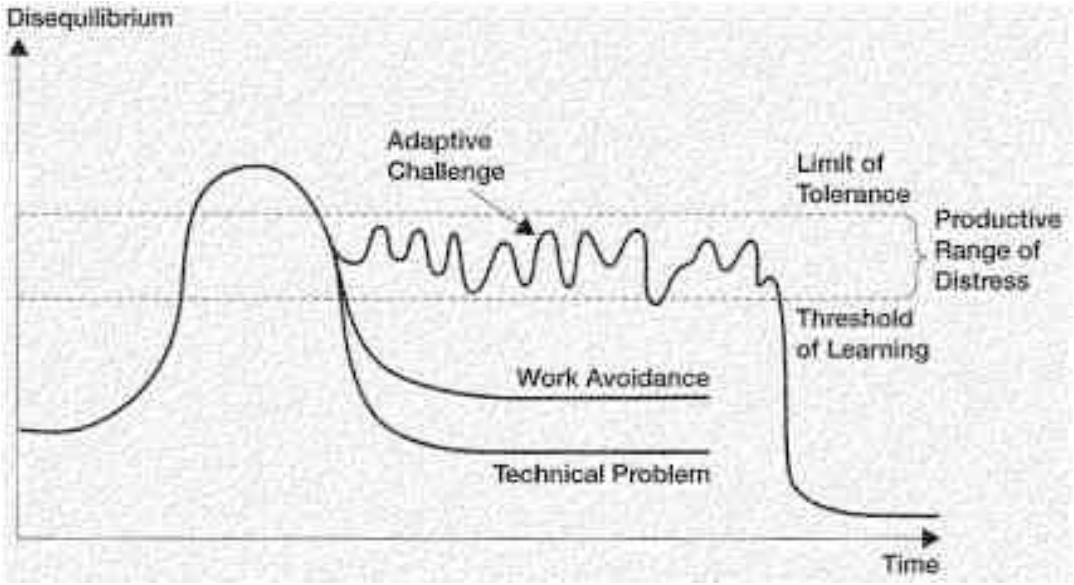

Figure 2.1 – Productive Range of Distress, Heifetz & Linsky, 2002, p. 108 (used with permission)

What is it that is being learned when change is significant? Spencer and Adams (2002), and Bridges (1991) suggested it is how to psychologically integrate the "new" while letting go of the "old." One must learn how to think, be, and act in a life space that is

[2] Vygotsky's zone of proximal development is focused on learning in children, it has however been extended to work with adults (Wennergren & Rönnerman, 2006).

different, a life space that no longer feels or responds in familiar ways.

> The life space is constantly changing, novel stimuli, fresh combinations of events, unique communications from others are received and assimilated. Some of these changes fulfill expectations and require little or no change in the assumptive world, others necessitate a major restructuring of that world, the abandonment of one set of assumptions and the development of a fresh set to enable the individual to cope with the new, altered life space. (Parkes, 1971, p. 103)

This is similar to Heifetz's (1994) concept of technical work vs. adaptive work. Technical work can be done using existing ways of knowing, providing confirmation that what we already know and do still fits our life space. Much of our knowledge is gained through *instrumental learning*, task oriented, understanding cause and effect relationships or *communicative learning*, oriented toward the understanding of others and making ourselves understood (Cranton, 1994).

Adaptive work requires *emancipatory learning*, critical self-reflection on our assumptions, including our knowledge (Cranton, 1994) because what we already know and do won't work with the changes in our life space. For Jack Mezirow (1991b), originator of transformation theory (a.k.a. transformative learning), this inability to apply what we already know is one way our assumptive world can be challenged, which can lead to a "disorienting dilemma" (the quandary that comes from not be able to ignore or distort information that conflicts with meaning perspectives, schemas, or assumptions). Should the disorienting dilemma lead to emancipatory learning *and* changes in one's assumptive world (Mezirow, 1991b, referred to this as "meaning perspective" or "frame of reference") then transformation may occur. This process is known as "transformative learning" (Cranton, 1994; Mezirow, 1991b) and is covered in more depth below.

Adaptive work is not easy and the anxiety created can cause one to take comfort in defensive thinking and behaviors. Heifetz (1994) believes that the leader or change agent

can use a "holding environment" (see section below) to contain the anxiety enough to minimize avoidant behavior, yet still encourage adaptation, so that the individual stays in the productive range of distress and makes a successful psychosocial transition.

There are two central ideas discussed above, maintaining equilibrium and adaptive learning. The implication is that the holding environment decreases anxiety, which increases the possibility that adaptive learning will take place. However, because this study was exploratory the results were based on the data. It was important to this study to discern how those processes contributed, if at all, to adaptation and if the holding environment concept is supported. Therefore, these concepts sensitized me to search for relationships, but I did not use them to organize the results prior to analysis.

Psychosocial Transitions

A "psychosocial transition" is conceived of as "those major changes in life space which are *lasting in their effects*, which *take place over a relatively short period of time* and which *affect large areas of the assumptive world*" (Parkes, 1971, p. 103). Parkes (1971) chose the term psychosocial transition to avoid using terms such as "crisis" and "stresses" along with their connotations. Parkes incorporated Lewin's (1936/1966, 1951/1997) *life space* concept, which integrates the state of both the person *and* the psychological environment, in a dynamic field of interacting forces. The life space concept is compatible with the symbolic interactionism (SI) view of symbols, interaction, and action (Charon & Cahill, 2001). Another aspect of Parkes' (1971) definition, the "assumptive world," is similar to the SI idea of perspectives or cultural frameworks (Charon & Cahill, 2001), Mezirow's (1991b) meaning perspectives, and social psychologists' constructs of schemas (Aronson, Wilson, & Akert, 1999).

> The assumptive world is the only world we know and it includes everything we know or think we know. It includes our interpretation of the past and our expectations of the future, our plans and our prejudices. Any or all of these may need to change as a result of changes in the life space. (Parkes, 1971, p. 103)

Mezirow (1991b) refined this by describing three types of meaning perspectives or assumptions: epistemic (ways of knowing and using knowledge), sociolinguistic (ways we believe, connected to cultural norms and language codes), and psychological (ways of feeling reflected in our self-concept and personality preferences[3]). Charon and Cahill (2001) added to this by pointing out that while there is a physical objective reality out there, "humans see the world through perspectives, developed socially, reality is *social*, and what we see 'out there' (and within ourselves) is developed in interaction with others. We interpret the world according to social definitions" (p. 42). Kegan's (1994) version of constructive-developmental theory[4]—"development of the activity of meaning-constructing" (p. 4)—contended that not only do we see the world through these perspectives, but that we also do not even know we are looking through them[5] (Kegan, 1994, 2000).

Reviewing various constructions scholars have used to describe assumptive worlds, Janoff-Bulman (1992) summed them up:

> Although different terms are used, there is clearly congruence in these descriptions of a single underlying phenomenon. The reference is to a conceptual system, developed over time, that provides us with expectations about the world and ourselves. This conceptual system is best represented by a set of assumptions or internal representations that reflect and guide our interactions in the world and generally enable us to function effectively. (p. 5)

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[3] Cranton (1994) makes an interesting connection between Jung's theories of psychological type/function attitudes and transformative learning.

[4] Kegan (1994, 2000) sees this as progressing in stages where the individual's ability to work with more abstract meaning making leads to increased social maturity (see also Dombeck, 2007).

[5] This is because they are *subject* to us not *object*, and we are embedded in them (Kegan, 1994, 2000)

To have our assumptive world—a conceptual system that guides our interactions and self-predictions about our future—out of balance, explains why a major psychosocial transition can disrupt our life space. "Either an event must be interpreted and explained in such a way as to fit our schemes, which is a difficult and painful task, or our schemes must be altered, an even more daunting task" (Smith-Landsman, 2002, p. 18).

Parkes' specific definition of psychosocial transitions has found its way into both the organizational change and breast cancer literature (cf. Brennan, 2001; Marks, 2007). It has several appealing features that make it ideal as a sensitizing concept for this study. First, it is not tied to any particular theory of developmental stages; it can stand alone as a concept. Second, it is neutral about the impact of the triggering event, allowing for both positive and negative elements simultaneously. Last, it places the interplay between the changes in life space and the effect on the assumptive world as central to the transition.

Holding Environments

From a psychodynamic perspective, the holding environment refers to several related concepts. First, it is used to denote the relationship between the parental figure(s) and the infant/child, from both a physical and psychological perspective. Second, psychoanalysts and social workers use the term to refer to the relationship between the therapist or counselor and the patient(s). Last, the concept of the holding environment is used to describe a supportive "container"[6] for the challenges individuals face in the developmental process (Kahn, 2001; Kegan, 1982; Phillips, 1988). The holding environment concept has been adapted by scholars and practitioners in a variety of fields (Kahn, 2001). Heifetz (1994), for

[6] Container is used in the holding environment literature in a manner similar to that found in group relations writing, (see Bion, 1961/2001; Colman & Bexton, 1975; Colman & Marvin, 1985; Gillette & McCollom, 1995; Obholzer & Roberts, 1994), which Heifetz (1994), Kahn (2001), and Van Buskirk and McGrath (1999) referenced in their writing about holding environments.

instance, employed the concept when he wrote about leading adaptive change in organizations, and he employed a medical scenario as an example of the implementation of the concept.

The concept of a holding environment was developed by Donald Winnicott (1958/1992, 1965a, 1965b), a pediatrician who later also became a psychoanalyst, and one of his colleagues Clare Britton[i] (1955/2004) (later to become Mrs. Winnicott) a child social worker and psychoanalyst. Donald Winnicott's observations of mother-infant relationships lead to his assessment that the social environment was a critical factor in development, and for D. W. Winnicott the mother is the first holding environment (Abram & Karnac, 1997). D. W. Winnicott (1992) said, , "there's no such thing as [just] a baby… if you show me a baby you certainly show me also someone [i.e. caregiver] caring for the baby" (p. 99).

> Winnicott's insight was that "good-enough mothering" involves physically holding infants, whose subsequent experiences of feeling safely encompassed enable the initiation and movement of developmental processes. When mothers (or other primary caregivers) create reliably safe boundaries that protect infants from potentially disruptive stimuli, they enable their children to experience themselves as valued and secure (Winnicott, 1960).… Individual development is thus a gradual strengthening of one's capacity to handle environmental impingement. (Kahn, 2001, p. 262)

Winnicott, his wife Clare, and others also saw the holding environment as extending to their work in therapeutic settings.

> For Winnicott, and those who were influenced by his work, psychoanalytic treatment was not exclusively interpretative, but first and foremost the provision of a congenial milieu, a 'holding environment' analogous to maternal care.… The therapist must have 'a capacity ... to contain the conflicts of the patient, that is to say to contain them and to wait for their resolution in the patient instead of anxiously looking round for a cure'. Cure was not something that the therapist did to the patient. In his consultations with children Winnicott found that the significant moment was the one in which the patient surprised himself. In fact the development of a capacity to be surprised by oneself could be said to be one of the aims of Winnicottian analysis. (Phillips, 1988, pp. 11-12)[ii]

An adequate holding environment is one of the means that enables a successful psychosocial transition. "The premise here is that adults who experience strong emotions often need settings in which to safely express and interpret their experiences, that is, to temporarily regress to intentionally nurturing environments" (Kahn, 2001, p. 263). Holding environments help to contain the tension, anxiety, and stress experienced during psychosocial transitions. The provision of a nurturing environment, however, is similar to some aspects of social support. How does a holding environment differ from the concept of social support?

Helgeson and Cohen (1999) defined social support as having three components, *emotional*, *informational*, and *instrumental*. Emotional support is the expression of caring and concern. Informational support occurs through the offering of guidance or advice. Instrumental support entails providing assistance or material goods. The holding environment concept adds to this a developmental aspect. Social support can enable development, yet development is not central to its effectiveness. In the case of dealing with an illness, social support would be considered successful if it aids in enduring treatments for example. However, for a holding environment to be successful it should also encourage change. Development is the holding environment's raison d'etre.

Starting with Winnicott's concept, Kegan (1982) expanded on it: "There is not one holding environment early in life, but a succession of holding environments… it is an idea intrinsic to *evolution*" (p. 116). Holding environments provide three things that are key to growth: *confirmation*, *contradiction*, and *continuity* (Daloz, 1999; Kegan, 1982). *Confirmation* lets the individual know that her or his ideas and emotions are understood by someone else, yet the other person does not need to agree with those ideas or be experiencing those same emotions directly (Daloz, 1999; Kegan, 1982).

Contradiction exposes the individual to the gap between the old and the new (Daloz, 1999; Kegan, 1982). This creates a state of disequilibrium between the "me-I-have-been" and the "me-I-am-becoming," and in a *good enough*[7] holding environment the individual can experience meaning making that ultimately leads to growth (Kegan, 1982). This state of disequilibrium is similar to Mezirow's (1991b, 2000) idea that one must pass through a "disorienting dilemma" for transformative learning to take place.

Continuity creates the bridge between the old and the new. The provision of a holding environment acts as a transitional element throughout the journey; it "sticks around" and is reliable (Bridges, 1991; Britton-Winnicott, 1955/2004; Daloz, 1999; Kegan, 1982; D. W. Winnicott, 1965b). Mentoring and coaching are examples of the many forms that a holding environment can take (Daloz, 1999; Kahn, 2001).

It is not only individuals interacting with each other that can provide a holding environment. "By creating, managing, and developing a shared task, one function of organizations and institutions is to provide a holding environment similar to that first experienced in the family" (Shapiro & Carr, 1991, p. 77). The health care team creates a holding environment when they work on the shared task of treating the patient's breast cancer. However, whole organizations and individual organizational members can become distracted from their shared task (see Bion, 1961/2001; Rioch, 1975). When this occurs the expectation is that the quality of the holding environment provided by the organization would suffer, just as it would if a mentor lost touch with their task.

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[7] Winnicott not only used the term "good enough" to indicate that the holding environment did not have to be perfect, just good enough, but also that if it were perfect it would lead to dependence because the child would not be able to mature (Abram & Karnac, 1997).

The holding environment concept can be applied to many situations where transitions occur. In a broad sense what is learned in one situation, e.g. social work, has potential application to other situations, e.g. leading change. To understand what role the holding environment plays we must also understand the transition it is supporting.

Transition Theories and Models

There are many transition models and theories. Some are generic in nature (e.g. Bridges, 1980), while others are specific to a phenomenon (e.g. Kendall & Buys, 1998). Some had their genesis in empirical research (e.g. Adams et al., 1977; Mezirow, 1991b), while others were generated using integrative scholarship (e.g. Schlossberg, 1981; Williams, 1999). There are many ways to categorize these designs, and I have created a broad typology that is suited to a brief overview. *Linear and cyclical* designs include stage, phase, recursive, pendular and spiral models. I use the terms stage and phase interchangeably throughout this document. *Interactive* designs include iterative models, field theory, systems theory, and chaos/complexity theory (CCT). A third design typology, *indeterminate*, stems from quantum theory, where indeterminism and participation become the focus.

Stage/phase models. Linear stage/phase models have an intuitive appeal to them. They seem to capture the experience of individuals who have gone through a major transition and even make sense to those who have not. However, this may be because they reflect the way we create narratives and make meaning of our life experiences (see Crossley, 2000), not necessarily the actual progress of events.[8] These models provide some sense of the typical trajectory over time, which is helpful for both understanding transitions and timing interventions.

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[8] Despite this, I have found stage models very useful with organizational change and have adapted Adams, et al. (1977) and Williams (1999, 2001) models in my own work (Foster, 2004).

The trajectory of the transition is plotted using time on one scale and a variable representing some state of the individual or group on the other. In some cases an "objective" measure such as quality of life (QOL) is used; in others a more subjective impact on one's self-concept, stress, or well-being is used (cf. Adams et al., 1977; Bridges, 1991; Heifetz & Linsky, 2002; Williams, 1999), see Figures 2.2 and 2.3. Another variation is to evaluate progress and put less focus on the temporal nature of the phases, which allows for a nonlinear (recursive, spiral or even pendular) path through the phases, yet captures the movement that would be common to most transitions (cf. Kegan, 1982; Livneh & Parker, 2005; Mezirow, 1991b). In other designs there can be multiple potential trajectories, that pass through events or time instead of phases, with different endpoints, see figure 4 (Bonanno, 2004; Helgeson et al., 2004; Knobf, 2007) or the trajectory can have bifurcation points that lead to different outcomes[9] (Foster, 2004; Smith-Landsman, 2002; Williams, 1999).

[9] A trajectory model with bifurcation points has proved quite useful in my organizational change facilitation consulting, yet, one of the drawbacks is that clients often push back saying they feel like they are experiencing being in multiple paths at once or shifting back and forth. Perhaps this is a function of the recursive nature of the path or that the metaphor of being on a path is too restrictive to capture the lived experience.

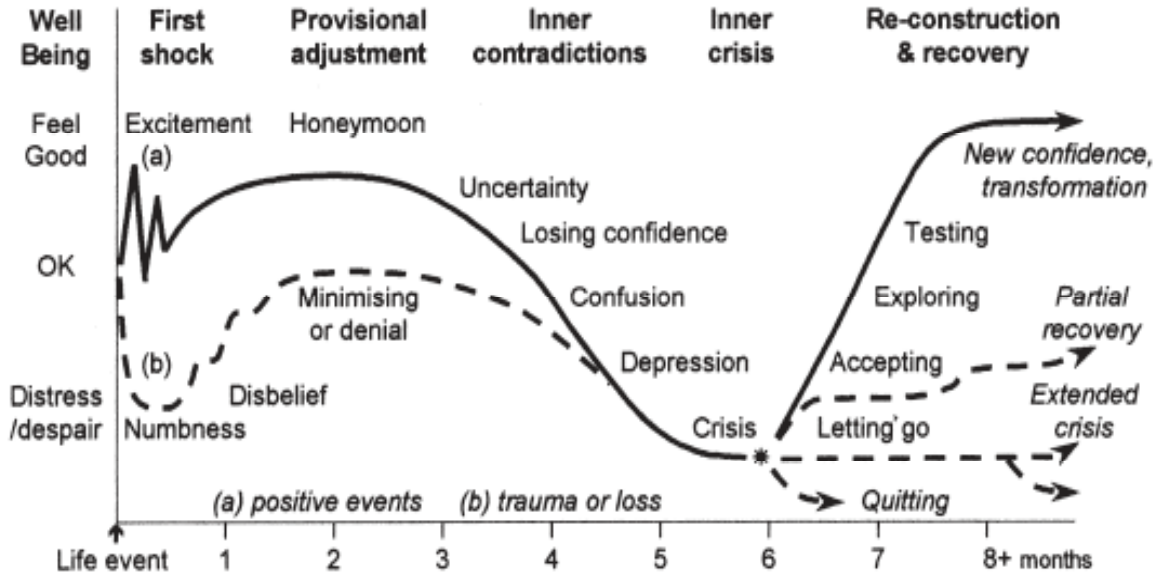

Figure 2.2 – Transition Cycle, Dai Williams, 1999, p. 611 (used with permission)

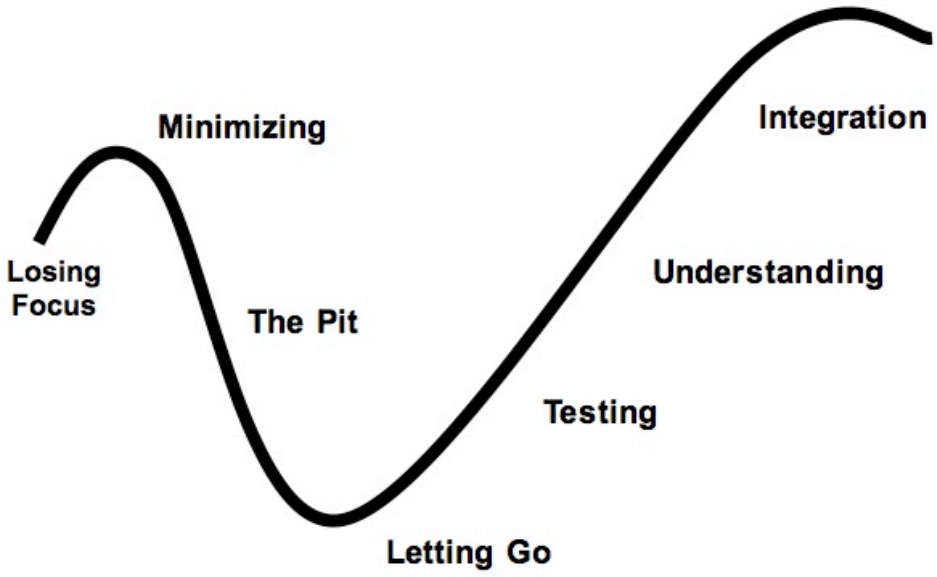

Figure 2.3 - Seven Stages of Transition, Spencer & Adams, 2002, p. 33 (used with permission)

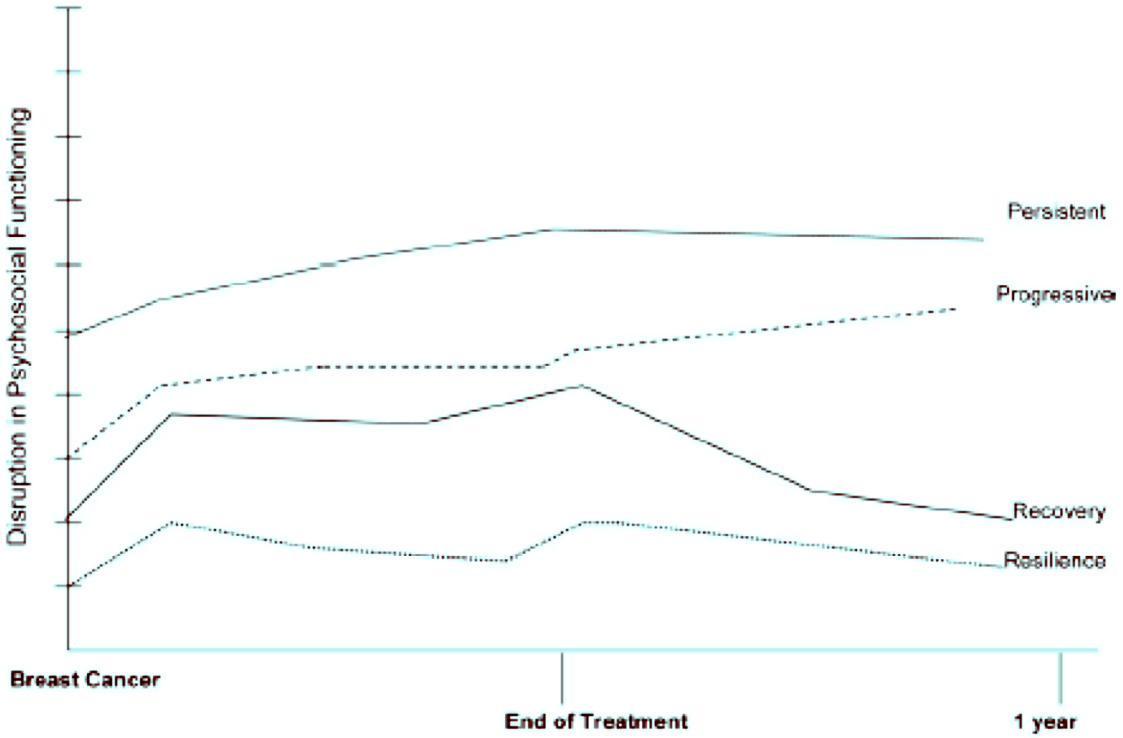

Figure 2.4 – Psychosocial Functioning, M. Tish Knobf, 2007, p. 80 (used with permission)

Interactive models. Interactive models focus less on changes measured against time, and more on the changes and interactions within and among a variety of factors. Some models focus on a large number of factors thought to be relevant to adaptation in general (e.g. Schlossberg, 1981), others focus on factors surrounding a specific type of adaptation or specific dimension (e.g. Brennan, 2001; Livneh, 2001; Smith-Landsman, 2002), see Figures 2.5, 2.6, and 2.7. When applied to transitions these models attempt to account for some or most of these factors: the triggering event (internal or external, perception of event, timing and pace), the duration of the change (permanent, temporary, unknown), the individual's or group's characteristics (psychological, ethnocultural, socioeconomic, demographic, developmental stage, past experience), the environment prior/during/post transition (social support systems, institutional support, instrumental support, informational support, climate of the situation, the physical environment), and outcome variables (intra-system, inter-systems,

extra-system). In many cases these models take the form of a system map and include feedback loops and interactions between factors, providing a sense of the dynamic nature of the elements.

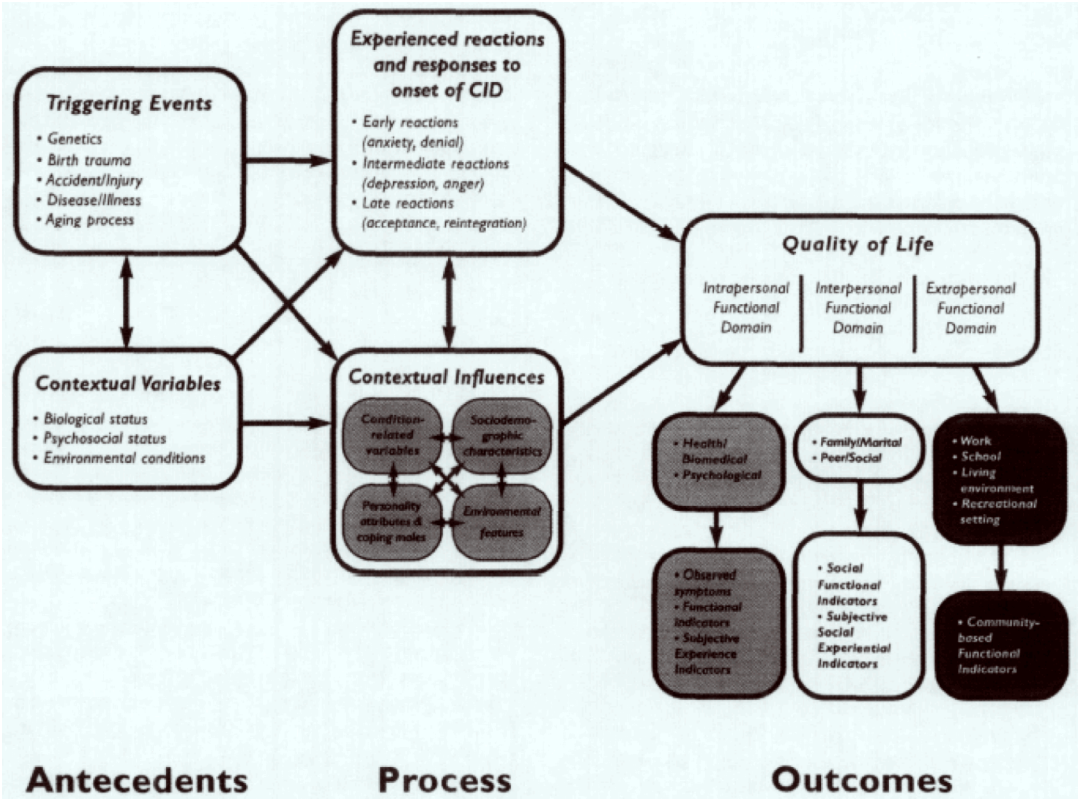

Figure 2.5 – Psychosocial Adaptation to CID, H. Livneh & R. Parker, 2005, p. 155 (used with permission)

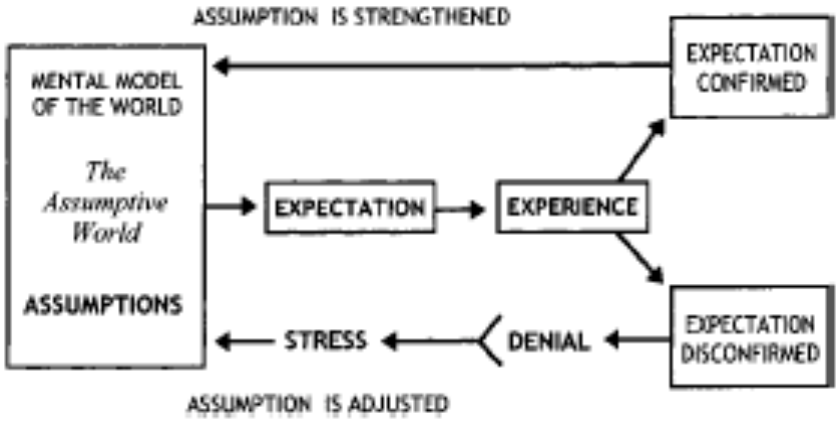

Figure 2.6 – Social-Cognitive Transition, J. Brennan, 2001, p. 8 (used with permission)

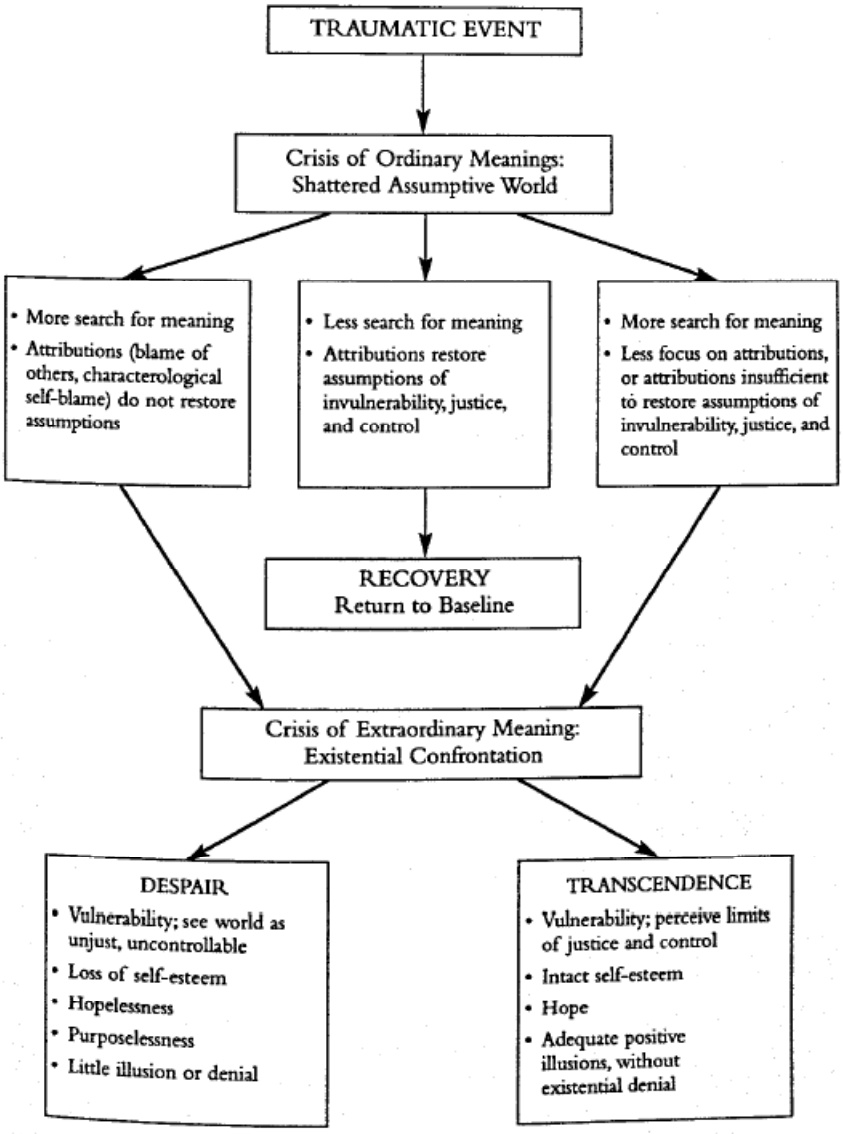

Figure 2.7 – Crises of Meaning, Smith-Landsman, 2002, p. 27 (used with permission)

Schlossberg's (1981) model included most of these factors making it quite comprehensive, perhaps at the expense of being a bit unwieldy. It is similar to what Clarke (2005) refered to as a situational map, "all the analytically pertinent human and nonhuman, material, and symbolic/discursive elements of a particular situation *as framed by those in it and by the analyst*" (p. 87). Lewin's (1936/1966, 1951/1997) life space concept and social field theory are early examples of thinking in this vein.

While Lewin is often portrayed incorrectly as creating linear models—see discussion below and see also Rosch (2002)—his life space concept is in fact an interactive and dynamic model. "The resultant 'life space' is continuously constructed on a moment-by-moment basis from the interaction between the individual and the environment" (Rosch, 2002, p. 10). The focus is on current forces interacting from an intra-, inter-, and extra-individual perspective, including multiple goals of the individual and groups she or he is a member of, and how equilibrium is maintained or reestablished when the life space is changed (e.g. the life space of spouses diagram Lewin, 1951/1997, p. 306). The life space is a unified concept where all factors are mutually influential, and forces change as a situation develops (Rosch, 2002). Equilibrium in these types of system maps could include maintaining movement toward a goal(s).

Lewin's and other's early work on nonlinear systems was expanded on and has evolved into what is now known as "Classic Systems Theory" (Senge, 1998b) or just "Systems Theory" (Marion, 1999). Concepts such as chaos/complexity theory, complex adaptive systems and situated action (Eoyang, 1997; Gharajedaghi, 1999; Ivancevic & Aidman, 2007; Marion, 1999; Olson & Eoyang, 2001; Overman, 1996; Rosch, 2002; Senge, 1998a; Wheatley, 1999) have continued to evolve this line of dynamic nonlinear thinking.

Indeterminate models/quantum theory. As strange as applying chaos/complexity theory may seem, it is still deterministic within probabilistic limits. Quantum theory, on the other hand, is indeterministic in nature and suggests that the results of our measurements of reality are affected by how we measure reality. Therefore the very ways we choose to measure in organizations determine organizational results, not some fixed underlying laws. Caution needs to be used when applying quantum physics to social science subjects, lest

authors like Overman, and Wheatley be seen as making unfounded claims such as those made in the so-called Sokal affair[10] (Crotty, 1998; Fish, 1996; Sokal, 1994). The "new sciences" (Wheatley, 1999) are used as inspiration to think about social sciences in new ways, not to suggest that there is no objective reality.

Quantum theory, when applied to the social sciences provides us with a model that is essentially constructionism (Overman, 1996). To understand a transition using this viewpoint means seeing through the subjective meaning making of each individual. Until the probabilities are collapsed through turning one's attention on the transition itself, the transition is indeterministic. We will not understand what the individual's transition is, nor how it progressed until meaning is made of it. That meaning is socially constructed. The transition becomes participatory in nature, involving meaning perspectives and interactive social processes where the social reality of the transition can change from one moment to the next (Charon & Cahill, 2001). Instead of the model reflecting reality, social reality reflects the tacit models we use in our interactions.

In the quantum social worldview, a metaphor becomes more useful than a model (Overman, 1996). In this worldview, instead of putting energy into measuring reality, it is more productive to construct social reality. Techniques such as appreciative inquiry (Hammond, 1998), appreciative leadership (Schiller, Riley, & Holland, 2001), and action learning (Yorks, O'Neil, & Marsick, 1999) are most applicable.

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[10] Alan Sokal, a physics professor at NYU, wrote a fake article that was published in the journal *Social Text*, in which he made claims about the social construction of physical reality. At the time *Social Text* was not peer reviewed. He exposed the deception after the article was published creating quite a stir about how social scientists misinterpret quantum physics theories. Interestingly, Sokal's article did affect the reality of journal publication by changing the very real social rules of peer review.

Transformative learning theory. Transformative learning theory was pioneered in 1978 by the publication of a study that focused on women community college students who returned to college after a long interruption (Cranton, 1994; Mezirow, 2000; Mezirow & Marsick, 1978; Mumford, Salomone, Farrokh-Tala, & Davidson, 2008; Robinson & Clune, 2001). The foundation for the theory was a grounded theory study that involved twelve investigators conducting more than 100 sets of interviews and field observations (Mezirow & Marsick, 1978). "In line with the principles of grounded theory formulated by Glaser and Strauss, our research objective was to construct a normative description that was derived inductively" (Mezirow & Marsick, 1978, p. 56). By nature, grounded theory studies are exploratory and the researcher(s) avoids allowing preconceptions and existing theories to unduly influence their early analysis of the data (Charmaz, 2006; Dey, 1999; Glaser & Strauss, 1967; Goulding, 2002; Henwood & Pidgeon, 2003; Locke, 2001).

> Transformation theory does not derive from a systematic extension of an existing intellectual theory or tradition such as behaviorism, neo-Marxism, positivism, or psychological humanism. Although I have taken ideas from the work of Jurgen Habermas, for example, I do not write from the perspective of the Frankfurt School with which he is associated, nor have I attempted to interpret systematically what Habermas or any other single theorist has to say about adult learning. (Mezirow, 1991b, p. xiv)

Mezirow's initial study, in keeping with the methodology of grounded theory, was grounded in data about the phenomenon that became known as transformative learning. Mezirow and Marsick (1978), working with a team of researchers further explored transformative learning through additional interviews, case studies, and surveys. This resulted in an initial theory that defined transformative learning.

Transformative learning process. Mezirow (1991b) suggested that transformative learning is a flexible sequence of learning activities with ten phases or moments of meaning clarification (following, pp. 168-169):

1. A disorienting dilemma
2. Self-examination with feelings of guilt or shame
3. A critical assessment of epistemic, sociocultural, or psychic assumptions
4. Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills for implementing one's plans
8. Provisional trying of new roles
9. Building of competence and self-confidence in new roles and relationships; and
10. A reintegration into one's life on the basis of conditions dictated by one's new perspective

In commenting on this sequence Mezirow (1991b) made several observations I will present below along with brief additional commentary from other scholars.

A disorienting dilemma may be triggered by a series of dilemmas or an epochal event such as illness, job change, exposure to eye-opening ideas or cultures, death, life changes, etc. These dilemmas neither require nor compel learning that leads to a change in meaning perspective, therefore a disorienting dilemma does not lead inextricably to transformative learning. Heifetz also discussed a similar concept by differentiating between technical problems and adaptive challenges (Heifetz , 1994; Heifetz & Linsky, 2002). Disorienting dilemmas may not be the only triggers, e.g. finding something missing in one's life could also be a catalyst, and researchers don't yet know why some disorienting dilemmas lead to transformative learning and others do not (E. W. Taylor, 2000).

Critical self-reflection on meaning perspectives, followed by the changing of those perspectives is required for the learning to be considered transformative (Mezirow, 1991b). Brookfield (2000) suggested that as the theory has evolved the importance and meaning of "critical" has been eroded by some scholars (not Mezirow) and that learning is only transformative when assumptions are fundamentally changed, not just understood more deeply. Because cultural norms and assumptions are not fully encoded until adulthood, and they are a major component to our meaning perspectives, transformative learning is considered an adult process (Mezirow, 1991b). Kegan (2000) challenged this notion and considers moving up a level of social consciousness as transformative, even though that move may mean embracing cultural norms not questioning them, i.e. going from an interpersonal to institutional stage of development (Kegan, 1982).

Mezirow (1991b) defined adult development as progressive, with transformative learning leading to ever more advanced meaning perspectives (this concept can also be seen in Kegan's (1982, 1994) work). Movement through the transformative learning sequence involves using others as resources and perspective transformation itself is a social process (this connects to holding environments which was explored above), because it affects how one makes meaning of the world around them (Mezirow, 1991a, 1991b). "Transformative learning results in new or transformed meaning schemes or, when reflection focuses on premises, transformed meaning perspectives" (Mezirow, 1991b, p. 6).[11] Changes in meaning perspective shift one's worldview, which as discussed above, can be a stressful experience (see also Cranton, 1994). Mezirow (1991b) went on to write that, "Perspective

[11] Meaning schemes are "specific knowledge, beliefs, value judgments, or feelings", while meaning perspectives are "rule systems governing perception and cognition" (Mezirow, 1991b, p. 5), in effect groupings of meaning schemes are used in meaning perspectives. For most purposes, frame of reference and worldview can be substituted for meaning perspective (Cranton, 1994).

transformation is the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world" (p. 167). Critical reflection is a fundamental aspect of this process for Mezirow.

Critique of transformative learning theory. Since 1978 Mezirow and others have refined and extended the theory through rigorous scholarly dialog, yet much of the empirical research on transformative learning is in uncirculated dissertations that have not entered into the dialog (E. W. Taylor, 2000). In reviewing this body of research E. W. Taylor (2000) created a critical review that identified areas in need of clarification and further research. However, empirical research done after E. W. Taylor's review has started addressing the need for clarification (Chapman, 2007). In some cases E. W. Taylor's (1997, 2000) reviews touched upon new critiques that originated from his analysis of these uncirculated empirical studies, and in other cases his critique echoed existing debate.

One existing critique suggested that transformative learning theory does not consider the role of others beyond the learner and teacher (Mumford et al., 2008). Mezirow (1997), who actively participated in the debate and refinement of his theory, clarified and pointed to the underlying foundation of social constructivism in his theory:

> What I have tried, apparently unsuccessfully, to communicate is that learning is fundamentally *social.* Our *frames of reference* are, for the most part, culturally assimilated. Critically reflective insights and conflicting beliefs require *discourse* to validate them and to find common meanings of our experience.… Learning is a social process, but it takes place within the individual learner. (pp. 61-62)

The point here is that there are two aspects to consider, that which is learned (internal to the learner), and the social processes by which the learning occurs (both original assumptions and transformations of them). In critiquing or dissecting transformative learning, writers must take into account its underlying social constructivism foundation and

what that implies. For example, Mezirow (1991b) saw *rational discourse*—an active social process of achieving mutual understanding—as essential to transformation. Therefore, transformative learning theory does not rule out the influence of others, quite the opposite, its social constructivism foundation requires us to consider the role others play in the cultural milieu we are socialized in and in the discourses that impact our life space.

However, Mezirow's (1991b, 2000) focus was mostly on institutionalized examples of discourse and he did not delve into the affective side of discourse, an area E. W. Taylor (2000) suggested needs more exploration. In reviewing research that focused on the relational aspects of rational discourse E. W. Taylor (2000) found that subjective elements such as helping, trust, support, and friendship created conditions that were necessary for rational discourse to take place. "It is through building trusting relationships that learners develop the necessary openness and confidence to deal with learning on an affective level, which is essential for managing the threatening and emotionally charged experience of transformation" (E. W. Taylor, 2000, p. 308).

E. W. Taylor (2000) also called attention to findings that suggested that transformative learners need to express and have recognized their feelings—if they are to engage in transformation—in a trusting relationship. This echoes what scholars had written about the benefit of a holding environment during significant change (Daloz, 1999; Heifetz, 1994; Heifetz & Linsky, 2002; Kahn, 1995, 2001; Kegan, 1982, 1994; D. W. Winnicott, 1965b; D. W. Winnicott, Winnicott, Shepherd, & Davis, 1986). The holding environment is formed through an interactive relationship that can help contain the anxiety created during the critical reflection necessary for transformative learning. Two aspects of a holding environment make it especially relevant to the recursive nature of the transformative learning

process; it creates a relational boundary that limits the stress-inducing swings (see Heifetz & Linsky, 2002), and it reliably sticks around even when the individual regresses to an earlier phase in the transformation (see Britton-Winnicott, 1955/2004; Kahn, 2001).

The transformation process also seems to be less linear and more recursive (E. W. Taylor, 2000). Perhaps this is why the process is sometimes described as being similar to a roller coaster ride. This might also explain the inconsistencies in breast cancer quality of life studies (Glanz et al., 2003; Macvean et al., 2008; Rustøen & Begnum, 2000). Instruments used in those studies typically capture snapshots at several points during and/or after treatments. If the process is indeed recursive then the results will depend on whether the subject is ending, repeating, or starting a phase at the moment the instrument is filled out. In addition, E. W. Taylor (2000) saw a need for a long term perspective in transformation research to determine if there is regression over time and also how the individual is behaving differently from before, if at all.

Studies of the breast cancer experience suggested a survivor's life can change in dramatic ways, and in some cases that process seems transformative. In books and articles written by breast cancer survivors there are stories of lives transformed at levels that suggested a changed worldview. In a thorough search of the medical, educational, psychological, and women's studies research literature (including dissertations) only one study was found that specifically mentioned transformative learning and cancer of any type. That study was focused on prevention through participatory research (Goldin Rosenberg, 2000). Therefore, no research that directly used a transformative learning framework has explored the breast cancer transition. This finding is supported by E. W. Taylor's (2000)

work, which suggests that much of the scholarly work on transformative learning is confined to theoretical debate.

However, there are studies that used constructs or reported findings similar to those found in transformative learning theory (Mezirow, 1991b; Mezirow & Marsick, 1978). Coward and Kahn (2005) used facilitation techniques in a support group research design that were similar to those suggested by transformational learning theory (Cranton, 1994). E. W. Taylor (2000) reported that some respondents asked themselves tough even painful questions, which seemed similar to the critical reflection process, and that some respondents had experienced transformation of the "tragedy" of breast cancer. Based on the reported data, it appeared that meaning schemas and/or meaning perspective did change along with new behavior. Halstead and Hull (2001) also reported interview data that had some similarities to critical reflection and transformative learning. It seems clear that in some cases a reflective process questions assumptions during the psychosocial breast cancer transition. What is not clear is how or what might change about those assumptions.

Since the initial transformative learning research was a grounded theory study (Mezirow & Marsick, 1978) it would be in keeping with classic grounded theory methodology to explore the dimensions found in the original study (Glaser & Strauss, 1967) in a new context, that of the breast cancer transition. Using the current model of transformative learning as a framing concept would allow for breast cancer to be conceptualized as a triggering event and then explore for data that would indicate critical reflection, discourse, and action on one's assumptions. Nonetheless, focusing solely on transformative learning would risk undervaluing other aspects of the breast cancer transition. Add to this E. W. Taylor's (1997, 2000) critical reviews and comments on research regarding

relationships and transformation mentioned above, it would seem prudent to use transformative learning theory only as a sensitizing framework.

Critical reflection and transformation. Critical reflection can emancipate one from assumptions and beliefs and even lead to transformation of those assumptions (Cranton, 1994). Brookfield (1987) suggested that most adults are capable of critical thinking, yet they resist questioning personal beliefs and culturally acquired values. Kegan (2000) took this further and proposed that the resistance is better thought of as an inability—based on an adult's current stage of development and their level of embeddedness in that stage —to see their own beliefs and values as assumptions.

Can we predict the circumstances under which someone will overcome this resistance or gain the ability to experience transformation? Interestingly Mezirow and Marsick (1978) found that psychological measurements, such as locus of control, sex role, self-concept, and personal competence did not predict transformative learning, however assessing "expectations, goals, and degree of sophistication with respect to problem awareness" (p. 51) showed promise. Perhaps it is not who you currently are that is so important to transformation, but instead your readiness to change that matters. Kegan's (1982, 1994, 2000) constructive development model may provide a window into the sophistication an adult can bring to doing critical self-reflection work and how the holding environment contributes to that change process.

Brookfield (2000, 2005) suggested that critical self-reflection on assumptions should focus on power relationships, hegemonic assumptions, cultural norms, and the socially created narrative forms we use to create stories about and make meaning of events in our lives. That is quite a tall order. For Brookfield (2000), learning without critical self-

reflection on assumptions leading to a fundamental change in those assumptions, is not "transformative" by transformative learning theory standards.

That is not to say that understanding one's assumptions at a deeper level—*emancipatory* learning—is not important in itself, or that transformative learning is the most valuable type of learning, they are both crucial to development—as is *instrumental* and *communicative* forms of learning (Brookfield, 2000). Instead, Brookfield (2000, 2005) challenged scholars to be thoughtful when applying the transformative label to any change process and to consider what other important processes also underlie adult learning and development.

To fully understand the psychosocial transition process frameworks applied to sub processes such as learning and reflection must allow us to consider a full range of possibilities. For example, Piaget's *accommodate* (modifying existing schemas to match new information) or *assimilate* (incorporating or modifying new information to complement existing schemas) concept may provide one way to frame the outcome of the reflective process (Kassin, 2001; Kegan, 1982, 1994; Smith-Landsman, 2002). Heifetz's (1994; Heifetz & Linsky, 2002) technical vs. adaptive work also comes to mind as a potential frame for learning.

Connections to Literature

In addition to the concepts and ideas mentioned above, several scholarly contexts also need to be considered. The first is the leadership and organizational change literature, which is at the core of my professional and academic background. The genesis of my initial research design was influenced by my knowledge of this literature. Therefore, a selective

review the leadership and organizational change literature will provide a background for the concepts I introduced above.

The second context is the psychosocial breast cancer literature. Prior to this study my exposure to that body of literature focused on gaining knowledge to apply to my wife Joyce and my personal experiences with breast cancer. I was struck by the similarities, at the individual level, to the situation encountered by change agents during second order organizational change. I wondered if there were ideas from both disciplines that might apply to the other.

The third context is critical-philosophical studies (Alvesson & Deetz, 2000). The early proponents of American pragmatism,[12] which had a critical thread running through it (Crotty, 1998), informed constructionism and symbolic interactionism. Brookfield (2005) also connected early pragmatist constructivism[13] and critical theory, then called for them to be reintegrated. Grounded theory methodology has a theoretical perspective of symbolic interaction, which has an epistemological foundation of constructionism (Charmaz, 2006; Crotty, 1998). To connect with this important aspect of grounded theory methodology, some relevant critical-philosophical literature will be reviewed. An overview of the leadership and organizational change, the psychosocial breast cancer, and the critical-philosophical contexts follows.

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[12] Pierce, James, and Dewey were constructionist and critical. Later popularized forms of pragmatism have lost much of its critical nature (Crotty, 1998).

[13] Constructionism and constructivism are often used interchangeably, yet, they are like twins separated at birth, sharing similar origins, but different development (Crotty, 1998). Constructionism focuses on social reality and constructivism on individual meaning making.

Leadership and organizational change. The organizational change literature elucidates the importance of a holding environment during adaptation to organizational change (Bridges, 1991; Heifetz, 1994; Heifetz & Linsky, 2002; Kahn, 1995, 2001; Van Buskirk & McGrath, 1999), yet that literature is not based on empirical research in organizations. Instead the literature is informed by studies and literature in the areas of development (see Kegan, 1982; D. W. Winnicott, 1958/1992, 1965a; D. W. Winnicott et al., 1986), social work and therapy (see C. Winnicott & Kanter, 2004; D. W. Winnicott, 1965a; D. W. Winnicott et al., 1986), and the practice of organizational development consulting (see Kahn, 1995, 2001; Schein, 1988, 1999a; Van Buskirk & McGrath, 1999).

While the contexts in those other disciplines are different from leading organizational change, they were nonetheless informative because of their similarities to the impact of psychosocial transitions on individuals. In the process of applying these ideas leadership and organizational change scholar-practitioners have added to our knowledge of facilitating psychosocial transitions. It would follow then that these leadership and organizational change ideas might also prove useful in shedding light in a different context, that of the psychosocial breast cancer transition.

There is, however, a shortcoming to my background in leadership and change, and the use of these concepts in this study. It is possible that I may be blinded to rival interpretations of the data. Senge (1990, 1995) Sturdy and Grey (2003), and Wheatley (1999) have each suggested that organizational scholars are stuck in outdated paradigms. This can also be read as a warning to consider alternative worldviews.

Psychosocial breast cancer literature. The literature on the breast cancer experience cuts across a multitude of disciplines because it involves biomedical, cultural, healthcare, political, psychological, and social issues. Each of these facets is important, yet utilized individually each is insufficient to fully comprehend the adaptation process during the breast cancer transition. There are many psychosocial breast cancer studies, including methodologically weak and contradictory ones, making it hard to discern what can be considered "established knowledge" (K. Glanz et al., 2003; Macvean et al., 2008; Rustøen & Begnum, 2000).

On the one hand, the literature increasingly acknowledged that women with breast cancer are at higher risk for negative psychosocial outcomes such as: anxiety, reduced quality of life, stress, body image concerns, sexual issues, depression, fear of recurrence, sense of loss, economic and employment concerns, relationship and family distress (see IOM, 2004; Knobf, 2007; Rustøen & Begnum, 2000; S. L. Shapiro et al., 2001). However, breast cancer also has "the potential for positive and negative outcomes… Research that has focused solely on detection of distress and its correlates may paint an incomplete and potentially misleading picture of adjustment to cancer" (Cordova, Cunningham, Carlson, & Andrykowski, 2001, p. 176). This is supported by the results of another study where 75% of survivors reported that the effect breast cancer had been more positive than negative (Tomich et al., 2005). However, Wilkinson and Kitzinger (2000) presented a notable critique of the constructs used in studies purporting to measure positive thinking and methods used to measure internal states. There is also disagreement about the extent and duration of psychosocial distress (Thewes et al., 2004), with studies having reported dramatically different findings (cf. Deshields et al., 2005; Kornblith & Ligibel, 2003; Lethborg et al., 2000; Vivar & McQueen,

2005).

This suggests that the psychosocial breast cancer transition is complex, and that psychosocial adaptation to breast cancer may not be fully understood. Some of the disagreement may be due to different definitions of psychosocial distress, measurement techniques, disciplinary bias, or research methods. Appropriately, much of the research focused on prediction, detection, and intervention of disruption in psychosocial functioning (Brennan, 2001). Nonetheless, there is also a need to better understand the psychosocial transition process as it applies to cancer, because few models specific to cancer have been put forth (see Brennan, 2001; Coward & Kahn, 2005; Kornblith, 1998). Because this study is focused on understanding the holding environments influence on the transition process, studies focused only on detection, medical sequelae, and/or intervention are not reviewed. Brennan (2001) asked, "what are the components of a normal 'adjustment' to cancer, what is it that is being 'adjusted' and what processes are involved?" (p. 2).

Several studies have suggested that there are adaptive patterns or trajectories[14] (Deshields, Tibbs, Fan, & Taylor, 2006; Helgeson et al., 2004; Knobf, 2007). Further research is needed to understand how this concept improves our understanding of the breast cancer transition (Knobf, 2007). Helgeson et al. (2004) discovered empirical support for trajectories within the breast cancer transition, which lends support to Knobf's (2007) and Bonanno's (2004) writing, although Helgeson did not reference other trajectory literature. Results from some studies have explicitly suggested trajectories (Knobf, 2007), while others have privileged one path as normal and implicitly suggested other paths by labeling some

[14] The studies cited in this section do not all gauge the path of the same psychosocial functions. Strauss' (1987) ideas also suggest that even when predicting the future trajectory of the physical side of an illness for an individual there is a socially constructed aspect to it since accurate prediction at the individual level is not often possible with illness that is not in a terminal phase.

respondents as "stuck" (Carpenter, Brockopp, & Andrykowski, 1999; E. J. Taylor, 2000). Because this study was concerned with understanding "normal adjustment" to breast cancer, the focus was on resilient or recovery trajectories, not those that involve psychopathology.[15]

Corbin and Strauss (1992) had put forward trajectories in the context of chronic illness and also pointed out that actual illness trajectories are retrospective, while future trajectories are only projections. Strauss (1987) connected projected trajectories to meaning schemas through the concept of *trajectory schemas*: the anticipated tactic(s) that will be used by the patient, spouse, and/or others to influence the path (see pp. 189-198). Strauss and his research associates delineated a framework that utilized the concept of trajectory to describe the shaping process used when managing chronic illness (Corbin & Strauss, 1992), which may be informative to the interpretive section of this study.

Starting with Strauss' chronic illness trajectory model, Diane Scott Dorsett (1992) related it to cancer as a chronic disease; she focused on the trajectory of recovery and theorized a model that included dimensions of survival, growth, and change. These dimensions suggested a transition process that includes many psychosocial issues. Empirical studies that focused on the time period after initial treatments end support this, however, they did not present models of the process.

In one study of psychosocial needs after treatments, dimensions such as: emotional, and practical support from family and friends; emotional support and reassurance from medical staff; a desire to *move on*; information seeking; and *debriefing* with peers were uncovered (Thewes et al., 2004, pp. 183-184). These dimensions suggested a psychosocial transition supported by a holding environment. Lethborg et al. (2000) also presented data

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[15] I will not attempt nor am I qualified to ascertain if any of the needs or symptoms respondents report would be considered a psychological disorder.

from their study that supports this.

> It was not until the trauma and threat of treatment was over that these women were able to really process their fears and existential issues. During the interview, they talked about notions of recovery; determination to survive; and interpreting, reconsidering, and reordering their experience. (p.83)

Lethborg et al. (2000) continued and discussed their after treatment findings as representative of a "reintegration" back into life, and pointed out difficulties respondents reported due to reduced support, disruptions in psychosocial aspects of their lives, and an urgent need "get on with their lives" (p.88). Again, these findings suggested a transition process, but Lethborg et al. stopped short of integrating their findings into a process model or theory. However, their study's method was thematic analysis and their intention was to provide descriptive results and make recommendations for care intervention, which their study did achieve.

The findings from these two studies suggested that there is a transition process after the end of initial treatments. When their results are considered in light of Strauss' concept of "shaping" the trajectory (Corbin & Strauss, 1992; Strauss, 1987), we find similarities to the use of the holding environment concept by leading change scholars (Heifetz, 1994; Heifetz & Linsky, 2002; Kahn, 1995, 2001), suggesting that the concept may be useful in the context of the breast cancer transition.

Trajectories or paths are often incorporated into psychosocial transition models, (cf. Adams et al., 1977; Bonanno, 2004; Williams, 1999). Bonanno (2004) proposed trajectories, he called them prototypical patterns, in his diagram of transitions after aversive events, and Knobf (2007) integrated Bonanno's diagram with her own research to create a theoretical rajectory of psychosocial functioning for breast cancer survivors. Heifetz and Linsky (2002) suggested that there is a zone within which an adaptive path is most likely and saw the

holding environment as key to an individual staying within this zone. Heifetz and Linsky's zone is an attempt to shape the trajectory, something that Strauss' model proposed (Corbin & Strauss, 1992; Strauss, 1987).

The suggestion here is that change agents can influence the holding environment, which can shape the psychosocial trajectory during the transition. Effective social support, one element of the holding environment concept, seems to make the breast cancer transition more manageable (Arora, et al., 2007; Helgeson & Cohen, 1999; IOM, Hewitt, Herdman, & Holland, 2004; Knobf, 2007; Kornblith et al., 2001; Lugton, 1997), however, it needs to be fitting for the individual and circumstance (Reynolds & Perrin, 2004). It was difficult to discern from this body of research the process through which the holding environment might work during the breast cancer transition, if at all. For example, when a partner was trained to be a "coach" along with attendance in a support group it is not clear whether the eventual point reached is an improvement over where most individuals would have gotten on their own or even if the journey was more bearable because of the intervention (see Samarel, Fawcett, & Tulman, 1997). Yet, theoretically and intuitively the expectation is that an intervention to improve the holding environment should have a positive effect.

A study by Coward and Kahn (2005) may shed some light on this. In their study, the treatment group attended support group sessions that were specifically designed to facilitate self-transcendence, while the comparison group was only provided with assistance and information about community support groups. Despite low attendance at community support group meetings by the comparison group, they had experiences similar to the treatment group of "transcending" breast cancer (Coward & Kahn, 2005). In both groups the women reported reaching inward, outward, and accepting support from others.

In neither of these examples was the quality of the intervention's design questionable; in fact, both were quite well designed. What was not taken into account prior to the implementation of each study was the adaptation process *without* facilitation, the role an individual's holding environment plays in that adaptation, and the timing of the intervention. Knobf (2002) presented the concept of *carrying on* in her study of premature menopause caused by breast cancer treatments. *Carrying on* allowed the women in Knobf's study to: "become focused on doing what they have to do to get through their treatment and manage their roles and families" (Knobf, 2007, p. 72). Similar concepts like "getting through" (Lethborg et al., 2000) and "survival mode" (Thewes et al., 2004) are noted in other studies specific to the after treatment transition.

These concepts are reminiscent of the sentiment I have heard organizational members express during major organizational change efforts, a tunnel vision like focus on getting through the changes while maintaining some sense of life balance, with the hope of returning to some sense of normal when the dust settles.[16] Perhaps this is a protective strategy that resilient individuals employ (Bonanno, 2004), that was not accounted for in the Samarel et al. (1997) or Coward and Kahn (2005) studies. Utilizing a protective strategy may lead to the hiding of emotions and distress (Cowley, Heyman, Stanton, & Milner, 2000; Knobf, 2007).

The Samarel et al. (1997) or Coward and Kahn (2005) studies focused their facilitation efforts during the initial treatment phase. However, emotions and distress are often processed near or after the end of treatments and the breast cancer survivor's needs during this time are typically unmet (Lethborg et al., 2000; Thewes et al., 2004; Vivar & McQueen, 2005). The holding environment has the potential to allow those emotions to be

[16] In my consulting practice I have facilitated many small group discussions during organizational change initiatives where participants have shared their experience with the group.

safely experienced so that the individual can temporarily regress and then pull them selves back together so that they can continue (Kahn, 2001).

It is uncertain how the process of adaptation progresses during the breast cancer transition and how the holding environment contributes, if at all, to that process. Is it possible that current techniques of change facilitation only mildly improve on adaptation that follows the recovery or resilience path suggested by Bonanno (2004) and Knobf's (2007) models? Does Heifetz's (1994) variation on the holding environment concept as a container during adaptation provide a better guide for change agents looking to support the adaptation process? If meaning schemas and perspectives (Janoff-Bulman, 1992; McCann & Pearlman, 1990; Mezirow, 1991b; Parkes, 1971; Smith-Landsman, 2002) are a large part of what adapts, should change agents consider mentoring or facilitating emancipatory learning?

It is possible that current theories presented throughout this chapter may hold part, none, or all of the answer, however, many of them are theoretical not empirical. Those that are empirical either differ in their results or leave gaps in our understanding of the transition process in the breast cancer context. That is why a grounded theory study that starts with an exploration of the lived experience and discovers the key dimensions of the breast cancer survivor's adaptation process, then compares and contrasts that data with existing holding environment theories is needed. This will ground our understanding of the process in the lived experience and suggest future avenues of research for *both* psychosocial breast cancer and leading change.

Exploring and diagramming the provision of a holding environment by change agents in support of the psychosocial breast cancer transition will help to shed more light on the process in that context. In the leadership and change context the literature that focuses on the

provision of a holding environment is not empirical (cf. Heifetz, 1994; Heifetz & Linsky, 2002; Kahn, 1995, 2001; Kegan, 1982, 1994). Therefore, this study will add additional empirical evidence to that body of literature, and will also generate research questions to be explored in future studies within an organizational context.

Critical–Philosophical Considerations

To some extent all studies are subject to social, political, cultural, economic, and even psychological influences. Unfortunately, *naïve realism* assumptions[17] (Shadish, Cook, & Campbell, 2001)—perhaps *scientific realism* (Schwandt, 2001) is a better term—keeps these influences from being considered openly in most studies (Shadish et al., 2001). Critical-philosophical studies (Alvesson & Deetz, 2000) are well suited as a "think outside the box" reminder for researchers during the design, analysis, and reporting phases.

In the breast cancer literature for example, King (2004) explored the changes in public discourse about how breast cancer is viewed; Bricker-Jenkins (1994) connected feminist practice to breast cancer treatment and healing; Thorne and Murray (2000) questioned how the Western biomedical culture shaped the breast cancer experience, including the choices made available to and decisions made by patients; Wilkinson and Kitzinger (2000) very effectively critiqued the constructs used in psychosocial cancer instruments, and challenged researchers to probe deeper into what cancer patients mean when they use idioms and metaphors during their interview narratives; and Petersen (2004) looked at historical constructions of breast cancer and their affect on the patient's relationship to the medical system, breast cancer advocacy, and public health.

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[17] That, "…scientific studies somehow directly reveal nature to us…" (Shadish et al., 2001, p. 28)

In organizational and leadership literature the critical voices seem muted, yet they still challenge the reader to think differently. Mary Parker Follett (Follett & Graham, 1995) encouraged us to conceptualize power beyond its coercive side to include a collaborative *power-with* versus a *power-over* construct. This perspective challenged one aspect of traditional leadership definitions and applies to patient/doctor relationships, a relationship Heifetz (1994) used as an example when considering the holding environment and authority. Wheatley (1999) posed that the Western organizational paradigm we use today is outdated because it is too deterministic; Sturdy and Grey (2003) and Marshak (1994) labeled current models of organizational development as too mechanistic and linear; Senge (1990) suggested we need to change the very way we think about cause and effect. Each of these challenged our thinking about interventions by change agents. Rost (1993) in his criticism of many of the leadership scholars that preceded him felt that the mainstream leadership discourse was colored by the industrial paradigm of the time, suggesting that our understanding of leadership is colored by the culture it is embedded in. These critical perspectives might be labeled as a postmodern call to question our Newtonian worldviews about organizations, change, and leadership.

Critical-philosophical research has a postmodern perspective that challenges our taken for granted thinking, and "the average person interested in social research has little interest or tolerance with an intellectual orientation that problematizes everything that social research tries to accomplish" (Alvesson, 2002, pp. 1-2). Alvesson continued by pointing out that most critical researchers have not offered us much in the way of pragmatic advice for the very challenges they exposed. The lack of applied advice does not diminish the importance of these perspectives: they still compel us to think critically.

"All research is, in a sense critical. The rule is that one does not accept any claims without careful monitoring of the reasons and other kinds of support for them" (Alvesson & Deetz, 2000, p. 8). Alvesson and Deetz (2000) went on to suggest Brookfield's delineation of the critical thinking process as useful to researchers. Brookfield (1987) defined critical thinking as: identifying and challenging assumptions, developing a *contextual awareness* regarding cultural and historical influences on ideas and behaviors, developing *reflective skepticism* about our own and others ideas, and exploring and imagining alternatives (pp. 15-23). Thinking critically about research can allow unseen patterns to emerge from the data, stimulate follow-up questions to probe the respondent's meaning making, and add depth to understanding the relationships among discovered categories.

Critical thinking can be an antidote to ossification in research, yet there are the risks of problematizing established knowledge, and starting from scratch only to "reinvent the wheel" (Alvesson & Sköldberg, 2000). Balance between these was an important consideration in this study. To achieve this a pragmatist orientation was used. "Pragmatism [in postmodern social research] means a balancing of endless reflexivity and radical skepticism with a sense of direction and accomplishment of results" (Alvesson, 2002, p. 15).

Foreshadowed Questions

There was no expectation that all, or for that matter any, of the concepts presented in this chapter would prove useful in understanding the data gathered from respondents. They are presented here in the interest of transparency, to not only alert the reader to ideas that sensitized me prior to the study, but also provide me with an awareness of where additional scrutiny of my analysis of the data might be needed. While the concepts discussed above lead to this study, they did not "overpower" the data and force the data to fit a preconceived

theory or concept (Alvesson & Sköldberg, 2000; Charmaz, 2006; Glaser & Strauss, 1967). To force the data would be to frame the data using preconceived notions from existing theory (Glaser, 2002). Therefore, they were introduced here as concepts that only sensitized me to the phenomenon (Alvesson & Sköldberg, 2000; Blumer, 1969; Charmaz, 2006) and provided an entry point from which to begin exploration. In effect, through induction the data provided a framework which a concept or theory had to fit to earn its way into the final grounded theory.

The concepts of adaptive change, psychosocial transitions, transition models, holding environments, transformational learning, and critical reflection on assumptions have been reviewed above. Many questions were surfaced, more than one empirical study could hope to explore. However, it was also clear from the above that to understand the role of the holding environment during the transition, there must be clarity about the adaptation process. To understand the role of the holding environment we need to know what is adapting that the holding environment is in service to. Meaning schemas, carrying on, critical thinking, piecing back together one's life space, keeping one's life space from falling apart, something else or all of these? Therefore this study's first task was to establish the broad dimensions of the adaptation process, followed by an exploration of support for the holding environment.

The main focus of this study was to better understand the adaptation process during a psychosocial transition. A secondary focus was to integrate or contrast current theoretical models with the results from this study's analysis. Therefore this study (as mentioned above) had a twofold purpose: 1) to explore empirically the adaptation process using the context of the breast cancer psychosocial transition, and 2) to consider if the holding environment concept, as it is used in the leadership literature, is supported by the results of this study.

Grounding those tasks in empirically gathered data contributed to both the psychosocial breast cancer literature and the leadership literature. The psychosocial breast cancer literature benefited from a process-oriented exploration of the transition. The leadership literature benefited from empirical scrutiny of the way in which scholars have applied the holding environment concept to psychosocial transitions.

This study focused on the processes involved in adaptation during the psychosocial breast cancer transition, which is a developmentally focused approach and broader in scope than support, coping, or learning. Adapting Brennan's (2001) suggestions for fruitful research questions about the cancer transition process[18] to the concepts presented above, there are several overarching questions. What are the broad dimensions to the adaptation process during the psychosocial breast cancer transition? What is it that adapts and how? Does the concept of a holding environment add anything to our understanding of the process? To explore these questions a constructed grounded theory methodology was chosen.

[18] I still only used Brennan's (2001) transition model (derived through integrative scholarship to answer his own question), as a sensitizing concept.

Chapter III: Research Design and Process

This study had a twofold purpose: 1) to explore empirically the adaptation process using the context of the breast cancer psychosocial transition, and 2) to consider if the holding environment concept, as it is used in the leadership literature, is supported by the results of this study. This study specifically focused on the transition period after any initial local and/or adjuvant chemotherapy treatments end. Additionally, based on the review from Chapter II, this study was sensitive to potential connections between the individual's life space, assumptive world, developmental learning, and critical reflection. The intention was to produce pragmatic knowledge that can be applied by scholars researching interventions for breast cancer survivors, and to add to the knowledge base that considers holding environments critical for adaptation to change, such as the leading change literature.

Methodology

Several methods were considered before deciding on constructed grounded theory. As pointed out in Chapter II a review of the psychosocial breast cancer literature suggested that the transition process is not fully understood in that context and that the leadership literature's use of the holding environment concept is based on anecdotal not empirical data. Therefore, a method that would provide a representation of the breast cancer transition process that could be used to examine the usefulness of the holding environment concept was needed. The study's exploratory nature suggested a qualitative method. The need to scrutinize the holding environment concept would be facilitated by a diagram or template of the process. Grounded theory met these needs and provided an additional benefit of generating additional hypotheses that could be tested in future research.

Grounded theory. Grounded theory methodology was chosen for this study because its features and procedures are well suited to this study's purpose. Grounded theory allows the researcher to explore a phenomenon and organize the results as a diagram or theory, while remaining "grounded" in the data. Grounded theory is also pragmatic because of its foundation in symbolic interactionism, and its connection to data from real world situations.

Constructed grounded theory variant. This study used grounded theory methodology as explicated by Kathy Charmaz (2006), and also by Henwood & Pidgeon (Henwood & Pidgeon, 2003). Charmaz presents her variation as an update to "classic" grounded theory that was first presented in its entirety by Glaser & Strauss (Glaser & Strauss, 1967) in *The Discovery of Grounded Theory*[iii]. Grounded theory's founders have since diverged in their thinking, creating at least two main branches or variations on the classic method (Birks, Chapman, & Francis, 2006; Charmaz, 2006; Dey, 1999; Goulding, 1998, 2002; Heath & Cowley, 2004; Henwood & Pidgeon, 2003; Locke, 2001). As qualitative methodology has evolved, researchers have attempted to update grounded theory (Annells, 1996; Charmaz, 2000, 2006; Clarke, 2005; Goulding, 1998; Henwood & Pidgeon, 2003). A third variation can now be delineated, constructivist grounded theory, that differs from the Glaserian and Straussian variants (Birks et al., 2006).

Charmaz (2000, 2003, 2004, 2006) has developed this constructivist variant over time, along with others (Annells, 1996; Clarke, 2005; Goulding, 1998; Henwood & Pidgeon, 2003). In Charmaz's (2006) *Constructing Grounded Theory* she clarifies the major differences in her variation: a rejection of the objectivist or detached researcher stance, and flexible yet rigorous procedures[iv]. This returns grounded theory to a theoretical

perspective—constructivist/interpretivist—that is congruent with its symbolic interactionism roots, while maintaining the pragmatist nature of the theory-generating procedures.

Theoretical perspective: Interpretivism—symbolic interactionism. Grounded theory's symbolic interaction roots came from Strauss' sociological training at the University of Chicago as a student of Blumer, who in turn was a student of Mead (Alvesson & Sköldberg, 2000). Charmaz (2006) retains the symbolic interaction influence as constructed grounded theory's philosophical underpinning. While grounded theory does not simply mimic symbolic interaction (SI), there are recognizable central features: pragmatism (SI has been critiqued for not retaining the critical nature of early pragmatism), idiographic research, qualitative data as primary, a focus on exploration, the use of sensitizing concepts, the importance of interactive social action, meaning as primarily cognitive (a critique of SI is that it underestimates the emotional aspects of meaning), successive induction of empirical data (intense study of single cases followed by comparison between cases) (Alvesson & Sköldberg, 2000, pp. 13-15). Several of these features can be seen in the methods' procedures.

The influence of pragmatism is best seen in the final resulting grounded theory or diagram that should be recognizable to the respondents as an abstraction of their lived experience of the phenomenon (Länsisalmi, Perió, & Kivimäki, 2004). The aim of the abstraction is a representation of practical empirical reality (Alvesson & Sköldberg, 2000), which fits the symbolic interaction tradition of eschewing grand or general theories (Denzin, 1992).

Grounded theory is an idiographic research method because it focuses on particular cases of a unique phenomenon, instead of seeking out large amounts of data from which to

generate general theories. This includes using successive induction where individual cases are first studied intensively, then compared between cases to generate the grounded theory (Alvesson & Sköldberg, 2000).

Blumer, who coined the label symbolic interactionism, is also credited with the idea of sensitizing concepts (Charmaz, 2006), which grounded theorists use to begin their studies. These concepts guide the empirical interests that frame the study and stimulate the ability to see new patterns. Glaser and Strauss (1967) however cautioned the researcher to not cross the line and start out with preconceived ideas, because it limits the ability of the grounded theory to fully emerge. They even suggested that at first the researcher might, "literally ignore the literature of theory and fact on the area of study" (p. 37). This should not be interpreted as a suggestion to attempt or pretend to be a *tabula rasa* when starting a grounded theory study (Alvesson & Sköldberg, 2000). Glaser and Strauss (1967) do not expect the researcher to erase or forget all the theory she or he knows, instead they wrote that, "the trick is to line up what one takes as theoretically possible or probable with what one is finding in the field" (p. 253).

One of the findings grounded theorists analyze are sequences of action and interaction in processes (Charmaz, 2006; Strauss & Corbin, 1998). Interactive social action and symbols are at the heart of symbolic interactionism (Charon & Cahill, 2001). Action is the result of a two step process where meaning is first created in interactions, and then used in a formative process to interpret a situation (Blumer, 1969; Charon & Cahill, 2001). This perspective allows grounded theory to capture the dynamic and interdependent nature of action, interaction, context, and meaning making.

Method

Analysis procedures. The primary data sources consisted of interview transcripts, group observations, and respondent diaries or blogs. Secondary data sources included popular literature that recounts the experience of breast cancer, educational material provided to breast cancer patients and family, and interview field notes. These additional data sources provided triangulation for the primary data. The main categories extracted from the analysis are discussed in the results section, and relevant literature is incorporated to better understand and explicate the grounded theory created.

Analysis started as soon as there were several interviews to work with. Initial codes and memos were written down while listening to the interview recording for verification of the transcript. The transcripts were then coded further using the qualitative data analysis (QDA) software NVivo. Analysis procedures and the labels given to those procedures vary from author to author. In general, coding is first used to define what the data are about, then the constant comparative method (Charmaz, 2006; Strauss & Corbin, 1998) is used to discern emerging patterns and integrate them into categories, followed by the creation of a theoretical framework (Charmaz, 2006; Goulding, 2002; Locke, 2001).

In actual practice the flow of the analysis was more flexible than the above sentence suggests. The grounded theory emerged through an iterative process of going back to the data or the field to cultivate and then incorporate new insights throughout the process, until theoretical saturation occurred in the categories of interest (Glaser & Strauss, 1967). Since analysis began while interviews were ongoing (Charmaz, 2006; Dey, 1999; Glaser & Strauss, 1967; Goulding, 2002; Locke, 2001) early emerging patterns were abandoned or modified because of new data. Emerging patterns took me back to earlier coding with “fresh eyes” to

seek out overlooked data or connections. This iterative and flexible process kept the analysis "grounded" in the data.

This study followed the coding procedures described by Charmaz (2006). *Initial coding*—also referred to as *open coding* (Dey, 1999; Goulding, 2002; Locke, 2001; Strauss & Corbin, 1998)—is simple and stays close to the data, often using the respondent's words (an *in vivo* code) to label a single passage in a transcript or field notes. During initial coding of the first few interviews input from other researchers was sought out to help illuminate the actions and interactions represented in the data. As some analytic frameworks begin to suggest themselves, *focused coding* was used to synthesize the data into categories (Charmaz, 2006). To refine the categories Strauss and Corbin (1998) suggest *axial coding* (sorting, reassembling, and organizing the categories and subcategories) to create a coherent early framework. Charmaz (2006) sees axial coding as optional, provided the researcher can tolerate ambiguity and the iterative nature of the entire process. Axial coding did prove useful and resulted in the creation of two diagrams (see the results and discussion chapters), one embedded in the other, to represent the data. However, Charmaz's point was well illustrated by both the ambiguity and recursive nature of the process. *Theoretical coding* was used to develop and refine relationships between categories and conceptualize the phenomenon into a grounded theory represented by core categories and its subordinate subcategories (Charmaz, 2006). During theoretical coding other theories were used to refine the diagram.

Feedback during analysis. During analysis the emerging codes were presented to other researchers for feedback. This occurred at several points during analysis. During initial coding two researchers in addition to myself were asked to read two of the first six

interviews and comment on passages of interest. Later, these same researchers were asked to comment on the emerging categories along with representative coding and quotes.

Respondent-checking was used later in the analysis to see how emerging ideas fit the respondent's experience (Charmaz, 2006). Several respondents were interviewed twice to provide feedback and clarity near the end of focused coding. Respondents interviewed later were asked focused questions to gauge the extent that data mentioned by other respondents applied to this respondent. This process allowed overlooked or understated data to surface and aid in refining the categories. Midway through the individual interviews a feedback group was organized, where participants could interact with each other, to present and test the early framework during theoretical coding. Involving respondents in this way improved the usefulness of the final grounded theory and kept my own bias in check.

Data collection. The first interviews were open-ended. As analysis proceeded and themes consistently reoccurred, the remaining interviews focused on those themes that emerged, and the questions become more focused. As the theory developed, the initial *open coding* (Goulding, 2002) will began to take the shape of more abstract categories. At this point, additional interviews, and field observations were sought out to specifically fill in the gaps. This is referred to as *theoretical sampling* (Dey, 1999; Goulding, 2002; Locke, 2001). Respondent checking, in the form of additional interviews and focus groups, was also done to insure the emerging categories reflected the respondent's meaning (Charmaz, 2006). Data collection stopped once no new meaningful patterns or categories of interest were found in the new data; in other words, *theoretical saturation* was achieved in the main categories (Charmaz, 2006; Dey, 1999; Goulding, 2002; Locke, 2001).

Interview plan. The first set of interviews started off by asking the respondent to talk about her experiences during the transition from breast cancer diagnosis to the present. Respondents were encouraged to tell stories that reflect both positive and negative experiences during that time. Follow-up and probing questions were asked based on responses, with an emphasis on actions and interactions mentioned in the story that represent adaptation and the provision of a holding environment. The respondent was also be asked to define key words, phrases, and metaphors used in their stories.

Terms such as support, holding environment, coaching and so on, were not be incorporated into the questions at first. Once categories of interest began to emerge, terms used by the respondents (*in vivo* terms) were incorporated into the questions in future interviews. As the first interviews were analyzed and certain dimensions began to consistently emerge, questions used in additional interviews focused on discovering the variance in those dimensions.

Main interview questions. The following questions were tested with the first few respondents and continuously modified or eliminated with experience.

- Tell me a few stories that illustrate the best and worst parts of your experience after treatments ended.
- What was/is your goal once treatments ended?
- What have been your experiences since your treatments ended? Tell me some of the stories that come to mind (positive, negative, mixed).
- In what ways has/will, if at all, being a survivor change(d) you? Tell me about process.
- Based on your experiences, what would you tell a newly diagnosed breast cancer patient to expect when their treatments end?
- What or who will/most helped & most hindered your transition?

• Tell me about finishing your treatments.

The main questions did not specifically ask about adaptation, transition, holding environments, learning, or support. Various probes (continuation, elaboration, attention, clarification, sequence, evidence, and slant/bias) were used to elicit additional data from respondents about those dimensions (Rubin & Rubin, 2005). Respondents were also asked to add anything they felt was important that I did not ask.

While the initial main questions were very open in nature, the flow of the interview was not phenomenological in nature, where the respondent is allowed to decide the subtopics of interest. Respondents were encouraged to elaborate on subtopics that seemed to be related to the sensitizing concepts presented in Chapter II. While the initial respondents were not steered toward these concepts, the progression of the interview was determined through a mutual interaction. Later interviews during the theoretical sampling phase became much more directive, however, the flow of the interview was still co-created by the respondent and myself. This allowed new data to emerge, while still exploring the initial categories.

As the analysis progressed modifications were made and additional main questions were added that were more focused. For example, early on I discovered that respondents had expectations about how their "recovery" after treatments would unfold. In most cases things did not go as they had expected. Therefore, I incorporated expectations and goals as the first questions and only probed for stories if the respondent did not provide any as illustration.

As the initial coding generated early categories several themes developed: the respondent's reflection on her future (mostly mortality), positive and negative interactions, how the respondent *situated* herself in interactions, the respondent's desire to be understood

and validated by supporters. This guided the development of new questions used during the later interviews:

- What was your expectations after your treatments ended?
- What goals did you have in mind after your treatments ended?
- What or who helped or hindered you around those goals?
- In what ways has/will BC change(d) your future? Tell me about process.
- Did you experience, after treatments, someone who just did not understand your point of view (partner, friend, MD, family, stranger)? - or - Have a negative contact with?
- Tell me what it was like talking with friends, family, partner right after your treatments.
- Has there been anyone you could really talk to about it all?
- Based on your experiences, what would you tell a newly diagnosed breast cancer patient to expect when their treatments end?
- Did you ask your doctor any questions after treatments where you were surprised how she/he answered?
- How has the transition since treatments felt to you?

Due to the variance in the responses probes were employed in most cases.

For example, respondents often used idioms or metaphors that need to be probed further to establish what the respondent meant (Wilkinson & Kitzinger, 2000). Many respondents made statements like, "breast cancer turned my life upside down." When asked to elaborate with specific examples one respondent would share stories about her change in health status, while another would talk about career changes, and another would talk about changes to her spiritual beliefs. Sessions with the feedback focus group proved useful in organizing this variance into categories.

Respondents

Respondents consisted of women who had been diagnosed with *local*, or *regional* (SEER system[19]) breast cancer and were near the end of or finished with all initial local (e.g. surgery and radiation) or initial adjunctive (e.g. chemotherapy) treatment. As the analysis proceeded, *theoretical sampling* techniques expand the sample to specifically seek out additional young survivors (under age 40) and women who felt supportive relationships played a key role.

Studies have shown that patients from different ethnocultural and socioeconomic backgrounds do vary in their psychosocial responses and adaptations to breast cancer (Ashing-Giwa et al., 2004; P. D. Henderson, Gore, Davis, & Condon, 2003; Howard, Balneaves, & Bottorff, 2007; Knobf, 2007; Matthews, Peterman, Delaney, Menard, & Brandenburg, 2002; Schmidt & Andrykowski, (2004); Tam Ashing, Padilla, Tejero, & Kagawa-Singer, 2003). While the focus of this study was not on diversity differences, including diverse respondents would have permitted exploration of greater variance in the categories. Attempts were made to recruit diverse ethnocultural and socioeconomic respondents.

However, despite invitations going out from cancer centers that serve communities with African American, Asian, and Hispanic populations I was not able to recruit diverse enough interview respondents. This is a limitation of this study and a follow on study testing this grounded theory with more diverse populations is warranted. From this study's

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[19] The SEER system "stages" breast cancer as *local* (restricted to the breast tissue), *regional* (restricted to the breast tissue and adjoining lymph nodes/tissue in the axilla), or *distant* (spread to other organs or metastasized). The simplicity of this system allowed for easier determination of qualification to be included in the study.

experience a better strategy to recruit more diverse respondents would be to do a face-to-face request at support groups who service diverse populations.

The initial interview respondents were sampled purposively, using convenience sources. Purposive sampling meant that each person who initially volunteered to be interviewed was considered for inclusion based on the needs of the study (Judd, Smith, & Kidder, 1991). The initial respondents were recruited through a variety of convenience methods (personal contacts and networking). Some recruiting was done through personal acquaintances made during my wife's treatment and personal contacts I made at several cancer events (event names withheld for privacy because participant lists are public); this accounted for several respondents. Some of the respondents had contact with other breast cancer survivors and they were asked to pass along information about this study. This resulted in posting of the invitation to participate on several discussion boards.

Respondents were also recruited through three cancer support centers in Connecticut and one national cancer support organization. To respect privacy, I did not see any of the support center's client list, I only know those clients who volunteered to be in this study. Potential respondents were contacted using these tactics: support group facilitators were asked to pass out information, flyers were posted, and an email invite was sent out (recipient list blind to me). From the initial pool of volunteers twenty-five respondents were interviewed formally. In addition, two support groups were observed (one once, the other twice), two feedback focus groups were held, and three breast cancer events were observed including informal conversations about emerging categories. Four respondents shared diaries, blogs, or poems they had written about their breast cancer experience, which were also analyzed.

Twenty-five women were interviewed formally. Six were under age 35 when first diagnosed, five between 36 and 40, six between 41 and 50, three between 56 and 60, one between 61 and 65, and one over 65. The youngest was 25 at the time of diagnosis and the oldest was 67. The average age of interview respondents was 45 at the time of diagnosis. The shortest time since last initial treatment was one day, the longest was 16 years. The average time since last initial treatment was 32 months, the median was 20 months. No respondent had metastasized at the time of the interview.

Chapter IV: Results

In this chapter I present the study findings in two frameworks. First, as a grounded theory organized by the core category *Transitioning*. Which includes the subcategories: *Holding Pattern*, *Coping* (broken down further into *Balancing* and *Engaging*), *Searching*, and *Focusing*. Some categories were further divided into subcategories to add richness to the descriptions. A phase diagram was developed to illustrate the relationship of the categories. Second, additional data is presented to support a re-conceptualization of the holding environment concept. In the next chapter, a hypothetical person-environment situating diagram is introduced and its implications discussed.

Results Introduction

Reestablishing equilibrium in one's life was the overarching activity after breast cancer treatments ended. While this description captures analytically the nature of the process, it lacks the personal aspect of what these women experienced. To reestablish a sense of equilibrium in one's life involves cognitive, behavioral, and affective processes that interact and overlap. Breaking the process down into its components hides the simplicity and paradox of the respondent's primary desire after breast cancer treatments end. She wants to continue living, literally and figuratively, *her* life, as she once knew it. When I am referring generically to a study participant I use "her," "she," and respondent interchangeably.

All of the respondents voiced this common desire in one way or another; yet, each respondent's experience was unique. The categories presented below organize the data in the interests of better understanding the transition process. However, presenting data in this way obscures some of the uniqueness. While the variation within each category is evident, the variation between respondents is hidden in this framework (because grounded theory focuses

on creating an abstract organizing framework this is a limitation of the method). In fact, respondents varied in which subcategories played a role in their transition and the impact that category had on their trajectory. The person-environment diagram presented below addresses this by incorporating the individual's personality system, though only at an abstract level.

The transition process starts when she begins to evaluate what it will mean to her life that her primary treatments will end soon or have ended. She needed to cope with all that has changed; some of those changes created disequilibrium in her life space. Coping strategies were used to reestablish equilibrium and range from *balancing* to *engaging*. These coping strategies vary in effectiveness depending on the individual and the situation.

The results of this study illustrated the dynamic field of forces that defined the transition from the perspective of the respondent's experience of those forces. For her, the main thrust of the transition to "get back to my life as I once knew it," was the motivational force that provided movement and direction. This goal was not an end in and of itself; it was a means to regain a state of equilibrium in the life space.

Transitioning

Transitioning is the core category for the phase diagram presented below. *Transitioning* is further broken down into the categories of *holding pattern, searching, coping* and *focusing*. The first phase is the *holding pattern*, *searching* combined with *coping* is the middle phase, and *focusing* is the last phase. Each woman began the transition after treatments ended with the realization that breast cancer has had a major impact on her life. Despite their intentions, it is rare for them to fully return to their former lives, the breast cancer experience with its psychosocial and physical aftereffects often prevented that. Most

women adjusted and moved on as best they could. Some women were transformed by their breast cancer experience; however, none of them started out with the intention of being transformed. They simply wanted to get back to their lives. First, she had to leave the holding pattern created to endure treatments.

The core category *transitioning* was further broken down into subordinate categories below. These subcategories explicate the properties of *transitioning* in a point-by-point manner. The core category *transitioning* has the following hierarchical structure:

Transitioning
- Leaving the holding pattern
- Searching for hope and stability
- Coping
  - Balancing
    - Distancing
    - Distracting
  - Engaging
    - Setting boundaries
    - Just living with it
    - Staying positive
    - Seeking
    - Redefining myself (broken down further into subcategories)
- Focusing

Leaving the Holding Pattern

The initial shock of the breast cancer diagnosis overwhelmed her and caused her to pull in her life space, to freeze it. Almost everything in her life was put aside, as much as possible, to muster the energy to endure the treatments. During treatments an individual often felt that her life was interrupted or went on hold, even if she had to fit treatments in while maintaining her usual life activities. She may not have wanted to and/or be able to suspend life's normal activities during treatments. Those women who tried their best to keep cancer treatments from taking over their lives still found treatments disruptive.

> I shouldn't say that my life stopped, because it didn't; I still went to work throughout chemo and radiation. I really didn't have a choice because I needed medical insurance and I needed to provide for my family. I had to keep going. I had to find the strength to just keep going. So I don't feel like my life stopped, but I felt like there was a big barrier or hurdle in my life that I had to get over with the cancer. So, [sigh] I just did what I had to do. **(**Amanda)

For other women life went on hold with most of their physical and mental energy focused on getting through treatments. "My life was kind of put on hold due to the cancer journey" (Joann). "While I was going through chemo I was just hoping that I wasn't [laugh] going to die. I couldn't think past that" (Linda). "Time changed for me when I was going through the treatments. I feel I lost a year of my life" (Mary Jane). "I had been so regimented for so long, especially with the radiation treatments, because it was every day for seven weeks. I just felt like I didn't have freedom. Everything had to work around that schedule" (Harriet). "You know, it was just a whole life shutdown. It was take care of Julie, get through every week" (Julie). I told Julie I would be asking her questions about the time period after her initial treatments had ended, she replied: "You mean when they [the doctors] are through with you?"

The word *holding* has two connotations in this category. Holding denotes both the state of the woman's life space and the need to be more dependent during the diagnosis and treatment periods. As she progressed from diagnosis to treatment, she added a cancer patient identity to the many identities that make up her self-concept. The patient identity has elements of dependence on others and loss of control over one's routine. For some women, especially younger ones, this was a new identity since she had never been a patient to such a degree before. "I kind of liked getting up and getting my kids ready and going off to my job and sitting in my cubicle and going home and starting again and waiting for Friday. That stopping, that was bizarre" (Brandy). "I'm not used to being a patient to that degree. I

wasn't used to having people always poking and prodding me and taking care of me" (Harriet).

She began to notice a diminishing of instrumental and social support (Helgeson & Cohen, 1999) as treatments ended. In fact, this is one of the cues that she was transitioning. "As I felt better, [husband] was not hovering as much. He started to let go a little bit. I was getting better and he wasn't so worried" (Julie). It is an expectation by others that the patient is returning to normal and needs less support going forward.

> I even said something to my mom and my sister, too. "Now that I'm done with all my treatments, you kind of forget about me."… I said to her, "Maybe this is the time I need you more because everything's done and over with, and I never really had a chance to come to terms with having cancer. But now that I have this time to look back and reflect, it's like, "Oh my gosh, I have cancer." People think that when you're going through the treatments, that's when you need the most support. Then after when you're finished they think, "Okay, everything's just back to normal now" (Amanda).
>
> When you start to look like yourself again, when your hair starts to grow back and you don't look like a cancer patient—people don't ask ya questions anymore. People just expect that you go back to the way things were before, but things will never be the same for you, no matter how well you coped. So you feel like there's a line that you can't cross anymore. (Rachel)

Other cues include treatment side effects diminishing:

> For a while, [I] looked pretty bad, but I guess I just chose not to see that. I didn't need to brush my hair in the mirror or anything like that, so I just didn't look for six months, but then it was nice to look and see me looking back **(**Melissa).
>
> The recovery process is when everything starts to come back. Your hair starts to come back, which is lovely. I remember asking the doctor, how will I know when I am like back to myself? He said: "when you look in the mirror and you recognize yourself." At first I thought, what does that mean? But he is quite right. And that took a long time (Julie).
>
> I still looked like a cancer patient for a long time because no one would really get their hair cut that short [laughter]. Recently, [my son's teacher] just thought I had short hair. That was the first time that I thought, "I don't really look like a cancer patient anymore and she didn't think I looked sick." (Dina)

Here the patient has evidence that indeed normalcy was returning. She anticipated and expected that she would transition back to what once was.

Eager to return to "normal," she welcomed the freedom from treatment regiments, yet, the increased independence could be frightening. "So you go from just saying I can't take one more doctor's appointment and then all of the sudden you're post [treatments] and it feels a little lonely because you're still not over waking up in the morning and saying I have cancer" (Ann). "I didn't get any counseling, I didn't like going to any support groups, and I felt bad even turning to my friends, because they'd already been through all this with me. I really felt alone and I was like that for a few months" (Maria).

> The radiation department's outstanding. They're just a really supportive group… When my radiation came to a close—it's like wait a minute, I'm not ready to stop coming here [laughter]. So that was a little traumatic for me, that I felt like I was stepping outside of a very supportive group. (Vicki)

Turning the corner. As her treatments ended, the respondent focused on getting on with her life. "It is mentally exhausting by the end. It was like, I am ready to be better, and this is enough already" (Julie). The energy that was tied up in enduring treatments is now redirected at making sense of it all. This brought the realization—often for the first time—of just what she had been through. This realization could come quickly or slowly. Regardless it was often disconcerting. "I'd been busy for a whole year dealing with [treatments]. It sort of snuck up and kicked me in the fanny exactly what I had dealt with and gone through… and it was WOW!" (Sandy). "I felt so lost, trudging through two jobs, just trying to keep my head on straight [during treatments]. I finally realized 'you're going through cancer.'… I've got this nasty, nasty, nasty thing" (Maria). "It's this ugly realization that you're not waking up from this dream" (Rachel).

> A week or two after I was done with my radiation I got a survey in the mail to rate their services… I was just sitting at my table, and I'm like, "Did I really just fill this out, over services of cancer treatment?" I'm like, [deep inhale] I'm like, it was just, I was just—I just sat there and I thought about everything: "Am I dreaming? Did this really happen to me?" kind of thing. (Amanda)

Questions like this formed the core of her search for hope and stability.

Searching for Hope and Stability

Although there are commonalities presented below, each individual appraised the situation based her unique personality system. She sorted and sifted information based on its perceived relevancy to her. She took stock of what it all means now (as treatments end) and in her future. "You know, it's really a psychological journey of how do I recover from this trauma that I went through and the real things that I feel now that I hadn't felt before or the real things that I can't do now" (Ann). "Once you get a life threatening diagnosis, life is not the same… it just fundamentally changes the way you look at life and living. There is just no way to get around it; it just changes it, utterly" (Julie). She felt unstable, familiar aspects of her life space had shifted and her future seemed uncertain. To compensate she searched for information to provide her with hope and strategies to make her feel more stable.

For some women moving on after treatments did come easily enough. Other women had to come to terms with a life space that did not return to "normal," which could be an upsetting surprise. While most respondents were not in denial about the challenges they would face after treatments, they were often surprised at the level of difficulty they experienced. "I was thinking I was gonna be kinda back to my old self within a couple months. That was not the case for me… I had heard about chemo brain and that stuff… I probably didn't have realistic expectations" (Natalie). They were frustrated by hindrances that obstructed the attainment of their intended goal—what D. W. Winnicott (1965b) referred to as *impingements*. Unless she dealt with those impingements somehow: "everything can get kind of out of control" (Ann). "I think I personally thought that somebody would wave their magic wand and my life would go back to quote 'normal,' that I would stop going to the

doctor and I would be well again. That wasn't how it happened. So that was a difficult transition" **(**Melissa). "[Sigh] I thought that everything was going to go back to normal afterwards, just because I had had such an easy time during the treatment… Well, it's not quite as normal as I hoped it would be [laughter]" (Eva). "I just kind of expected everything to just magically fall back into place… I had post-treatment issues that I have to take medication for and my reconstruction is still not finished. So my issues still go on from cancer" (Melinda). "My anticipation was things would get back to normal, that it would take time, and it could take a year, but that I would get back to, quote unquote, 'the woman I was before.' That did not happen [laughs]" (Nancy). It was common for the respondents to refer to this as the "new normal," a changed life she had to learn to cope with.

Some features of her changed life she had to learn to adjust to, while others required her to adapt her assumptions about who she was, who she is right now, who she is becoming, and the social world surrounding her. These challenges interacted and overlapped as she worked at: surviving this life-threatening illness; managing the physical, emotional, cognitive, and social aftereffects of the disease and treatments; integrating what it means to be a cancer survivor; and piecing her life back together again.

For some women life had changed dramatically. "The optimism and thinking that things were going to get back to normal changed very quickly, because I had a bad case of lymphedema" **(**Nancy). "I just wanted to put it all behind me and move forward. After chemo and radiation I ended up with shingles, which was a devastating setback for me. I think that's what put me over the edge" (Mary Jane). In all cases, their story reflected the challenges they faced and the strategies they used to regain as much of their "old normal" as

they could. In each case she made adjustments and adaptations in her quest of "getting back to my life as I once knew it" (Joann).

"I miss my pre-cancer life… I miss the naïveté that I walked around with, the feeling that I was invincible and nothing bad could touch me" (Melissa). Wanting a life that would be predictable and stable again, she asked difficult questions about her future. Searching for answers that would give her hope and diminish the uncertainty. She wants to continue living, literally and figuratively, *her* life, as she once knew it. Initially, much of her focus was on questions about mortality and her future.

She wanted assurance that the breast cancer was gone, or at least solace that what was done to her was the best that could have been done, that enduring the treatments was worth it. She searched for hope that her future would not be cut short. "That this [treatment] journey wasn't a waste of my time, that my life matters. That I'm going to be here for the long haul" (Joann). She searched for hope that she would continue to live her life without being haunted by the possibility of cancer returning. This searching for hope could be disorienting and often brought up additional questions. "I thought, okay, I finished my chemo and I'm never gonna think about this again. It didn't work out that way [laughter]… Five years later that's all I think about, when's it gonna come back?" (Rose). While there was relief that the main treatments were over, the threat of death from cancer remained. Often she asked her doctor, "am I cured now?" The ambiguous answer brought hope, but not complete relief. There was still uncertainty about the future.

> I had asked my doctor the last time I went what my status was. She's like it's called NED. I said NED? I thought it might be "remission" or something like that. She said no, that's leukemia. I said what's NED? She said, no evidence of disease… It just becomes, like, [UHG]. You can't pretend it didn't happen but I don't know, I'm looking forward to… moving on. (Brandy)

"Breast cancer is never considered quote, unquote, cured. It's considered no evidence of disease. So, you're never cured from breast cancer. The hard thing with breast cancer is figuring out if you have a metastasis" (Rachel). "You know how we keep calendars. Sometimes I just look a year out and say, 'I hope I am okay then.' [laugh] I never thought that way. I don't dwell on it, but I do think about that [now]" (Julie). Not knowing made it hard to project herself into a desired future self, what Markus and Nurius (1986) referred to as "possible selves." This brings goals and aspirations for the future into doubt.

She found herself questioning if she would live to experience major milestones that most people her age take for granted. At 37, Dina wonders: "Am I going to be able to see my kids graduate? Because for the longest time I just kept thinking, 'oh no, I'm going to get [cancer] again,' and then I won't get to see them grow up." One respondent, Darlene, provided the analogy that: "Once you have breast cancer you wonder—what our [support] group calls the guillotine effect, where it's always over your head—is that lump or that pain in my back cancer? Maybe it's spread." Each physical anomaly she discovered tests her hopefulness while driving home that: "everything that happens now is magnified" (Julie).

Reminders of her mortality also came from the environment. One support group member told the group: "My mother-in-law had passed away and we had to go down to the funeral, and I was just like I don't think I can do this. I mean, I'm going to see my husband walk up to a casket, you know, and I was having all of those thoughts". Another member added: "Someone like Elizabeth Edwards [dying] will freak me out."

As she put her life back on track she worked to understand: "who I was then and who I am now" (Julie). If a return to her old life was not possible she began to "think about how I

could be going forward" (Ann). She strived to become herself again and live a life she recognized as her own, while at the same time learning that: "life's never going to be the same because so much has changed" (Joann).

This realization created disequilibrium both because it meant life had changed and because aspects of her old life were lost forever. The ability of the schemas in her assumptive world to contain the disequilibrium determined how vulnerable those schemas were to change. If her current schemas did not provide adequate answers to tough questions then she had to cope with the disequilibrium. She searched for ways to attain equilibrium in her life space, to feel her life was stable, and have hope about the future.

Coping With a Changed Life

To meet this challenge she engaged in a complex coping process—that involved *balancing* and/or *engaging*—that was in service to transitioning. The term coping is used here to portray both the actions taken and the emotional self-management aspect of her personality system (see discussion below). Overall coping strategies were often a blend of both balancing and engaging, with specific behaviors focused on one or the other. Although there are commonalities between the respondent's transitions, their individual personality systems, histories, socioeconomic conditions, and current situation influenced the specifics of how her coping impacted the transition.

In the last stages of analyzing the data, other theories were compared and contrasted to see if they added to the analysis. Several of these will be discussed in the next chapter. Lazarus's (1991) cognitive-motivational-relational theory explained the coping data quite well. Lazarus viewed the process and structural (both psychological and environmental) elements of coping through the lens of the emotions. There was no attempt to qualify the

effectiveness of any particular coping strategy. In fact, judging effectiveness may be misdirected and instead we should focus on coping attempts (Lazarus & Folkman, 1991).

Balancing. The results for the balancing category are organized into two subcategories *distancing* and *distracting*. Her motivation behind *balancing* was to maintain equilibrium by attenuating emotions. From an outsider's perspective these behaviors may appear to be denial, which can have overtones of psychopathology. However, that judgment can only be made when the entire context is considered (Lazarus & Folkman, 1991).

Distancing. Distancing entailed individuals getting far enough away from breast cancer so they could put it behind them - to have the treatment ordeal fade somewhat, to even forget some or all of it. "You know you forget things in life anyway. I mean childbirth; can you really remember the intensity of that pain? No… time moves on. You're living every day. If you keep living behind you're never going to go forward" (Mary Jane). "Life goes on. I don't want to dwell on it forever" (Joann). Some of the respondents shared their journals and blogs with me. I asked them to read the sections I had highlighted about their after treatment experience. I asked for their reaction to reading it:

> I was a bit surprised that I'd forgotten some of my own feelings, especially the paranoia that I felt a few times. I didn't forget altogether, as reading about them brought them back to memory, but before reading this again, I had really not recalled those emotions, even though I occasionally have them still! (Harriett).
> I cried while I was reading all the stuff you pulled off last night. It's interesting for me to look back and remind myself of what I've been through. People say that when you have a baby your mind kinda blocks out the pain so that you'll do it again [*laughter*]. I think that there's some of that with cancer. (Melissa)

There is a temporal aspect to distancing. Some women found solace in marking the time since diagnosis; the longer it had been, the less anxious they were about recurrence. This is distancing by waiting.

> The more time that passes the better. I have the most aggressive type—grade three and triple negative. I worry about dying. My worry gets less the further I get out. Time is helping… When I was done with treatment, I had a huge party to celebrate and I think I'm gonna have a two year and a five year party, too. (Natalie)

Five years is a symbolic milestone for many cancer patients.

> The five-year benchmark is something that came up in my support group. Studies have shown that if that you survive five years, now your chances of surviving ten and 15 are even greater and your risk gets lower. So it's like you have to make it to five years before we're out of the woods. Everyone's waiting for that five-year mark. So, it didn't magically go away just because I hit my five years. I do feel better about it finally, these past few months, since my five-year anniversary. (Rose)

In addition to a temporal quality there was a quality of the pace of the distancing. "It's really been a gradual, feeling more and more and more positive; more and more healthy… There are days when I feel great, really happy, and there are days when I feel like, 'oh my God'" (Julie). For others, being in the present distanced them from breast cancer and kept them from reliving the past. "I work really hard just trying to live in the present moment and not worry about what might happen in the future" (Eva).

Distracting. One way to tolerate the waiting game was for women to distract themselves by filling the time with things other than breast cancer reminders. It restricted what felt like an abnormal part of the life space to a smaller portion by filling the rest of the life space with more "normal" activities. It was a way of occupying the mind and feeling some sense of normal. "I still get up and go to work every day. We go out on the weekends and enjoy. Like I said before, sometimes I even forget that I even went through this" (Mary Jane). "See friends, go out to lunch. I don't want to be isolated. I need to be seeing people and doing my everyday life stuff" (Joann). "Because of all the corporate stuff going on, I didn't have time to worry about it. Maybe that was a good distraction" (Carrie). "I was still capable of doing the work that I was doing and it took my mind off any worries or concerns

for six or eight hours a day. I love what I do" (Julie). "I think it'll just be little mental milestones. Before I know it the summer will be here and gone. Maybe going [back] to school will keep my mind totally off of it" (Brandy). "For me it became having another project, and that project was building my house. So I had something else that I could think about every day and obsess about [laughter]" (Melissa).

Engaging. *Engaging*, on the other hand can be differentiated from balancing because it focused on changing the relationship with the impingements. Although there were similarities to this with balancing, the main distinction is in how proactive she was. The deeper the level of engagement the more likely she would go deeper when she searched for meaning. Engaging is further broken down into subordinate categories of: *setting boundaries*, *just living with it*, *staying positive*, *seeking*, *redefining myself*, and *reframing*.

Setting boundaries. These strategies created a boundary that controlled how much breast cancer intruded on her day-to-day life after treatments. In effect, it was her self-management (Bollas, 1987) that contained her anxiety through manipulation of the situation. This was active self-management. Her knowledge of her past experiences, including affect, provided her with a sense of her tolerance level. Several women referred to it as "knowing where your edge is." At first her tolerance may have been quite low and she may have avoided as many of the reminders as possible. Reminders however seemed to show up everywhere.

> I think it's great that there is an awareness of all types of cancer like there never has been before… But when I turn on the television at night, it's because I want to *not* think about cancer for a little while… I don't want to be reminded of the one thing I struggle every day to forget. (Melissa's blog)

If you are trying to put something behind you then you certainly don't want to talk about it. "I was pretty tense about it at first. Like, how am I going to live with this? I really

wanted to get as far away from talk about breast cancer as I possibly could" (Julie). "I don't really talk about it, I don't dwell on it. I try to truthfully to forget I even had it, forget I even went through it" (Mary Jane). Sometimes the talk was about someone else who was dying or had died of cancer, "I am like, [friend's name] I can't have this conversation. I have just been diagnosed with something that I haven't even digested yet… So I was very careful who I talked to" (Julie). "It's really strange to talk about it out loud. I usually change the subject off of cancer" (Brandy).

Even talking to other survivors could be something to avoid. There was a self-concept aspect that is related to the *situating* and *redefining myself* categories (see below), but the focus here is on boundary management, not role taking. It illustrates the dynamic connection between her working self-concept and how comfortable she is allowing breast cancer to define her at this moment.

> I had my car pointed in the direction of the young women's breast cancer group on Tuesday, but I just couldn't make myself go. I decided going to the gym would be a better use of my time than sitting around talking about cancer when I'm trying so hard not to focus on it. I'm hoping with every step I take away from this, it will get a little easier. (Melissa's blog)

For others the reminder came from the setting itself. Her oncologist referred Julie to an after-treatment support group after complaining about "chemo brain" aftereffects (chemo brain is how many survivors refer to memory problems they experience after chemotherapy). The support group met at the treatment center where she had chemotherapy and radiation. "I walked over to the [treatment center] and there are dreadfully ill people there. They don't look well, and you're feeling pretty good. I was like, no, I'm not going here every week or I'll never mentally feel better" (Julie). For Julie the perceived emotional cost outweighed the perceived benefit the support group might have provided.

The permeability and where the boundary is placed changed both over time and with context. For some women the boundary was drawn to include other survivors, firmly placing themselves within the "breast cancer sisterhood." These women go to support groups and breast cancer rallies. Other women drew the boundary much closer, including only a select inner circle. "I think people think I'm over it because I never really bring it up. It's in the back of my mind that there could be a recurrence. Of course my husband, my sister and my son know how I feel" (Mary Jane). To an outsider this avoidance can appear to be denial.

The difference between setting boundaries and denial was that in setting boundaries she was attempting to control the impingements so she could learn how to tolerate them. Setting boundaries was part of her plan to reach her intended goal. The women interviewed for this study readily acknowledged the reality of their situation and dealt with the challenges breast cancer had laid at their feet as best they could. Indeed, as an overall strategy, controlling the intrusion allowed these women to gradually integrate breast cancer into their lives at a pace and intensity level that allowed them to continue living their lives as normally as possible.

Taken out of context, Julie's "not wanting to know" (mentioned above) appeared to be a case of denial. However, when seen in the context of her other behavior, it can be interpreted as coping used to sustain her own morale (Lazarus & Folkman, 1991). From a holistic perspective, one needs to also consider that Julie put considerable effort into choosing a medical team that she could trust (see *situating* below). In effect, this was proactive behavior on her part to avoid having forces within her life space that would create disequilibrium. As Julie points out: "I just need to kind of get my life back and get some balance and then I will do something like I am doing today [talking in depth about her breast

cancer experiences], when I feel ready to." In effect, Julie was pacing herself until she built up a tolerance to reminders of her breast cancer. The goal was not to make her cancer magically go away by not talking about it, but instead to cope with the anxiety until she could better tolerate the stress. "I felt fiercely that I needed that separation, to come to some kind of a balance with who I was then and then who I am now" (Julie). Julie was teaching herself to tolerate more and more by pacing her exposure.

In one of the observed support group sessions, the members talked about being aware of where their "edge" was in a given situation. Knowing how much they could tolerate allowed them to pace themselves and know when to avoid a particular situation. For example, when famous women announced a recurrence, most members decided how closely to follow the story based on their current ability to tolerate that information.

Just living with it. This was an acceptance of her changed life as something she must just live with. It was a conscious attempt to change her attitude and move on. "It is what it is and you can't change it, you just live with it" (Eva). There is an element of coming to terms with reality, a surrendering to what is. "I'm not who I used to be but I've gotta be okay and get to grips with the fact that I'm going to feel the way I feel and I've got to be okay about it" (Ann). It was making do with what you have without putting a positive spin on it. "My [breast] reconstruction is done. It's not great but I don't care" (Carrie). There was acceptance of the changes tempered by why there were changes in the first place. "I miss these breasts but I still feel like I'm a whole person. They've just been altered a little… I had to do this, to keep the breast cancer away" (Joann). "For me, it was just accepting that this was the new normal. To make it something, not too accepted, but to compensate in the best way that I can" (Nancy). "So to try to accept what has happened in a very positive way, not

to be haunted by it, not to be consumed by it. But to accept that it has changed your life" (Julie).

Staying positive. Staying positive is a popular coping strategy, so much so that it has entered the breast cancer culture as a feature of fighting the good fight against cancer (King, 2004). It is an avoidance of the dark side of survivorhood. "I consider myself a positive person and I just wasn't going to get dragged down by this" (Carrie). There was a situating (see below) aspect where women compared themselves to others and placed themselves as being better off. "I would go to the support group meeting and listen to other women and what they were going through… I remember coming home, saying to myself, I'm lucky" (Nancy).

Staying positive had a surface quality to it, like Joann's "putting on a good face." Nancy continued and illustrated that staying positive provided good cover for underlying concerns: "Sometimes I think that if you whistle a happy tune, no one will know you're afraid." There was also a sense that staying positive would bring future acceptance. "What do they say? Whenever you start to believe it, it's true. I think that there's some truth to that" (Nancy). Staying positive maintained a partial illusion in the hope that it would solidify into reality.

This illusion avoided its opposite, being consumed by negativity. Because her situation was ambiguous enough—she really could not be sure what the future holds—she needed to replace her pre-cancer illusion that she had plenty of life left (see *searching* above) with one that allowed her to continue on. "I only want to hear the good stuff. I want to stay on the positive side of the railroad tracks. I don't wanna be dragged down with the ones that

are going down" (Joann). The motivation to stay positive may have involved the holding environment provided for others.

> When I was diagnosed, I had the initial shock of, "Oh my gosh. I'm twenty-eight and I have breast cancer. What's going to happen to me?" After I dealt with that initial diagnosis, I got it in my head, "Well, I could either sit here and feel sorry for myself, or I can beat it and go on with my life." I had a four-year-old daughter that needed me, so I really couldn't in a sense feel sorry for myself, or anything like that. I took it for what it was and did what I had to do, and continued to live my life. I said to myself, "I am not going to be negative. I am not going to feel sorry for myself. That's not me as a person. I'm going to take this and deal with it, and turn it into something positive in my life." Because otherwise, you're just miserable. (Amanda)

Some women rejected the idea of thinking positively because it denied aspects of their situation that are realistically negative.

Seeking. Respondents assessed the resources they thought they needed and then sought them out. Information and support were the most prevalent things sought after. Seeking information had the opposite effect to distancing (see above) and could cause additional disequilibrium. This was especially true if the information was not useful for problem solving. However, the added benefit of feeling validated could make it worthwhile because it reduced the feeling of isolation (see holding below). "I would ask my the support group and they were like absolutely that's a side effect or this happened to me. It's the people who have gone through it that can give you the best answers" (Linda). "When I was deciding whether or not I was gonna do the bilateral [prophylactic mastectomy], I went back to the message board, and I posted. I got a lotta great feedback and information" (Melissa). "My approach, the way I tackle everything, is I wanted to know as much as I could about it" (Carrie). "I would call up my one aunt who is a pharmacist and ask her if she knew anything about the drugs that I was on or anything that could help me" (Melinda). "Within the week I found out I actually had it I immediately called [friend who is daughter of a survivor]. I was

like, I need to talk to your mom, now" (Maria). "I found several friends who wanted to walk with me, that was very helpful, particularly ones who have been through breast cancer treatment. I could say things to them, you know, just woman-to-woman" (Julie). "There's always a feeling that, if something bad happens to me, I want to have that support network in place, and I don't want to come back [to the support group] as a stranger" (Harriet).

Redefining myself. The examples presented below focus on what can be described as transformations of self-concept and worldviews. Redefining is further broken down into subordinate categories: shifting priorities and lifestyles, life purpose, changing worldview, survivor sisterhood, body image, and reframing. Questions that came up during searching that could not be easily resolved triggered a deeper reflective process. Some were related to expectations and beliefs about her, others were more global in nature and challenged larger meaning perspectives (Mezirow, 1991b). In some cases, what was transformed was the illusion that life is predictable, which connects to the searching category.

> I think what breast cancer did was it really helped me get over the illusion of immortality. We all know we're going to die, but when you have an event like [breast cancer] you really think a lot more about death and you really think a lot more about: "How have I spent my life?" (Ann)

It is this deeper reflection that differentiates this category from the others. In this deeper reflection schemas about who she is and how the world works become pliable and able to be reshaped. These schemas form an interconnected cognitive system that is resistant to change (Kelly, 1963; Mischel & Shoda, 1995). Therefore, putting them at risk of change created tension. Many times, the resolution of the tension came through supportive interactions where she was able to reflect on and change her assumptions (see *holding* and *transitioning space* below).

Shifting priorities and lifestyles. After reflection Ann decided to shift her priorities in life. "I've always been a workaholic and I just said, this is ridiculous. I have a great husband, great kids, and grandson. The other things in my life just matter too much." Carrie, who worked a stressful job, also decided to change her relationship to work: "I was able to retire, at 52. Breast cancer had a great deal to do with that decision. It changes your priorities, in terms of what's most important in life. Life is too short." "I always wrote lists. [Now] I have lists of things that I want to do with or things I want to teach my kids. I'm already planning a vacation two years from now to Hawaii with my kids" (Natalie). Ann, Carrie and Natalie were not adding new priorities as much as they were reprioritizing. Their self-concept evolved and shifted more than it changed.

> You're faced with reality when you're handed something like this—I may live for another week, I may live for another 70 years. So you have to decide what your priorities are. I moved the things that were lower down up higher. I kicked some things off all together, there's no room for them, they're not important. (Melissa)

During searching for hope and stability she may have compared who she was before breast cancer and who she will be after cancer. This could lead to behavioral changes in her lifestyle. "I really wanted to, and have changed my lifestyle. There's a part of me that felt that the unhealthy food that I was eating could have played a role in my cancer" (Amanda). "I am doing Tai Chi, acupuncture, and I tried meditation. These are huge steps for me; I am not someone that ever paid any attention to stuff like this" (Julie).

Life purpose. Other women changed who they are. "I have a different purpose in life now, calling is too strong a word, but my life is changed in a more positive way, even though I feel I have suffered a little bit because of it" (Darlene). Faith or spirituality could provide a purpose. "He's chosen me to survive this cancer journey. It's really helpful to me to have a higher power that I choose to call God and to believe that I have a purpose in this world"

(Joann). Yet when Joann asked God to help her determine what that purpose is, she did not get an answer and concluded that part of her purpose is to discover that answer. Amanda, on the other hand, knew why she had breast cancer, "I came to terms that God has put cancer in my body for a reason, and maybe it was a wake up call." As Amanda reflected on her life she realized, "I wasn't really happy in my career. I wasn't happy with what I was doing. So I thought maybe this was given to me now to find a new path for me." After treatments Amanda wanted to give back to the breast cancer support group, so she did a fundraising event, "I had so much fun raising the money I felt that that was maybe my calling." This caused Amanda to seek a new position in the organization she worked for coordinating fundraising and special events, "I love it. I'm so much happier at work. So I really feel, in a sense that it led me in a new career path."

Changing worldview. Pondering the "why me?" question could lead to critical reflection about how the world works. Prior to breast cancer Jane had a healthy lifestyle, running every day and eating a mostly vegetarian diet. Why would someone like her get breast cancer? Jane concluded that her breast cancer did not originate from the lifestyle choices she had made. "Afterwards I just thought, crap, you can do everything right and still get stupid breast cancer." This leads her to reflect critically on her assumptions about life, "I just don't really believe there is anything more, this is all there is." Jane credited this line of thinking with her ultimate decision to turn away from organized religion. "You know how some people find religion? A stronger faith in a higher being that's going to get me through [cancer]. I would say that I did the opposite." Prior to her diagnosis Jane was religious, "I grew up Lutheran and can recite every Bible verse you want to hear." This was a dramatic change in Jane's assumptions about life; it came as a result of critical reflection in dialogue

with her husband and reading many books about different faiths, about losing one's faith, and humanity's place in the universe.

"It got me to thinking about a lot of things," Jane sent me a quote she feels captures the essence of her new viewpoint:

> The Buddha's Five Remembrances (Thich Nhat Hanh's version)
> I am of the nature to grow old. There is no way to escape growing old.
> I am of the nature to have ill health. There is no way to escape ill health.
> I am of the nature to die. There is no way to escape death.
> All that is dear to me and everyone I love are of the nature to change. There is no way to escape being separated from them.
> My actions are my only true belongings. I cannot escape the consequences of my actions. My actions are the ground upon which I stand.

This was not a move from Lutheranism to Buddhism as a spiritual practice for Jane. "Basically it's saying it's okay to be sick because you're going to be sick in life, it's okay to die, because we're all going to die, and just be okay with what is. That's the gift of life." For Jane it was about removing all illusion about life's meaning.

Jane was not alone in questioning her worldview. Maria went through a similar reflection: "To tell you the truth, I think it has really changed even the way that I think of life in general." Maria thought of herself as a good person who, "believed that there was a higher power. After I was diagnosed, my faith and whatever religion I believed in went to shit." This did not happen overnight for Maria; she was already questioning her religious beliefs prior to her cancer diagnosis.

For Maria the turning point was a cancer support group where there was too much focus on God for the fragile state of her belief in God: "I was like, you're kidding me." Yet, Maria left room to bring faith or spirituality back into her life later on: "not that I still don't believe, but He's on hold. I'm taking a break from having any part of any organized religion." Although not as dramatic as Jane's change in worldview, Maria had reflected

critically enough on her beliefs to be freed of the hegemonic aspect. For Brookfield (2000), both Jane and Maria had transformed their meaning perspectives on religion. The difference was that Jane had replaced her old belief with a new one and Maria was still in process. In fact, Maria could conceivably come back to a very similar belief, just one that is adapted to her new understanding of the world and freer from hegemony. As Joann and Amanda's quotes above indicated, breast cancer can also strengthen her existing worldview. For both of them their spirituality and connection to God became stronger.

Survivor sisterhood. Some respondents actively avoided not being redefined by breast cancer. They mostly saw breast cancer as an event that happened to them, not one that redefined them. "The sisterhood thing. The way I always think about it, maybe this is negative, it's like a club that I didn't want to join" (Brandy). While each breast cancer survivor identified with other survivors to a lesser or greater extent, a subset of women choose to create a stronger bond with other survivors. Several women had lightheartedly referred to this as becoming a member of a sorority they did not volunteer for. There was no evidence in the data that one or the other was more effective for coping or provided for a higher quality of life.

While this membership provided an opportunity to share and gather new information about breast cancer, to vent emotions with other women, who understood what you had been through, and provide and/or receive social support, there was another less obvious function: to be an active member of this group validated that part of her identity. The breast cancer experience became integrated into her self-concept.

As a woman integrated her breast cancer identity into her self-concept, she became more adept at moving her breast cancer identity between foreground and background. There

was an aspect here of how much she felt this new identity impinged on who she feels she is in that particular situation. The amount varied situationally (see *setting boundaries*), and could include a sense of acceptance that she had survived cancer.

> Tomorrow is [Komen] race day!… Even though I've participated in the past, I know it will be a different experience this year. The pink shirt feels like more responsibility than I'm ready for. I put it on last night and felt like I shouldn't be wearing the "survivor" shirt. I'm just not quite ready for a label that heavy. (Melissa's blog)

Body image. Part of our self-concept involves how we perceive our physical body. Chemotherapy can cause hair loss and weight gain. For those women who had surgery (lumpectomy or mastectomy) body image issues could impact her self-concept. Pre-cancer Maria saw herself as a young woman with pretty long hair and large attractive breasts, features she said she accentuated. Several months after treatments ended she found herself depressed at what she saw in the mirror and stopped going out with friends. Her depression lasted a few months until she realized something had to change. She was faced with a dilemma. On the one hand she enjoyed going out and saw herself as a fun person to be with. On the other hand she saw her physical attractiveness as part of why people want to hang out with her.

These two schemas created tension because her hair is short now and she had a bilateral mastectomy followed by a dramatically smaller breast reconstruction (large reconstruction is not feasible when the original tissue has been removed). Maria's friends contradicted her assessment and tried to get her to go out again. Finally, something had to give and Maria adapted her perception of her physical beauty. She allowed the fun, outgoing part of her self-concept to come to the forefront and the physical side to take a back seat. "I got my life to live. I need to stop being a depressed piece of crap, and realize that hair is just

hair, boobs are just boobs. Your friends are all waiting for you to stop being at home all the time" (Maria).

During observations of a support group, two contrasting examples that illustrated a positive and negative redefining of the self were discovered. In both cases *situating* (see below) of the self with respect to the group was an important factor. The group's conversation had shifted to breast reconstruction. Several of the women had waited until after treatments to have their reconstruction done and were curious about what other women had done.

Sue became very animated as she told the group how happy she was with her reconstruction. Sue described it as a "work of art." In fact, she offered to show anyone who was interested her reconstructed breast in the ladies room during the break. Lisa, who had a lumpectomy said, "I can't believe you are willing to show people your reconstruction!" Lisa then continued to tell the group that her lumpectomy scar bothered her so much that she had not even let her husband see her breasts naked in the year since her surgery. Lisa described what a change this is for her because she had always taken pride in her body before her surgery, even wearing two-piece bathing suits at the beach. Situating herself in the group discussion revealed the change in her body image.

Lisa shared that she avoided anyone seeing her breasts naked because she now construed them as mutilated and unattractive. Sue on the other hand held onto a positive body image by construing her new breasts as a "work of art" worth sharing with others. For Sue she had held onto herself as a sexy vibrant woman, whereas Lisa had lost that aspect of her self-concept. In both cases, the body image aspect of their self-concept had changed.

Other respondents showed varying levels of modification of the body image aspect of their self-concept. Some respondents offset the sense of loss over their natural breasts by focusing on the positive aspects of their reconstruction. Those women joked that as they got older they would still have the breasts of a 20-year-old, because implant reconstruction breasts don't sag over time. Although this type of coping focused on minimizing the loss, she had also modified her sense of body image and accepted what she now had.

Even older women, who decide to have bilateral mastectomies instead of only one side (prophylactic contralateral) without any reconstruction, adjusted their sense of body image too. They rationalized that the small amount of risk reduction they gained was worth giving up breasts, because breasts were no longer that important to them at their stage of life. This sense of body image had more to do with their stage of life; however, the decision to have a bilateral mastectomy brought that schema to the foreground.

Reframing. Redefining herself includes both acceptance of what is and a reframing of what is possible. Letting go of the past and moving on is not easy. It helps to have adequate support (see below). Ann worked with a therapist who helps women come to terms with life after breast cancer, "She helped me reframe the fact that I can't, I couldn't, wish for what it had been. I could only think about how I could be going forward." With the support of her husband, understanding doctors, and her support group Nancy overcame debilitating aftereffects and moved on too, she is different now. "My hair grew in grey and I left it. I realize now, a year from that time, how much I have accomplished, accepted and overcome. The point that I've come to now is, the 'new normal' is fine" (Nancy). Through conversations with her best friend and mother, Natalie also reframed her life. "I don't know what it's like for other people that have gone through cancer, but life has a completely

different meaning for me… I live life differently than before cancer" (Natalie). This is not just a shifting of priorities for Natalie; it is a new attitude toward life and death. "It's examining my life differently than I did before, so that no matter at what point I do die, I've gotten the most out of my life up until that point" (Natalie). These women saw their change in attitude as a positive transformation based on acceptance and reframing.

Focusing

Transitioning evolved into the last phase, a *focusing* on *redefining*, *balancing*, or *loss*. At this point stability became more prevalent than instability and the phase has a trajectory quality to it. There was a sense of acceptance and/or surrender, perhaps readiness to change, which was found in the stage diagrams of Adams et al. (1977), Bridges (1980), Spencer and Adams (2002), and Williams (1999). Redefining brought an expansive transformation of schemas with a future full of possibilities. A focus on balancing brought stability through adjustments that made the "new normal" tolerable, however, schemas remained mostly intact. Focusing on what has been lost became a contracted transformation of schemas. It was a stripping away of life's typical illusions without a suitable replacement yet. These outcomes were not so much a destination as much as they were themes in her evolving life story; they were waypoints along the journey.

Acceptance and reframing were key elements to positive transformation. Without acceptance it was difficult to leave the loss in the past. Without reframing it was difficult to create a new future. The bifurcation between a positive or negative transformation depended on how she perceived both her past and future. Did she focus on what she had gained or lost? Had breast cancer replaced what was lost with something more valuable? Could she

imagine a "better" future? Focusing brought stability to her life space and diminished the recursive nature of the transition. However, new impingements could disrupt the stability.

Although these data were not developed to the point of saturation, it suggested that some women might have integrated a sense of loss into their self-concept—sadness over what she can no longer have. Grieving for what was lost partially defined her. This is not to suggest that focusing on the loss was inevitably pathological; however, it may not have been a very satisfying way to cope. We should also not construe a focus on adjusting to her changed life through balancing as less worthwhile than transforming. In the end her appraisal and coping strategies were selective (Lazarus, 1999) and some aspects of reality were put aside in favor of others. The aspects that were focused on dominate her life space, relegating other aspects to the background. Even a transformation must include some illusion to be maintained. Perhaps the goal should not be interpreted as "getting back to my life," but instead "getting to a life that I can live with."

Transitioning Summary:

- Various cues trigger the *searching for hope and stability* process, while impingements create the need to establish equilibrium through *coping with a changed life*.
- *Searching for hope and stability* can bring up difficult to manage emotions
- Coping strategies range from reestablishing equilibrium through *balancing* to *engaging* with the challenges by adjusting and/or adapting.
- *Searching for hope and stability* and *coping with a changed life* occur simultaneously during the *transition* process and are recursive in nature.
- *Redefining myself* involves changing her schemas to better meet the challenges of her changed life and often involves support from others

- *Focusing* occurs when *coping with a changed life* and *searching for hope and stability* result in a stable life space. The focus can be on *redefining*, *balancing*, or *loss*

The categories were incorporated into a diagram representing the grounded theory:

Transitioning Phase Diagram

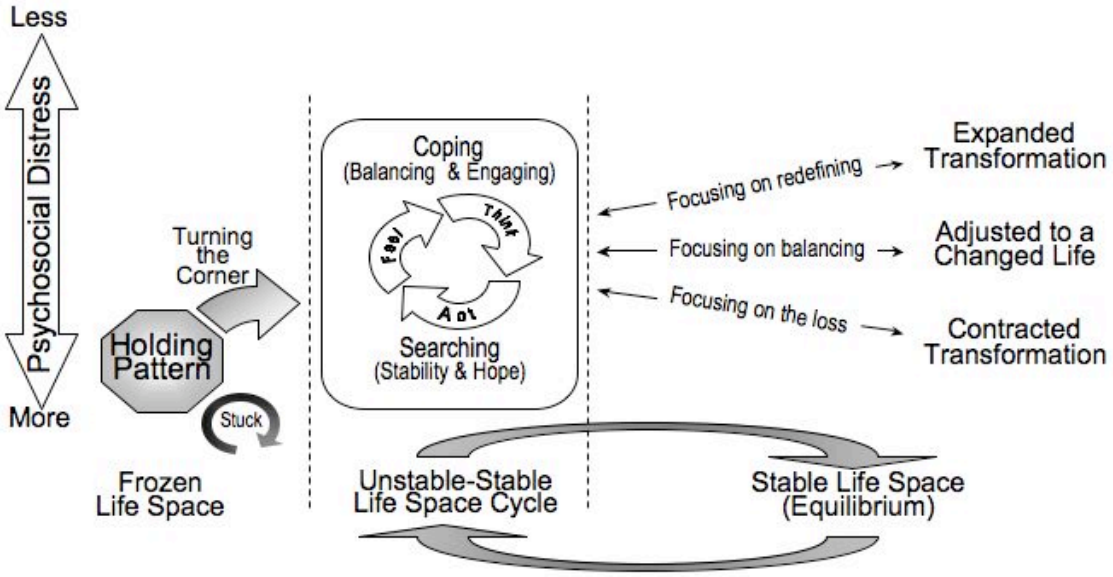

Figure 4.1 - Transitioning Phase Diagram

The phase diagram incorporated phases or what Mezirow (2000) referred to as movements. Throughout this dissertation I have used the terms stage and phase interchangeably. However, I intentionally used phase in this diagram because I felt it lends itself better to being recursive than the term stage did.

The *holding pattern* was a phase where the life space is somewhat frozen. This was a time where she focused as much as possible on enduring the treatments. There was so much uncertainty at this point that much of her life went temporarily on hold. The holding pattern allowed her to cope with the intensity of the situation. Her natural psychological defenses regulated how much she processed at this point. It was a time of being overwhelmed, confused, and in a state of shock.

Because the focus of this study was on the after treatment period, most of the data from the first phase focused on the last part of the phase, which was *turning the corner*. This occurred near the end of or just after her treatments. Her focus changed from enduring treatments to what it all meant. She had expectations about her recovery from treatments and began to plan for the near-term. Her natural defenses dropped enough to allow her to also begin processing the impact on her future life. As the realization of what had happened to her began to dawn on her, her life space unfroze. She began to process what had happened to her at deeper levels and to consider what her near-term and longer-term future would be.

Once triggers caused her to leave the holding pattern, she began a recursive cycle of *searching for hope and stability* and *coping* with what had changed. I labeled this phase *Transitioning* and it was the core category in this diagram. Each of the diagrams mentioned in Chapter II broke down the middle process into multiple segments that included some variation on avoidance, confusion, meaning making, testing, and exploring. Although the authors presented these stages/phases in a linear fashion, each of them alerted their readers to two things: 1) not everyone went through all of the stages, and 2) the stages could be recursive. This became apparent during my analysis when the data from respondents who were through the transition phase was compared to that of respondents who were still transitioning. Those transitioning talked about a "back and forth" sense to their experience. Those beyond the transition phase told their story with a much clearer sense of phases (often centered around events), however, when questioned further, the time before and after those events were recursive too. The recursive nature was also confirmed by comparing longitudinal representations of the respondent's experience in the form of diaries or blogs.

Because life is temporal in nature, phases are a natural phenomenon (Strauss, 1993/2008). Within those phases or second order changes are a constant cyclical process of first order changes aimed at maintaining equilibrium. For the purposes of this study first order change involved adjustments to existing schemas, while second order change added new schemas or modified existing schemas (see: Watzlawick, Weakland, & Fisch (1974); and Levy & Merry (1986)). To represent the recursive nature of the transitioning phase, the two broad activities, *coping* and *searching*, were represented as a cyclical feature. The basic psychological processes of thinking, acting, and feeling (cognition, behavior, and affect) were shown as circular arrows that connected *coping* and *searching*. The addition of a recursive element was an important contribution of this diagram.

Although this representation lost some of the detail of the categories presented above, it did bring forth an important aspect, which was the *Unstable-Stable Cycle* feature of the life space during *Transitioning*. This means that while the *x*-axis of the diagram no longer represents time so literally, it did capture the recursive nature of the movement toward adaptation. Nonetheless, at some point one must fall on one side of a dilemma or the other, or life becomes stagnant.

Without resolution from their coping and searching activity the individual became stuck instead of transitioning. With resolution stability returned and the individual began *focusing* on *reframing*, *balancing*, or *loss*. The *focusing* arrows are bidirectional because some respondents had temporary stability, but then went back into a transitioning cycle. With the exception of Williams (1999), none of the other stage diagrams indicated any bifurcation or trajectory from this point in the transition. The data in this study support Knobf's (2007) and Bonanno's (2004) diagrams of trajectories, with two distinctions. First,

this study was not clinical in nature so no attempt was made to discern if a trajectory represented recovery or resilience. Second, the persistent (Knobf, 2007) or chronic (Bonanno, 2004) trajectory found in their diagrams was represented as being *stuck* in a cycle that has no movement without any transitioning work being attempted in this diagram. Therefore, although inspiration was found in these diagrams and there are similarities with these two trajectory diagrams, no attempt was made to achieve equivalence.

Additional data supporting the holding environment concept

Social support was an important aspect of the transition and exploration of these interactions was key to examining the usefulness of the holding environment concept. These interactions were developed into categories that will be used in the discussion chapter below. Aspects of the holding environment concept were incorporated into these categories. Therefore, these categories are informed by the data but not fully grounded in the data.

These categories are *situating*, *holding* (further broken down into *understanding*, *containing* and *guiding*), and the *transitioning space*. These interactions can influence equilibrium and/or movement during the transition. However, the individual's enduring cognitive, behavioral, and affective patterns interacted with the total environment. Therefore, if the holding environment concept is to be incorporated into our understanding of adaptive change it must be as an interacting element of the larger person-environment relationship.

Situating

Situating is the core category of the hypothetical person-environment diagram presented in the discussion chapter that follows. Unlike the core category *Transitioning* used in the phase diagram, *Situating* does not subsume the *holding* and *transitioning space*

categories. *Situating* is the social process focal point of the interaction between the *holding, transitioning space*, *coping*, and *searching* categories.

Situating impacts the transition through the negotiation of roles. The negotiation is accomplished through narrative and nonverbal communication; however, each party draws upon socially learned schema and their self-concept. For example, respondents had role expectations of their doctors. Julie selected her oncologist very carefully. Part of Julie's plan was to not have to deal with worrying about the treatment details. She asked around and interviewed oncologists until she found one who matched her idea of what a top oncologist should be like. Julie was confident he would do the best that could be done and she could focus on enduring the treatments and tolerating the idea that she had a life-threatening illness. With an oncologist that Julie trusted, she could situate herself as a dependent cancer patient.

Harriet's plan was quite different. She wanted lots of information about her treatments, yet to not take it too seriously. Harriet saw herself as having a good sense of humor that would help her tolerate the treatments and the implications that a cancer diagnosis brings. Harriet did not view this attitude as avoidance, after all she was very involved in treatment decisions, but instead as a way to tolerate what she knew would be stressful. The goal was to temper the stress with humor so she could stay involved. To this end Harriet sought out an oncologist who was competent and had a sense of humor, so she could take up the role of patient to suit her self-concept. Harriet projected how she would situate herself in the relationship and then sought out an oncologist who would fit.

Doctors also expressed expectations of the role they expected patients to take up. In some cases this involved information seeking by the patient. Some doctors asked patients to not trust Internet sources and bring all questions to the doctor instead. This set the stage for

how much authority was granted to the other and how much was requested. The roles were dynamic and shifted in attempts to maintain equilibrium. Julie situated her oncologist as an expert who could be trusted with her life. However, after treatments ended, he did not have an answer for her chemo fog dilemma (mental processing difficulties many chemotherapy patients report). His response did not satisfy her so she downgraded his role to only being interested in the tumor treatments, which meant his main role was done. She then situated peers—who knew more because they were experiencing chemo brain—as a more reliable source of information on the topic of chemo brain. Not only was this a shift in how Julie situated the doctor, but also herself. She was no longer a patient whose very life depended on the doctor. She was now a survivor who was dealing with treatment aftereffects by seeking problem solving information.

Vicki's story about her surgeon ignoring her pain issues illustrates how perceived inequities in the interaction can trigger the respondent to situate themselves differently. First, Vicki took on the role of self-advocate to get herself what she needed. Second, Vicki took on the role of teacher with her surgeon. This situating had a practical aspect because the doctor should "learn" to not make the same mistake in the future. However, there was a social role aspect too. Teachers are often in a higher status role than those they teach. By situating herself as the teacher, Vicki also reclaimed some status and repaired what felt like an inequity to her.

Situating relates to the *redefining myself* category through self-concept. For example, some respondents reached out to newly diagnosed women to support them. Situating oneself as someone who can coach others is a role that makes one's experience valuable and provides additional meaning for the survivor. Not only am I a survivor who has integrated

breast cancer in my life, but also my experience and therefore I have value. Situating herself like this expanded her self-concept and increased the integration of being a breast cancer survivor.

As mentioned above, in the staying positive category, women compared themselves to others and placed themselves in relation to the other(s). Nancy saw herself as being better off, despite her struggle with aftereffects like double vision, "I would go to the support group meeting and listen to other women and what they were going through… I remember coming home, saying to myself, I'm lucky" (Nancy). Bonanno, Papa, and O'Neill (2002) refered to this as "downward social comparisons to less fortunate others" (p. 198). Nancy's next comment suggested there were underlying motives, "Sometimes I think that if you whistle a happy tune, no one will know you're afraid." This situating herself as "lucky" sent a message that she was doing better than she actually felt. This was not just an attempt to convince others, it also bolstered her own meaning making and allowed her to hold on to a sense of self that is acceptable.

Situating is the act of taking on dynamic roles in relation to others involved in social interaction. The roles taken change as the interaction transpires. The roles are consistent with aspects of self-concept, although those aspects may not be in conscious awareness. It is finding a place within the interaction to stand, to choose a possible self (even a future self) from our self-concept (Markus & Nurius, 1986) and bring it to the foreground.

All of this occurs in a dynamic setting. Other social actors are situating themselves too. Power, authority, and social norms color the interaction, and the social interaction itself shifts as the fields interact. In each situation there is a cultural expectation of the possible roles each person can occupy in the interaction. These roles are negotiated and may not fit

cultural stereotypes. Each person also situates the other(s) in the interaction. That role may or may not match cultural expectations or what the other will accept.

Situating illustrates Lewin's (1935) concepts that "*forces control the course of a process*… [and] In every process *the forces in the inner and outer environment are changed by the process itself*" (p. 48). Situating diverges from Davies and Harre's (1990) positioning theory by focusing on psychological forces as fields (Lewin, 1951/1997), which interact to achieve equilibrium in the life space, instead of narrative structuring actions. Currently these two theoretical perspectives are at odds; however, Neisser (1994) encouraged collaboration between psychological and textual inquiry into self-concept, which future research could focus on.

Holding

Holding is made up of social interactions that supported or retarded the respondent's adaptation to impingements. *Holding* could contribute to a respondent's maturation, growth, and adaptation, however it was not sufficient. *Holding* had three subordinate social processes that impacted the transition: *understanding*, *containing* and *guiding*. Actions by supporters contributed or detracted from one or more of these processes. The subcategories below are presented from the perspective of the respondent; no attempt was made to gather data from those providing the *holding* unless the original interaction was observed. During the early analysis the term "supporting" was used to code passages that contributed to this category. In later analysis it was determined that the word "supporting" as a label did not adequately capture all the properties of the category, specifically the alignment of a supporter with her coping and searching for hope and stability.

This prompted what Glaser and Strauss (1967) referred to as "pinpointing" (p. 173) and searching for additional "library data" (p. 174), procedures that can be used late in the analysis. Pinpointing refers to checking specific points in the evolving categories and can include returning to writing by other social scientists (i.e. library data). For this study the focus of the additional exploration was on interaction in a helping relationship. Various sources were examined, specifically: Lazarus's (1991) writing about openness in interpreting an individual's emotional reactions, Mischel and Shoda's (1995) writing about the interaction of an individual's personality system with the environment, and Schein's (2009) writing about understanding in helping relationships proved most useful (further elaborated in the discussion chapter below).

In turn this directed me back to D. W. Winnicott's (1965b) original writing on the relationship aspects of the holding environment concept. "Holding" was the way D. W. Winnicott described a supportive relationship that was open and dynamic, yet, provided developmental guidance. Returning to D. W. Winnicott's work with the "fresh eyes" of this study's data suggested that "holding" was a better label than "supporting" or "helping." Continued exploration may suggest other ways of organizing this part of the data, therefore, future revisions may warrant a different label for this category. However, the grounded data should drive that choice.

Understanding. Understanding in the interaction meant that the other(s) could empathize with and validated her experience. For the holding environment to be helpful, understanding was critical. Understanding built rapport and trust. Empathizing confirmed that the supporter could relate to what the respondent was feeling.

This was not an easy task when it came to dealing with a life-threatening illness. The supporter almost needed to be someone who has had the experience so that they could truly empathize. "I don't think that anyone can get it unless they've been in my shoes or have someone extremely close to them in those shoes" (Melinda). In fact, other survivors provided quite a lot of support for respondents. "I mean my sister was definitely a big support because she experienced it" (Mary Jane).

Other survivors are the respondent's peers. Many of them had similar experiences and truly knew what it was like to be in that situation. "They understand what it's about, what I went through. Maybe not exactly the same, but the same kinds of emotions" (Harriet). Respondents found they could talk to other survivors about things non-survivors would not understand.

> There were four people other than me, so it wasn't quite the turnout I was expecting, but it was nice to chat with people who get it. We chatted about how our friends reacted, how our employers reacted, dating, treatments, you name it. I'm getting to a spot where I'm over the whole cancer thing, so I wasn't even sure I wanted to go, but overall, I'm glad I did. It was great to meet some new people and know that I'm not alone in this whole thing. (Melissa's blog)

Not having anyone who can empathize with you can be a lonely experience, as many young survivors attest. For young survivors, at a different stage of life than the typical survivor, regular cancer support groups did not fit their needs. Friends the same age who were not survivors had a hard time empathizing too.

> I was 33 when diagnosed, and always felt like some kind of one-off, freakish outsider. This was true when I went for treatment (lots of old folks) and when I attended information sessions (prior to surgery and chemo). I've never really gotten past that sense of aloneness (now 35), and really don't like to talk about it with my own peer group. It's like a shameful secret I harbour [sic] (im_jd, 2009, comment posted on *Breast Cancer Chronicles* web site in response to article about young survivors).

> First of all, my friends did not get it. No one was really there for me. So I tried to go to a support group. It definitely wasn't worth it to me. I went to one and I never went back. They were all, I don't know, 60 or older, and I definitely felt out of place. I could not stand getting that, oh, you're so young look which [sigh] I still get that when I go to doctors. It drives me frickin' crazy. (Melinda)

Melinda shaped her holding by seeking out a support group that could relate to her as a young survivor. "About five months after treatment I found the Young Survivor's Coalition online, and it's been the most amazing experience to be able to talk to these women, and I've just had the best experience with it" (Melinda). Because other young survivors were dealing with similar issues they could relate to and understand what it meant to be young and have breast cancer. Age was not the only factor. Some survivors could not empathize with other survivors who had very different treatments. This was because their aftereffects and the experience of what they endured were different.

Although empathy seemed to require some level of experience, validating required deep listening. Validating acknowledged the current emotions and coping mechanisms in use. However, validating (unlike encouraging) did not necessarily support the current coping mechanisms as the best choice. Validation opened up possibilities because it reduced the concern that what one was experiencing was abnormal for the situation.

Validating took what the respondent was experiencing as not only real, but also normal for someone in the same situation. It provided assurance that one is not crazy and acknowledged that her coping and searching for hope and stability were reasonable.

> He was very nice about reassuring me that I had done everything that we needed to do to fight this and that most likely everything would be fine, but understood that this is cancer and it is something that I will worry about a lot. (Melissa's blog)

Listening goes a long way to establishing a trusting relationship.

> I've never had any reason to disbelieve [doctor's] sincerity because if I do have a question about chemo brain or pain or anything like that, he always not just explains

> it to me, but he really does a good job at listening to what your fears are and then addressing them one by one. (Rachel)

Validation followed by reassurance leads to understanding and containment of anxiety.

> I had a lotta hip pain about a year after my chemo. [The doctor asks] "what's the problem" and I told him. He goes, "I know what you're thinking; you're waiting for the elephant to come out of the closet." He goes, "don't worry. Let's just clear that up right away and make sure you're fine. Let's do a bone scan." So he validated my fears. I don't feel like they dismiss my concerns at all. I think they truly understand my concerns, and they do what they can to reassure me. (Rose)

In addition to being empathetic, other survivors also validated her experience. "I had two or three women friends who had been through the same kind of experience. They are the ones that stick closest to you and give you the most support" (Mary). The validation went both ways when survivors reached out to others who had been diagnosed. "I think what that did was give my feelings and my story a level of validation because through what I had experienced I could listen to other people and I could actually help them" (Ann). This validation brought new meaning to her experience because that experience became even more valuable in helping others.

On the other hand, not being validated could be upsetting when it came from an expected source of support. From the perspective of *situating* herself in the interaction it puts her on the defensive. She felt a need to fix the inequity.

> My sister-in-law said to me once, when the treatment was finished—I was probably complaining about an ache or pain. She said, "Oh, Rose, you have to move on. You could cross the street tomorrow, get hit by a truck and die." I says, "You're right, but if you cross the street and get hit by a truck and you live, you better believe you're gonna think about that truck every time you cross the street" (Rose).
>
> There are days that you just can't think positively. If [other survivors] can think positively, why can't I. Why do I have these bad days? It's about being able to say [in my support group], "You know what, I just feel like crap today, and I feel like I'm gonna die early, and I feel like I have a [recurrence]." You don't want somebody to say to you, "Oh, you're fine, think positively." You just want somebody to listen to you. (Rachel)

Vicki was experiencing "severe pain" after her reconstruction and called the surgeon's office looking for help. She did not feel heard at first:

> I had not heard back about any kind of help with this and I was calling saying, "This medication is not helping and I'm out of it anyway." I physically went up to the clinic because nobody was returning my call, and [the doctor] sent her nurse out to tell me that they weren't gonna do anything else for me. It just dumbfounded me, and I sent her a long email message saying, "What do you mean you're not gonna do anything for me," and that's when she referred me to the pain clinic. (Vicki)

Vicki's experience at the pain clinic was completely different. First they validated her experience of being in severe pain that was not responding to the current pain medication. Upon examining her they discovered she had a severed nerve from the surgery and that she was on the wrong pain medication. Being vindicated further validated her, but Vicki still needed resolution:

> My first appointment after that [with the surgeon] I was very straightforward with her and explained to her what my disappointments were with the way that I was being treated by her and her staff. I got an apology. I stayed with her because I wanted that apology. I wanted her to continue to have to deal with me [laughter] so that the next time somebody comes out of surgery and says, "I've got terrible pain" she won't dismiss it like she did with me.

This need for resolution connected directly to the *situating* category above. It was an attempt to restore the inequity that Vicki felt in the interaction.

Containing. *Containing* lessened the grip the emotions had on the respondent. When containing was successful it contributed to her attempts to balance her emotions. The supporter's ability to also tolerate the impingements, consistently be available, and provide reassurance all contributed to containment. This allowed her to relax a bit and process everything because she could count on her support system.

The impingements she experienced could be difficult to tolerate. Seeing her supporter's willingness to tolerate what she is experiencing bolstered her. Tolerating means

hanging tough, no matter what. It helped her tolerate what she was experiencing because her supporters could. "A friend said to me, you will have an outer circle of friends and you'll have the inner circle who will stick with you all the way, and that was true" (Julie).

Her significant other's ability to tolerate was put to the test by the changes her body is going through. Not only has surgery physically altered her body, but also chemotherapy and adjuvant hormonal therapy often decreased her libido. Respondents whose significant others were able to tolerate and work around this had reduced anxiety. In fact, most respondents felt that successfully working through those issues improved their relationship. If talking about sexual difficulties could cause anxiety, then imagine what talking about your own death was like!

Having supporters who can tolerate talking about death was helpful for many respondents because reflecting on mortality could bring up existential angst.

> My dad's been really good and my husband too. I've been able to talk to them about my fears of death. What I want for the kids and how I want the kids to remember me. You know, my fears of everything. They don't throw, "Oh you need to think positively" out at ya. I have found it easier to talk to them than I have other people. (Rachel)

> I make people nervous sometimes because I am so open and honest. So it's good to have somebody that wants to go a little further in depth. Because everybody is so fearful of it. They get squeamish. They'll change the subject if you've gone a little too far. (Joann)

Tolerating was not sufficient, being reliably there was also important. Reliability provided a sense of continuity during the transition. She could count on certain supporters to get her through all of it. "I really feel like my whole support system helped me a lot. I think that's really important to have a really good support system to help you get through things" (Amanda). However, if your normal support system had never experienced something like

cancer it might be difficult for them to be there for you. For Maria, a young survivor, friends could not be there for her because they could not relate:

> I really wanted to have a shoulder to cry on. Even if they couldn't give any advice, just hear me out. Let me vent. I just got a lot of silence. It was not that they didn't want to hear it, it was that they did not have any experience with it.

Even older survivors found that the inability to empathize made it hard for supporters to truly be there for them. "In terms of friends and other members of the family, they didn't know because they had never gone through it" (Nancy).

> More specifically I think that what was the hardest for me was my mother… I wanted that special shoulder to cry on and she wasn't it. She could not be my pillar of strength. That was most upsetting… Well I got that women and motherly stuff from my support group, my new sisters. That's where I got a lot of strength. (Linda)

Knowing she needed that support to manage her emotions Linda sought it out and joined a support group. This supports the *engaging* category above, specifically the *seeking* subcategory. This illustrates that holding is more than something that is simply provided.

In fact, many respondents found that other survivors rallied around them, even women they weren't friends with before. "None of them were friends during treatment. But I knew a couple of them who had been through breast cancer so when I told them, they immediately offered to walk with me [and talk]" (Julie). Supporters could directly reduce disequilibrium by providing reassurance. "The initial reaction, when I got the diagnosis, was I'm going to die. But I think a little bit of talking to people and getting information turned that around" (Harriet). Just knowing other women who are similar to you and are long-term survivors is reassuring.

> This weekend I met a woman who was diagnosed with cancer when she was 28, between the birth of her daughter and son. Her son is now my age, so I guess she's around a 30-year survivor. And she had a child after breast cancer! Everything I read paints an ugly picture of breast cancer in young women, so it was so wonderful for me to meet a real person who has beaten the beast! (Melissa's blog)

Not all interactions with other survivors brought reassurance, because some survivors represent the very thing she wanted to avoid. "There was a cancer patient who proceeded to tell me, 'Oh, this is my second time around. It metastasized' and she proceeded to tell me how cancer's probably gonna come back. I was a basket case" (Dina). Avoiding these reminders was one reason some respondents did not go to support groups.

Avoiding support groups may not be enough. Not understanding the impact it has people often shared stories about people who died or are dying of cancer. "It's totally offensive. If you wanna talk to me about somebody who has breast cancer, tell me about somebody that did good. I don't need to know about the bad ones, and people do say really stupid things" (Rachel).

Most doctors knew that these women needed reassurance in addition to understanding. Many respondents found their doctors reassuring them right from the beginning. "The surgeon said with [the type of cancer] you've got a mastectomy is like a 99.9% cure" (Carrie). After treatments ended, respondents wondered if the cancer was gone (see *searching for hope and stability* above). She looked to her doctor for reassurance. Some respondents wanted evidence from a scan that would detect any remaining cancer. Doing these scans is not the protocol for most breast cancer survivors. However, some doctors knew when not following protocol was warranted.

> He said the only instance where he would have someone have a PET Scan is if they're really so nervous about it that they're going to have more distress by worrying about it. I said, "I really want to know." So he, he did refer me for a PET Scan and I was all clear. I just feel so much better having had that. (Harriet)

For Harriet, this built trust in her doctor and the following year he was able to use this trust to persuade her to accept the standard protocol.

Although the focus of containing was a balancing of emotions, there was a deeper aspect to consider. Containment also protected schemas from impingements. Impingements that threatened the illusions schemas provide us about life, the world, and who we are.

Guiding. Guiding was an attempt to influence the direction the respondent's motivation was taking her. Guiding could align with her coping strategies and encourage her behavior. Guiding could also contradict her coping strategies in an attempt to alter direction. Encouraging was similar to validating with the addition of what Kegan (1982) and Daloz (1999) referred to as confirmation. What was being confirmed and encouraged was the coping strategy currently being attempted.

In one of the observed support group sessions, Sally (not her real name) expressed anxiety over not having heard back about her most recent tumor marker tests. Sally wanted to be more assertive but was concerned about stepping out of line with the doctor. A variety of points were made by various members (the group is self-led), however, two members focused on encouraging Sally to continue taking an assertive stance about getting her results as soon as possible. They countered Sally's reservations about doctors' offices not wanting to be pestered about results. They joked with Sally about their pet name for the doctor, a reminder that he was just a person too. They made the case that it is important to get test results to a survivor quickly because of the natural anxiety a survivor feels about the possibility of a recurrence. Then they began brainstorming possible solutions where Sally could be assertive without jeopardizing the relationship with her doctor.

The sequencing here was important. First, they validated Sally's emotional experience of anxiety as being reasonable for a cancer survivor. Then they switched to

problem solving. By validating her experience first, they created a safe environment. Clearly Sally was among friends who understood what it was like to be in her situation.

Notice the tension created in the way Sally perceived the situation. On the one hand she was anxious to hear about her results because as a survivor she feared the return of cancer and desperately wanted to push that fear into the background again. On the other hand she did not want to step out of her mental schema of the power and authority dynamics between patient and doctor. To take on more agency threatened her dependent relationship with the doctor. Tension was created because these now conflicting schemas had a rigid hold on Sally. With adequate support she was able to consider alternatives.

Validation of her emotions reduced the intensity of the experience. Brainstorming solutions allowed her to recast how she might situate herself in the relationship with the doctor. Encouragement spurred her to take action in a still unfamiliar way, to experiment. In fact, from previous sessions, it was clear that Sally rarely advocated for herself, yet was developing that aspect of her self-concept. Sally eventually came up with an acceptable plan, she would text the doctor, a compromise that accomplished her goal without stepping out of line too much. Sally's dialogue with the other members was the encouragement she needed. Encouragement validated her strategy and added energy to the direction she was already pointed in.

Nancy was struggling to cope with a variety of treatment aftereffects that seem intractable. The only thing she felt she had control over was whether to take her adjuvant therapy medication. The side effects of that medication were something that affects her quality of life that she could eliminate, at the cost of reduced risk reduction.

> I said, "I'm going off of this. I can't take it anymore." And [husband] said, "I don't blame you. I don't think I could do it either." He understood the statistics, and he

> said, "It's really up to you, honey, and I'm fine with whatever decision you make." I did feel that it was important to talk to him about it, because if a recurrence were to happen, he's right there in the front lines. (Nancy)

When the guidance was not in alignment with her coping, it created friction. If it took the form of what Karen Horney (1991/1950) called "healthy friction" (p. 18) the contradiction could support adaptation. The friction itself became an impingement that caused disequilibrium. The added disequilibrium could unfreeze assumptions and acted like a wake-up call.

> It was like a daily thing for me that I had that fear in my head. Oh, this is gonna be cancer again. Then finally my husband said to me, 'they took it all out, it's gone, calm down, relax, let's get on with things.' It was almost like a bell went off in my head and I thought, you know what, I can't think like that again. I have to think more on the healthy side - you know - me living. (Dina)

Understanding and trust made contradicting more likely to succeed.

Ann had a trusting relationship with her reconstruction surgeon. Ann's reconstruction relocated her own abdomen tissue (autologous) to form the new breast. This type of reconstruction is very complex with a longer operation and recovery time. Breast reconstruction goes in phases, with the last phase being the creation of a new nipple after everything else has settled into place. This last phase involves a relatively simple surgery. When it came time for Ann to have this last bit of surgery, her life was quite busy and she was trying to put breast cancer behind her. Ann wanted to put off the final phase of her reconstruction until later:

> I don't want any more stitches. The thought of any more surgery on my body was just so overwhelming, and [the doctor is] saying "Come on Ann, you've gone this far, you need to have something that actually looks like a breast, it's not that big of a deal, it's minor." I think he did the right thing by calling me on it. It worked for me. (Ann)

With trust, contradiction could help ground the respondent in a more reasonable version of reality. Contradiction could be especially hard to hear under stressful conditions.

> [The surgeon] definitely was looking out for me. I went in there thinking one thing, and then came out with a completely different treatment course for me. I heard the word, mastectomy, and had a heart attack. It was just really hard for me to see that at the time because it just so wasn't what I wanted to hear. (Melinda)

Without trust, contradicting could backfire. Eva was suffering from a bad case of lymphedema. She felt her doctor was not helping her resolve the lymphedema, just passing her off to a physical therapist that specialized in lymphatic drainage. Eva was frustrated with the whole process and not buying that there was not more they could do for her. She sought out other help and found a masseuse to do deep tissue massage on the area. Although it felt good immediately afterward, unfortunately, deep tissue massage to an area with lymphedema is contraindicated and Eva's condition worsened. Despite the doctor and lymphedema specialist contradicting her, Eva did not trust them enough to alter course and stop the deep tissue massage.

Transitioning Space

The transitioning space is the interaction between the *coping* and *searching* of the respondent, and the *holding*. From the perspective of the respondent, the holding either increased or decreased her disequilibrium, while simultaneously being in or out of alignment with her coping and searching for hope and stability. It is important to view this interaction from the perspective of the respondent, because her willingness and ability to experiment with possibilities determined the outcome.

D. W. Winnicott referred to a similar concept: "variously as transitional space, the play space, or potential space" (Siegelman, 1990, p. 154). For D. W. Winnicott (1951/1971) the potential space is created by the support. It is a space where experimentation can safely

take place. I extend Winnicott's concept here by focusing on the social interaction and developmental aspects of the space. In many ways this category overlays Vygotsky's (Gredler, 2001) scaffolding concept onto Winnicott's idea. Vygotsky's (Gredler, 2001) zone of proximal development also relates to this category. This will be taken up further in the discussion chapter.

Because the *transitioning space* was dependent on interaction, it could be collapsed from either side. On the one hand she needed to be vulnerable enough to experiment with possibilities. On the other hand the *holding* needed to properly support that experimentation. Therefore building rapport and trust were important if the *transitioning space* was to remain. Without trust, respondents were unwilling to put their assumptions at risk. In fact, understanding and trust are necessary elements of any helping relationship (Schein, 2009).

The *transitioning space* expanded when adequate *holding* allowed impingements to be tolerated. The impingement could "unfreeze" part of the assumptive world. The more adaptive the coping style, the more likely this would occur. However, avoiding styles of coping could lead to a crisis where the impingement(s) overwhelmed her. The crisis pushed her to the point of feeling like she was falling apart. This left the individual with two choices, more avoidance or engaging. This aspect was not fully developed in this study.

Despite being on track for transitioning, some respondents experienced setbacks. In effect something triggered a collapse of the transition space. Some examples were presented above: Julie being overwhelmed by seeing the patients in chemo treatment and not being able to go to support groups in the same building; Maria feeling rejected by the support group and having no one to turn to because her friends had never experienced something like cancer. The transitioning space is fragile. Threats to the illusions meaning schemas provide can be

so overwhelming that she must regress to a safer environment that uses less adaptive forms of coping.

Situating Summary:

- Situating is a social interaction between *holding* and the individual's *coping* and *searching for hope and stability*.
- *Holding* is negotiated and shaped through situating.
- Adequate *holding* creates a safer *transitioning space*, therefore encouraging experimentation with schemas.
- *Holding* helps contain negative emotions improving equilibrium and encourages movement toward growth.

Results Interpretation

The creation and presentation of these results does not mean that my interpretation of the respondents' experience is the same as *their* reality or *the* reality. Instead, the results should be viewed as a map that presents one perspective of the territory, with the understanding that any map, by the nature of its intended use, will distort or neglect some features, while highlighting others. The intention of this study is to add to the intellectual discourse by providing a lucid analysis of the transition process.

The first step was to create the grounded theory presented above and illustrated graphically by the transition phase diagram. The second step was to use the data to examine the holding environment concept. By comparing these results with the literature reviewed above and additional theory to be presented in the next chapter, a second diagram emerged as a hypothetical representation of the holding environment concept. This second diagram focused on the interaction between the supporters and transitioning.

Chapter V: Discussion

In this chapter the data is discussed from a theoretical perspective. Additional theories are considered and integrated. Next, the implications of this study are discussed from the applied, organizational change, and future research perspectives. Three main points are made. First, to fully understand the psychosocial transition both phases and interactions need to be considered. This supports the usefulness of the holding environment, but only if it is conceptualized as a social interaction. Second, there is a recursive nature to the transitioning that phase diagrams should incorporate. Third, it is not sufficient for change agents - which leaders and health care professionals are a subset - to only consider the holding environment when they are promoting adaptive change. The individual's coping and searching, which uniquely emerge from their personality system, must also be accounted for.

Viewing the Holding Environment as Social Interaction

Additional questions arose from the sensitizing concepts presented in Chapter II that went beyond the transition process. Does the concept of a holding environment add anything to our understanding of the transition process? Is the social support reshaped or negotiated to meet the challenge? If so, what or who reshapes it? Does data about the psychosocial breast cancer transition inform the process of adaptive change? To answer these questions the analysis went beyond the generation of the grounded theory represented in Chapter IV as a phase diagram. As mentioned in the results chapter I explored additional writing late in the analysis to aid in organizing the categories that represented social interactions.

This prompted what Glaser and Strauss (1967) referred to as "pinpointing" (p. 173) and searching for additional "library data" (p. 174), procedures that can be used late in the analysis. Pinpointing refers to checking specific points in the evolving categories and can

include returning to writing by other social scientists (i.e. library data). For this study the focus of the additional exploration was on interaction in a helping relationship. Various sources were examined, specifically: Lazarus's (1991) writing about openness in interpreting an individual's emotional reactions, Mischel and Shoda's (1995) writing about the interaction of an individual's personality system with the environment, and Schein's (2009) writing about understanding in helping relationships proved most useful.

If the respondent told a story about feeling like she had made the transition from patient to survivor, these questions were posed about the data: What events or change agents pertaining to development were involved if any? What events did she identify? How did she portray herself and the change agent(s)? To explore these questions the usefulness of the holding environment concept as representing social support was examined.

Helgeson and Cohen's (1999) description of social support in the cancer setting included *emotional*, *informational*, and *instrumental* types of support (see Chapter II). Helgeson and Cohen reviewed and critiqued studies of interventions to improve social support. They concluded that future research should address, "five psychological mechanisms: enhancement of self-esteem, restoration of perceived control, instilling of optimism about the future, provision of meaning for the experience, and fostering of emotional processing" (p. 75).

The results of this study demonstrate that Helgeson and Cohen's (1999) mechanisms were indeed at work in the transition and that the psychosocial breast cancer transition can present developmental challenges. Extrapolating from the categories presented in Chapter IV these challenges included: impingements on self-concept, searching for hope and stability, imagining an acceptable future, coping with emotions, and challenges to meaning schemas.

Extending Helgeson and Cohen's (1999) mechanisms through the lens of this study's results would suggest a forth type of social support, *developmental* support. The holding environment concept, as originally developed by D. W. Winnicott (1965b) and presented in Chapter II, focuses on development through social interaction with those in one's environment. Consequently, Winnicott's original writing was seen with "fresh eyes" and I realized that social interaction needed to be brought to the forefront.

As the *situating*, *holding*, and *transitioning space* categories presented in the results chapter above demonstrate, using a social interaction perspective is informative. It allows one to hypothesize how supporters could influence the transition process and better understand the dynamics at play. The leadership literature currently focuses on the holding environment as a container for anxiety (see Chapter II). The results of this study demonstrate that the support or *holding* is negotiated and at the same time influenced by the individual's *coping* and *searching*. I see these two aspects as crucial elements that must be examined if the holding environment concept is to be applied to adaptive change. Construing the holding environment concept as a somewhat static container that guides the individual during the transition is insufficient.

During analysis I also discovered that a phase diagram could only provide a macro view of the process. This was not sufficient to examine the holding environment concept's potential contribution. To understand the differences between and within individual behavior a micro view that incorporated the interaction of the individual's personality and the environment was necessary. When taken together they provided an expansive view of the transition process. The person-environment diagram is a hypothetical view of the interactions during the transition that combines the data with additional sources.

Person-Environment Situating Diagram

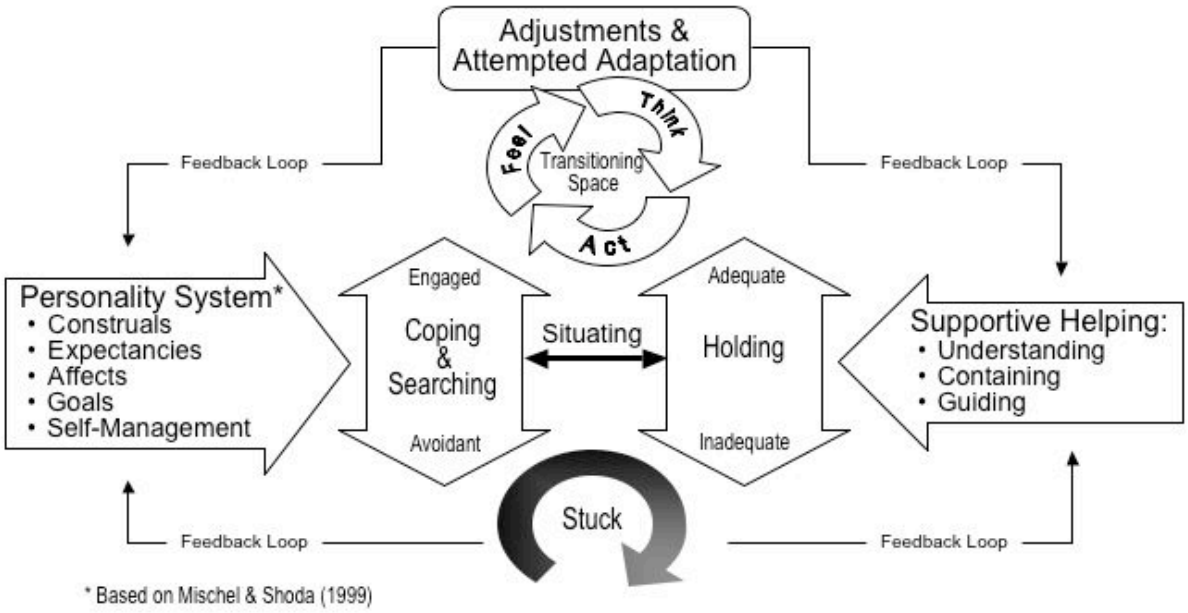

Figure 5.1 - Person-Environment Situating Diagram

This diagram focused not on the phases, but instead on the interaction between the individual and the environment, what was described as the *Situating* category above. Specifically, the *coping* and *searching* interaction with the *holding* category is represented, with *Situating* as the core category. Like other interaction diagrams (see Chapter II), this diagram focused on field forces in the life space. Arrows denoted the flow of forces in the process. Feedback loops were used to indicate that forces interacted with other forces because the system is open. An example of the open nature of the system was seen in the data presented above about treatments ending. Both the respondent and the supporters reacted to the change, interacted through *situating*, and changed behavior based on the interaction. Social interaction is the key.

The forces of *understanding*, *containing*, and *guiding* interacted with the individual through *situating* (see results chapter above). Situating is how she negotiated what she needed from her supporters and what impact (if any) she allowed the support to have on her

coping and searching for hope and stability. If she was willing to put her schemas at risk a *transitioning space* opened up where she could experiment with possibilities (see above). *Holding* facilitated, but did not guarantee that a *transitioning space* would develop. That was because features of the environment activated different aspects of her personality system (see personality discussion below). The ability to create a *transitioning space* was dependent on the interaction with and the adequacy of the *holding*.

Those women who coped through *redefining myself* (see above) were attempting transformation of schemas. This has similarities to transformative learning (Mezirow, 2000). In each case the better the *understanding*, *containing*, and *guiding* were the greater risk she took with her schemas. Yet, not all of the respondents were capable of taking the same amount of risk, their developmental level was not yet up to that level of adaptation. It became apparent that the interactions on the person side are complex. The best explanation for this was to explore the dynamics of the personality system, which will be taken up below.

At a broad level, most social process can be divided into stages or phases (Strauss, 1993/2008). There are several disadvantages to using stages or phases. First, the stages or phases must be broadly defined so they can be applied to different settings (i.e. transferability). Because each individual interacts with the process in his or her own ways, the specifics of the process cannot be determined without consideration for that individual's personality system (Lewin, 1935; Mischel & Shoda, 1999; Shoda & Mischel, 2000). Second, stages or phases naturally define a beginning and an end point to the process. In processes that involve longer-term development there may be elements of the process that are missed because temporary equilibrium is interpreted as an endpoint. Third, in social processes the ends are often defined retrospectively, making it difficult to determine if the ends occur as a

natural part of the process or are imposed by the individual during meaning making or the researcher during analysis. "The 'end' is merely a series of acts viewed at a remote stage; and a means is merely the series viewed at an earlier one" (Dewey, 1922/1988, p. 27). The outcomes in this study's phase diagram are not intended as endpoints.

What is being represented is a stabilizing of schemas in the life space. For example, focusing on the loss is not intended as an inevitably pathological outcome, but instead a waypoint. However, there was a tendency in the literature to do so, "historically much of the research and theory on bereavement has tended to pathologize what are otherwise normal and natural reactions to loss" (Bonanno, Papa, & O'Neill, 2002, p. 193). There is also an undercurrent in the breast cancer culture that the "right" way to experience breast cancer is to be positively transformed by the experience (King, 2004), making adjusting and moving on seem mediocre. As the results chapter demonstrates, some respondents found that bias difficult to deal with and pushed back. This bias appeared in the literature as well.

The stage models presented in Chapter II, with the exception of Williams (1999), took a normative approach to transitions, where developmental adaptation was seen as superior to adjustment or grieving. This was to be expected because the authors were investigating "positive" transformations. There was also substantial literature that explored "negative" transformations, notably the literature on PSTD. By focusing on the two extremes we neglected several features of the transition.

First, as pointed out by Adams et al. (1977) and Vaill (1996), transitions are not isolated events; they overlap and intertwine. The life space is not normally a static field of forces because equilibrium in adaptive systems consists of movement and direction (Lewin, 1951/1997). Therefore, schemas are constantly interacting with multiple impingements and a

changing holding environment. This is most salient for organizational change and will be taken up below.

Second, there is a full range of outcomes. A focus on one extreme or the other missed the opportunity to explore why respondents with similar situations ended up transitioning differently or why individuals who used different coping strategies could have similar outcomes. This aspect is especially important to consider when intervening at both the group and individual level (see below). To address these limitations the person-environment diagram includes interactions.

We can go from a life space of disequilibrium, where direction feels unstable, to one of stagnation, where forces struggle against each other canceling out any movement. The life space has a future that not only has its genesis in the past, but also has the potential to reach back into the past, from the present, and alter our life narrative. This can be conceived as revised memories, reconstructed life stories, or a blend of each (Neisser, 1994). This illustrates our need as humans to have a sense of continuity, even if we must alter history and the present to achieve it. From this perspective, time has a different meaning. We view ourselves as temporally extended, from our present, back into the past and forward into our possible futures (Markus & Nurius, 1986).

It is our anticipation of how that future will unfold which channels our energies and colors our meaning making of events. We expect things to go a certain way. In writing about his theory of personal constructs, George Kelly (1963) used the analogy of placing bets. While we may make some bets that are inconsistent with other bets, overall our wagers do add up in a way that supports our anticipation of how our life will unfold. While our predictions may be wrong or sometimes seem incongruent, there is a certain amount of

consistency over time. This dynamic process maintains equilibrium - which includes movement toward goals or motivation - until unmet expectations force a larger shift. For Kelly (1963) the system of one's personal constructs (mental schemas) and attempts to anticipate events come together to organize an individual's behavior. This fits well with Lewin's (1935, 1951/1997) representation of the life space as those forces that are intra-person and those of the environment.

The difference with Kelly (1963) was his highlighting of a person's mental models as the foundation for our anticipations. Kelly saw anticipation as more than making a prediction (which could be an outcome of anticipation); it is a dynamic process that involves cognitive, affective, and behavioral aspects. The life space is more than the simple sum of all the forces at work—it is a personality system.

Conceptualizing personality as a system was important to extending this study's data. Using a personality system was useful in two ways. First, it explained why seemingly similar individuals, under similar circumstances, could behave very differently. Second, during analysis there was variance within a respondent's reactions to similar situations that could only be understood by incorporating a sophisticated personality theory.

Personality systems. Two personality system theories proved useful in understanding the data from this perspective. Mischel and Shoda's (1995, 1999) Cognitive-Affective Personality System (CAPS) and Lazarus's (1991) cognitive-motivational-relational theory. Mischel and Shoda's theory is a unified personality system that was particularly well suited to understanding an individual's behavioral patterns across differing and similar situations. Lazarus' theory focused in on the role of emotions in searching and coping.

To understand the interaction of the person with the environment, we must understand what both sides contribute. CAPS (Mischel & Shoda, 1995, 1999; Shoda & Mischel, 2000) provided a model of the individual's personality system that specifically allowed for interaction with the environment that impacted behavior patterns. In short it is a modern version of Lewin's (1935) dynamic personality systems theory. CAPS originated in earlier work by Mischel (1973) and has been updated to its current form through extensive research (Mischel & Shoda, 1999; Shoda & Mischel, 2000). At the heart of the theory were three concepts that applied to this study. What follows is based on Mischel (1973) and Mischel & Shoda (1999).

First, there are five cognitive-affective mediating units that are interdependent. These are: encodings (construals of self, others, situations, events), expectancies and beliefs, affects and physiological reactions, goals and values, competencies (abilities) and self-regulatory plans. Second, features in a situation activate one or more of the mediating cognitive-affective units, which in turn interact with other cognitive-affective units to generate behavior. Third, there are organized predictable patterns based on the individual's sensitivity to certain features of a situation. These patterns created what Mischel & Shoda (1999) described as "*if* . . . *then* . . ." (p. 203) signatures that are characteristic of the individual.

It was these signatures that I began to notice during analysis. There were patterns that emerged; yet, the patterns did not yield to a simple cause and effect explanation. A key aspect of CAPS is that the cognitive-affective units are not assessed in isolation, because it is their interaction that is paramount. At the risk of oversimplifying, a brief review of these cognitive-affective units as related to the data in this study will provide a foundation for discussion related to application. What follows, unless otherwise indicated, is based on

writing by Mischel (1973) and colleagues (Mischel & Shoda, 1995, 1999 ; Shoda & Mischel, 2000; Mischel, Shoda, & Smith, 2004).

Encodings are made through the filtering effect of schemas. We selectively attend to information based on our schemas and construe meaning based on the selected information. Jane had schemas about the health of people who exercised and ate vegetarian diets. She also had a self-concept (schema about the self) that she was a health conscious person who exercised at high levels, ate right, and was, in fact, healthy. *Expectancies* are the hypothesized outcomes of behavior in a situation. This includes beliefs about the ability to perform certain behaviors and the probable outcomes if the behavior is preformed successfully. Jane knew she could lead a healthy lifestyle because she typically ran six miles a day, ate a vegetarian diet, and did not smoke or drink. Therefore, she should have had an outcome of being healthy because her belief was that people who lead that lifestyle are in fact healthy. Certainly this was not an unusual expectation and any impingement on this belief would have been upsetting.

Then, Jane was diagnosed with breast cancer, yet, had no family history, "Afterwards I just thought, crap, you can do everything right and still get stupid breast cancer." Her anger and frustration represented her emotional reaction or *affect* over information that had important consequences for her. Lazarus and Folkman (1991) have made clear that the event itself, whether positive or negative, was not as important as the appraisal (a particular type of encoding) of the impingement on one's well being. This distinction was similar to differentiating the "hot" and "cold" sides of the affective system (Metcalfe & Mischel, 1999), which I will discuss below in relation to transformation. The appraisal is partially based on the perception of how the event impinges on the individual's *goals* and *values*, which provide

organization and direction to life's activities. The life-threatening feature of a breast cancer diagnosis seems to have first impinged Jane's personality system at the cognitive-affective unit of expectancies, interacted with her goals and values, and spread. Jane dealt with the disequilibrium using a variety of coping strategies. Her *competency* to *self-regulate* behavior was seen in her ability to critically reflect on other schemas in her life, including her religious beliefs (see *changing worldview* above) and transform them. To use Kegan's (1982) model, Jane had the competency to examine her schemas because they were objects for her. Her schemas were something she had (objects), not something she was (subjects).

Her competency to reflect ranges far and deep within her personality system. Jane did not just question her lifestyle choices; she questioned and searched for information about broader beliefs based on groupings of schemas. Jane read books on different religions and faith, books questioning religious faith, and books about the meaning of life. She also discussed them with her husband and open-minded friends. Prior to breast cancer Jane did not think about such things, she was too busy with day-to-day life to pause for such reflection. Breast cancer's life-threatening aspect triggered emancipatory learning that progressed to adaptation (Mezirow, 1991b; Cranton, 1994). Jane's experience illustrated the interaction not only of the cognitive-affective units but also on the entire CAPS with the environment.

Incorporating CAPS into the diagram provided a better understanding of the person's coping and searching, and the interaction with supporters. CAPS helped me to relate other theories to the specific part of the personality system that is being impinged on. Not only does this improve our theories, it also helps us better understand the process, which has an impact on practice (see below). Broadly speaking, Mischel and Shoda's (1999) self-

regulation is similar to Lazarus and Folkman's (1991) conceptualization of coping, each proposed that the individual behaves in ways they predicted would impact emotions and/or the situation. In my diagram, coping represents the range of emotion self-regulation strategies the respondents used (see results chapter).

However, those self-regulation strategies did not exist in a vacuum, they interacted with her social support system, each influencing the other. The person-environment diagram allows us to examine those interactions; specifically the creation of the transitioning space and the situating the individual does with supporters. Ultimately, whether the individual developed or grew from the experience was based largely on those interactions. Support alone was not sufficient for development to occur. While this statement may seem obvious, theories like Heifetz and Linsky's (2002) adaptive change model (see above) focused on the creation of a holding environment to contain anxiety and downplayed the role of the individual's unique coping and searching for hope and stability.

Coping, searching for hope and stability, and emotions. There is logic to emotional reactions that revealed itself when the individual's personality system was understood (Lazarus, 1991). Lazarus's (1991) theory is a systems model, as is Mischel and Shoda's (1999) CAPS. Lazarus focused on adaptation to stress and the role of emotions and appraisal; yet, he included most of the other personality elements found in CAPS. One difference was the emphasis each placed on the original emotional reaction. For Mischel and Shoda there was a "hot" side to affect that generated the original emotion, which has elements of conditioning and physiological response. They also posited a "cool" side to affect that was more cognitive in nature and could attenuate the hot side.

Lazarus (1991) accepted that there is a physiological response, but had emotion arising from appraisal, in effect taking the stance that a physiological response was not the same as emotion. However, the cognitive path to emotions may not be apparent in all cases. Brennan (2001) pointed out that "Many core assumptions (at least those represented at the propositional level (Power & Dalgleish, 1997) are *preconscious* (i.e. available for scrutiny and discourse, but rarely consciously examined)" (p. 8), therefore from the perspective of the individual the emotions may have felt like they appeared without thought.

For Lazarus (1991) emotion was a process and recurrent patterns represented personality structures. These differences do not make the two theories incompatible; differences are mostly about where in the theory elements were placed and what the overall focus was. For Mischel and Shoda (1999), CAPS was an attempt to unify much of personality theory into a systems model. For Lazarus the focus was on the interactions between appraisal, affect, and self-management. Appraisal was a central tenet for Lazarus and was a particular type of construal that makes meaning of events we perceive as significant to our wellbeing. Lazarus further broke down appraisal into *primary*, what was the relevance to the person's goals, and *secondary*, what were my coping options. Lazarus saw this process continuing with later reappraisal being responsive to feedback from the environment (therefore it is an open system). I have labeled this *searching for hope and stability* and it is also central to my diagram. As stated earlier, coping in my diagram represents actions taken *and* the overall strategies in use to self-manage affect. Coping and searching for hope and stability are intertwined because coping behaviors influence what features of the environment are given attention and therefore, what construals and

expectancies are activated. This highlights an important difference between the phase diagram presented above and the person-environment diagram.

The person-environment diagram interprets the data from the perspective of the respondent. For example, whether she noticed and/or experienced the holding environment as providing understanding was based only on her perception. As the results showed, each respondent had a different take on reality.

> because the environment is enormously complex and not everything can be attended to, and because it is often ambiguous, we attend to and process it selectively in ways that are, in a sense, programmed by goal hierarchies and what we believe about ourselves and the world. There are also many realities, not a single one, and we must not fall into the habit of thinking of personality factors as necessarily distorting reality. Instead, out of several possibilities, personality factors influence which realities are relevant (Lazarus, 1991, p. 135)

Therefore, even an adequate holding environment that provides an ideal setting for development may not lead to adaptation. If the individual used an avoidant coping strategy then they were not putting their schemas at risk of change and development did not occur. From Kegan and Lahey's (2009) perspective the individual can only change what they are willing to put at risk. This has implications for application, which will be covered next.

Intervening

Two things emerged from the results and diagrams in this study that impact intervening to create change. First, that there is logic to the emotions arising from transitions. There is a reason people cope and make the meaning they do when faced with change. To be truly helpful a change agent needs to understand that there is a unique logic to the strategy that individual uses in that situation. Second, the personality system of the individual determines which features of the environment are attended to and what the possibilities are for change. We cannot concern ourselves as change agents only with the

"external" environment we attempt to create. That environment will interact with each individual's life space in a different way. Without some understanding of the prominent and dynamic forces currently at play in an individual's life space, any help a change agent provides that moves the individual in a better direction will be accidental (Dewey, 1938; Schein, 2009). It is praxis that needs to be considered.

It is not that the theories and models don't help us understand the process better; it is in the application of them that we stumble as change agents. In the results chapter above there were examples of many people who understood and sympathized with what cancer patients go through, yet, interacted with respondents in ways that unintentionally collapsed the transitioning space. They did not view themselves as a social actor who was interacting in her life space and was also simultaneously acted upon. Change agents not only interact with the system, they are a part of it too.

Understanding first. Even the best holding environment will not allow someone to adapt if they are not in Vygotsky's (Gredler, 2001) zone of proximal development (see Chapter II). This is not about the motivation to change; it is about the ability to change. Kegan's (1982) subject-object concept discussed in Chapter II is another way to frame the ability to change. The inner holding environment also applies because how the individual self manages impingements matters. If I don't allow myself to go there then the impingements can't create the disequilibrium that is needed for adaptation, I am left only with adjusting as best I can. Two examples from the results chapter illustrate this.

The shattering of mental models focused on deep existential questions can add angst to a life space that already has increased tension. Despite the "emancipation" from the hegemony of socially dictated norms (Brookfield, 1987, 2000) and the potential impact on

Jane's ability to see her other mental models as objects that could potentially be modified (Kegan & Lahey, 2009), the end result might not be superior. Jane's experience was eventually satisfying because she let go of illusions that were not serving her. However, Jane was ready for transformative change. Her willingness to explore other ways of knowing through reading and discussion suggested she fell into Kegan and Lahey's (2009) self-transforming level of mental complexity.

In contrast to Jane's experience, Joann's experience asking the same "why me" question brought her to a different conclusion. Joanne was a spiritual person who believed in Jesus and she found comfort in her faith. Joanne concluded that life could not be random and there must be a reason why God gave her breast cancer. Joann did not ask if there was a God, she asks what God's purpose was for her. When God did not provide an answer she adjusted her thinking by concluding that no answer means she was not supposed to know. In effect, Joann's line of reasoning allowed her to maintain her existing beliefs with only minor adjustments. In Piaget's terms Joann *assimilated* the impingement while Jane *accommodated* it (Gredler, 2001).

The difference for Kegan (1982) was in their mental complexity. The important point was not that Joann found solace in her faith and Jane found freedom in transforming hers. What was critical was realizing that their stories differed in both the willingness *and* ability to adapt their beliefs. While it may not have been emancipatory for Joann it was a potentially more satisfying result that reduced the prospect of additional angst and allowed her to move on. Joann's own personality system naturally protected her. Heifetz (1994) wrote about pacing the adaptive work. Yet, the person in the transition is also pacing herself or himself, just as Jane and Joann did. Before one can judge if the individual can handle more challenge,

understanding and trust are needed (Schein, 2009). Then a pace can be set that is beyond, but not too far, where the individual is now. This was the principle behind Vygotsky's scaffolding concept (Gredler, 2001).

Kegan and Lahey's (2009) method improved the possibility of successful adaptation by first seeking to understand the individual's schemas. Kegan and Lahey (2009) referred to schemas as "immunities to change," and their intervention attempted to first understand how the individual construed the world and then to facilitate changing that construal. To adapt schemas one needs to see how certain schemas block attainment of a desired goal. Kegan and Lahey (2009) even had the individual map out these conflicts in a table that was reminiscent of Lewin's (1935, 1951/1997) force field analysis.

Another example from the data that illustrated how forces in the individual's personality system need to be understood first comes from Julie. As seen in the results chapter Julie did not want to talk about breast cancer because it was upsetting to her. However, with select breast cancer survivors she trusted she could and did discuss the impact on her life. From this it would seem to follow that Julie would do well in a breast cancer support group. Yet, when her oncologist suggested she check out a particular support group, she could not bring herself to do it. Not because she feared the group would not be a safe environment, but because the group met in the same building where she had been treated. In effect, a feature of the environment, its location, interacted with Julie's personality system to trigger memories that were intolerable for her. This also demonstrated how incorporating Mischel and Shoda's (1999) CAPS into the person-environment model improved understanding the variation within a respondent's behavior.

If understanding is critical to facilitating adaptive change, then we must also consider that understanding implies the possibility of change on both sides of the interaction. To understand an individual's coping strategies and searching for hope and stability the change agent must be willing and able to make their own assumptions objects available for scrutiny. The change agent must be willing to risk his or her own constructs, to suspend judgment long enough to understand before intervening. D. W. Winnicott (1965b) described this as being willing to be surprised by what came from the interaction.

Leading change. Although there are many differences between surviving cancer and organizational change, the experience of transitioning and the holding environment has transferability to other settings. I have consulted to leaders who could not understand why followers were doing some of the things they were doing because these were normally rational good workers. It was disorienting for both leader and follower. The leader could not see things through the eyes of the follower and the follower could not adapt to the changes without either transforming schemas or modifying the incoming information. Much of the discussion above about interventions applies to leading change. There are several additional points that are specific to leading change.

According to Marshak (1994) most organizational change plans followed steps that resembled Lewin's intervention phases of Unfreeze-Change-Refreeze or something very similar. If the process of going into a *holding pattern* during treatments (found in this study) has transferability to other contexts, we can expect that while the organization unfreezes then changes, the individual may actually go into a holding pattern or "freeze" to endure the initial changes. Then, as the organization stops making changes and attempts to refreeze, the individual has an expectation that things will go back to the way they were before. In fact,

when I viewed the data in this study and compared it to previous organizational change interviews I had done I saw a similar pattern in some people.

Organizational change affects whole groups or organizations, and each individual brings their own life space or situation to the group. Leaders cannot treat everyone exactly the same and conclude that those that don't leave the holding pattern are somehow resisting or broken. In fact, the leader may have failed to provide an adequate holding environment for that individual's unique set of inner forces. Dewey (1938) suggested that the success of a learning intervention, which does not take into account the individual's "internal conditions," was accidental. To be more purposeful understanding is needed.

Understanding is at its best when it does not restrict the interaction to only one way of construing the situation. The leader needs to be open, tolerate ambiguity, and to be able to hold potentially conflicting schemas simultaneously. This suggests that the best change agents are those who have self-transforming minds (Kegan & Lahey, 2009). In *Leading Change*, Kotter (1995) wrote that, "most of the executives I have known in successful cases of major change learn to 'walk the talk.' They consciously attempt to become a living symbol of the new corporate culture" (p. 64).

When leading change, a leader needs to put her or his schemas at risk of being changed. Burns's (1978) transforming leadership definition had *both* the leader and followers being transformed, "transforming leadership… occurs when one or more persons *engage* with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (p. 20). Couto (1997) commented that Burns used the gerund transforming, "with the implied and subtle change from a process in which the leader participates to a state of being or character of a leader" (p. 88). In effect, the leader must be

self-transforming (Kegan & Lahey, 2009) to be a transforming leader by Burns's (1978) definition.

Heifetz's (1994) work suggested a more directional transformation where the leader mostly decided what the goals were. In fact, Heifetz's inclusion of a cancer story where the doctor withheld information to pace the change (see pp. 76-88) suggests he took a leader-centric view. There was no suggestion that the doctor should have sought to understand the unique individual in front of her. Because she is a doctor or leader she must have known what was best. That is not to suggest that Heifetz did not portray the doctor as sympathetic and well intentioned. It is just that the order is wrong. It should have been understand first, then contain, and guide. The notion that we can know what is important for the other's recovery is an authoritarian, power over, approach.

A more constructivist approach would be to honor their narrative construction of reality by first understanding it. That is a difference I see in how Kegan and Lahey (2009) took up facilitating change. Their interventions focused on helping the individual overcome the individual's immunity to change to achieve a goal the individual valued. However, organizational change does not necessarily align with a member's goals. Typically the leader has authority to implement the changes that organizational management intends. Leaders, in trying to overcome resistance to change, may push adaptation that is not yet possible. Instead, Kegan and Lahey (2009) focused first on developing the individual's mental complexity around goals they valued.

The nature of organizational change models. One of the most written about areas in organizational studies has been the very nature of organizational change. Stage models are popular with organizational change theorists. While the organizational change literature has

evolved over time, the phase diagram presented above suggests changes to those models may be in order. First a brief review.

Theorists focused on many dimensions when studying organizational change. Change can be deliberate, anticipated, or unexpected (French & Bell, 1995; Nadler & Tushman, 1990). Its scope can encompass Global communities, whole industries, an organization, or down to the smallest elements within one organization (French & Bell, 1995; Van de Ven & Poole, 1995). The magnitude and speed of the change can vary (French & Bell, 1995). The nature of the "new" organization can be similar, incremental or first-order change, or fundamentally different, discontinuous or second order change (French & Bell, 1995; Nadler, Shaw, & Walton, 1995). The multidimensional nature of organizational change makes it a complex subject to study.

"The study of change and development is one of the great themes in the social sciences" (Pettigrew, Woodman, & Cameron, 2001). Armenakis and Bedeian (1999) dealt with the large number of publications on organizational change by focusing "on publications particularly sensitive to the dynamics underlying organizational change" (p. 294). All of the literature on organizational change processes that Armenakis and Bedeian (1999) reviewed was some type of stage/phase model. As will be developed below, Marshak (1994), Olson and Eoyang (2001), and Wheatly (1999), questioned the underlying assumption that change processes progress in inherently linear stages, something this study also challenges.

Proponents of stage models downplayed linearity by pointing out that individuals move back and forth between stages and a group may have individuals in various stages simultaneously (Adams et al., 1977; Bridges, 1991; Mezirow, 1991b). The stage/phase models Armenakis and Bedeian (1999) reviewed fell into two categories, recommendations

for implementing change, and understanding the change process. It is apparent that both of these topics are of interest to change agents. The direct applicability to leading change efforts warrants further investigation into several of these models below.

Most organizational change studies have only focused on isolated factors. A meta-analysis done by Damanpour (1991) suggested that there were moderating effects and interactions among the factors. This empirically substantiated something that seems obvious to many change agents from her or his first hand experience. The practice of organizational change involves many moving parts that are interconnected, making attempts at influencing the system difficult at best. Damanpour's (1991) intention in the study was to inform organizational studies that generated or added to theory. However, research in the field of organization studies has a dual standard to meet: scholarship and practical relevance (Pettigrew et al., 2001). Practical relevance in the case of organizational theories often means providing the change agent with a simple diagram or metaphor that can be applied to aid their efforts (Astley, 1985). Ironically, Damanpour's research study pointed to a need to consider even greater numbers of variables, adding dramatically to the complexity, if we were to understand organizational change.

There was an underlying assumption here that one can understand the whole by fragmenting it to analyze even greater numbers of pieces, noting how they are interconnected, and adjusting as needed. Margaret Wheatley (1999) wrote about this assumption in *Leadership and the New Science* as a "Newtonian" and mechanistic worldview, a distinctly Western cultural perspective. Underlying any approach to organizational change, scholarly or pragmatic, are core assumptions. For example, Sturdy

and Grey (2003) identified one of the core assumptions underlying the field of organizational change management (OCM).

> Organizational change and its management have become a huge field of study and practice. Readers of this journal will need little introduction to the dominant approaches or perspectives (e.g. rationalist, processual, humanist, political and contingency), or the various typologies of change (e.g. emergent, planned, first order, second order) or the seemingly endless models for organizational change (see Ford and Ford, 1994; Morgan and Sturdy, 2000; Van de Ven and Poole, 1995). What holds together this variety is, within OCM, a core assumption that change *can, should and must* be managed. (p. 653, emphasis added)

Wheatley (1999) saw this as a misguided position that was based on the Western or Newtonian belief that the universe "cannot be trusted with its own processes for growth and rejuvenation. If we want progress, then we must provide the energy to reverse decay" (p. 19). Like Atlas, we bear the weight of the world, resisting or attempting to manage natural processes, instead of being in harmony with them (Wheatley, 1999). Underlying Newtonian assumptions blinker us to the multifaceted and holistic nature of the change process.

These underlying assumptions or worldviews determined which organizational change factors were addressed by theorists (Hunt, 2004) and practitioners alike. Marshak (1994) believed our cultural biases influenced how we understood organizational systems and the intervention options we believed were available to us. This same perspective can be applied to psychosocial transitions.

Brookfield (2000) suggested that our assumptions and narratives about life were illusions that served us by keeping the fragmented chaos of day-to-day experience hidden. We create stories about who we are in relation to others. When our schemas are challenged the illusion is at risk and we begin the recursive cycle of coping and searching uncovered in this study. If the leader is expecting a linear reaction their interventions may be out-of-sync with the follower's actual transition.

Future Research

Three follow on studies were suggested by this study. First, a longitudinal study of breast cancer survivor transitioning that uses diaries, blogs, and journals they wrote while transitioning. It would test this study's grounded theory and expand it. At the same time interviews with minorities would be added to expand the diagram further. Second, the testing of this grounded theory in other settings. Possibilities include organizational change settings and other types of illnesses. Third, a participatory research study done in collaboration with breast cancer survivors. The study would use Kegan and Lahey's (2009) immunity to change model to create workshops for survivors that included the survivor's input.

In addition several other research avenues came to mind:

- Operationalize the *understanding*, *containing*, and *guiding* aspects of the holding environment, then create a survey to test the hypothesis that they improve adaptation. This could be done with breast cancer survivors first, then in organizational change settings as well.

- Does Kegan's (1982, 1994) level of mental complexity predict the coping strategies used? The person-environment diagram in this study suggests that, because the personality system accounts for the developmental level. Lazarus and colleagues created typologies of coping styles and instruments to measure them that could be used. However, there is a study design problem here. It is feasible that an individual would regress to less complex states of mental complexity when faced with an impingement such as a cancer diagnosis. Also, if subjects were tested well after the fact the study may be measuring the growth that a cancer diagnosis has already had on their mental complexity. Still, the study does have potential.

- A variation on the above would be to hypothesize that someone who is in Kegan's (1982, 1994) self-transforming stage has less need for a holding environment to adapt. In effect their own internal holding environment allows them to critically reflect on their own schemas as objects without too much outside help.

- Respondents seemed to have coping themes to their experience. I had a sense that I could have remapped them into preferred coping styles. Is there a correlation with Kegan's (1982, 1994) mental complexity? The hypothesis to be tested would be that more adaptive coping styles correlates positively with greater mental complexity (it should be noted here that Kegan's mental complexity is not the same as intelligence, see Chapter II).

- Respondents related during their interviews aspects of how they perceived it to be difficult for their partners too. Theoretical sampling of partners - which was not done in this study - would provide a perspective on their provision of a holding environment and would provide variance data around the holding environment category. In addition, the diagrams could be tested with partners to see if they also transition in a similar fashion.

Conclusion

This study explored the breast cancer survivor's psychosocial adaptation after initial treatments ended and created a grounded theory that represents the transition. The data was further analyzed and it was determined that support for the usefulness of the holding environment concept was only warranted if it was construed as a social interaction. This study presented the results as categories in two organizing frameworks, a transition phase diagram and a person-environment situating diagram. The results suggested that the leadership adaptive change literature should integrate an understanding of coping and searching into organizational change interventions. In addition, incorporating the social interaction represented by *situating* would enrich any attempts to intervene in adaptive change, including the psychosocial breast cancer literature. From this study several conclusions can be made.

The holding environment is made up of social interactions that support or retard the individual's adaptation to impingements. The holding environment facilitated, but did not guarantee that a transitioning space would develop. That is because features of the holding environment activate different aspects of the individual's personality system. The ability to create a transitioning space was also dependent on the interaction itself, including the

adequacy of the holding environment. Even an adequate holding environment that provides an ideal setting for development may not lead to adaptation. If the individual used an avoidant coping strategy then they were not putting their schemas at risk of change and development did not occur. The holding environment concept could contribute to an individual's maturation, growth, and adaptation, yet the individual's recursive *coping* and *searching,* which emerges from their personality system, must be taken into account.

This impacts intervening to create change in two ways. First, there is logic to the emotions arising from transitions. There is a reason people cope and make the meaning they do when faced with change. To be truly helpful a change agent needs to understand that there is a unique logic to the strategy that an individual uses in that situation. Second, the personality system of the individual determines which features of the environment are attended to and what the possibilities are for change. We cannot concern ourselves as change agents only with the "external" environment we attempt to create. That environment will interact with each individual's life space in a different way.

Change agents must take into account not only that different individuals will interpret the same support differently, but also that the same individual may react differently when that same support is provided in a different context. In effect each interaction between the individual and the holding environment involved *situating* on both sides. To truly offer understanding change agents need to be open, to be able to hold onto multiple schemas simultaneously and put their schemas at risk for transformation. Understanding is at its best when it does not restrict the interaction to only one way of construing the situation.

Lastly, the addition of a recursive element was an important contribution of this study. To represent the recursive nature of the transitioning phase, the two broad activities,

coping and *searching*, were represented as cyclical features. The basic psychological processes of cognition, behavior, and affect were integrated as circular processes that connect *coping* and *searching*. Incorporating this recursive phase is a departure from past models; however, its existence has been alluded to in the literature. It is an improvement of transitioning theory to explicitly include this recursive nature in the theoretical diagram.

APPENDIX

Appendix A

Individual Interview Informed Consent Form

Participant Consent: Individual Interview

Overview: This study involves research that explores the experiences of breast cancer survivors after treatments end. By listening to and understanding your stories, I will gain knowledge that can be applied to other areas and to help those in similar situations. This interview is part of Charles Foster's doctoral study at Antioch University. Results may appear in future articles and/or books.

Your Participation: You will have one main interview, a follow up interview, and a chance to comment on the study's results. These will be recorded and notes will be taken. In addition, you will be contacted a few days after the first interview to see if you have any questions.

Your Rights and Risks: As far as I know, there are no risks to this research study. Participants may actually enjoy and/or benefit from telling their story. If you find talking about your story upsetting, please let me know. You can choose to not answer any question and stop the interview at any time. You may also choose to withdraw from this study for any reason and at any time. If you choose to withdraw before the results of the study are in review, I will not use any quotes from your interview.

What Happens to Your Interview? After the interview is typed up I will edit out actual names, places, and events. A research team will read the typed and edited interview. Nameless quotes may be used in the dissertation or future writing and presentations. Some people want their actual names used, if you do please let me know.

Thank You for Being a Part of This Study.

Contact me with any questions: Charles Foster, (203) 270-0444 cfoster@phd.antioch.edu
My committee chairperson is Jon Wergin Ph.D. (804) 269-3826 jwergin@phd.antioch.edu

If you have any questions about your rights as a research participant, please contact:
Dr. Carolyn Kenny, Chair, Institutional Review Board
Ph.D. in Leadership & Change, Antioch University, ckenny@phd.antioch.edu, 805-565-7535.

Print Name: _____ Date: _____

Sign: _____

Focus Group Informed Consent Form

Participant Consent: Focus Group or Group Interview

Overview: This study involves research that explores the experiences of breast cancer survivors after treatments end. By listening to and understanding your stories, I will gain knowledge that can be applied to other areas and to help those in similar situations. This interview is part of Charles Foster's doctoral study at Antioch University. Results may appear in future articles and/or books.

Your Participation: You will be part of a group talk about some results of the study. I may quote things from interviews, without using names. This group talk will be recorded and notes will be taken. I ask that you keep what others have said here private. Keep in mind that someone may repeated what you say outside of this room.

Your Rights and Risks: As far as I know, there are no risks to this research study. Participants may actually enjoy and/or benefit from talking with the group. If you find this talk upsetting please let me know. You can choose to not talk about any topic and stop participating in the talk altogether at any time. You may also choose to withdraw from this study for any reason and at any time. If you choose to withdraw before the results of the study are in review, I will not use any quotes from your interview.

What Happens to This Talk? After the talk is typed up I will edit out actual names, places, and events. A research team will read the typed and edited talk. Nameless quotes may be used in the dissertation or future writing and presentations. Some people want their actual names used, if you do please let me know.

Thank You for Being a Part of This Study.

Contact me with any questions: Charles Foster, (203) 270-0444 cfoster@phd.antioch.edu
My committee chairperson is Jon Wergin Ph.D. (804) 269-3826 jwergin@phd.antioch.edu

If you have any questions about your rights as a research participant, please contact:
Dr. Carolyn Kenny, Chair, Institutional Review Board
Ph.D. in Leadership & Change, Antioch University, ckenny@phd.antioch.edu, 805-565-7535.

Print Name: _____ Date: _____

Sign: _____

Invitation to Participate

The following text was used in invitation letters, my web site about this study, sent by email and posted on cancer center bulletin boards.

I am looking for participants for a research study that looks at the experience of breast cancer survivors after treatments end. I am also the husband of a breast cancer survivor. By listening to, recording, and understanding your stories, it is my hope to gain knowledge that can be applied to help others in like situations and to other areas also. I am interested in hearing many different stories. Even if you do not think your story is that interesting, I am sure there is something I can learn from you.

You will not be named in the study, you can change your mind at any time and withdraw. Time of day and location is flexible. You must speak and understand English.

To qualify you must be a woman who has been diagnosed with breast cancer that has not spread beyond the lymph nodes and you have not had a recurrence. You should be or almost be finished with initial treatments and no more than two years have past since then. If you are unsure if you qualify, a short phone call or email will clarify that.

Please call or email me, or if you know of someone who might be interested pass along this information.

Charles Foster (203) 270-0444 cfoster@phd.antioch.edu

Request to Recruit Participants

My name is Charles Foster and I am a doctoral candidate in Antioch University's Leadership and Change program, and the husband of a breast cancer survivor. I am conducting a grounded theory research study that looks retrospectively at the provision of a *holding environment*[*] for women breast cancer survivors during the period after the end of initial treatments. The goal of this research study is twofold: to inform the study of psychosocial breast cancer transitions and to add knowledge to the scholarly study of mentoring and leadership during a crisis.

Participants will primarily be women breast cancer survivors. To gain additional perspective it is possible that some breast cancer survivor's partnres, doctors, nurses, and other staff may also be interviewed. Participants may withdraw at any time and interviews will be anonymous. Interviews will be recorded. The participant must speak English.

Invitations to participate will be done so that I will not know names until after the individual has volunteered. I will not see any medical records nor will I ask participants for any specific details about treatments, staff, or the institution. Should a participant give specific treatment details, those will be removed from the transcript as they do not pertain to the topic area and will be considered private information. Transcripts and quotes will have all names, institutions, events, and other identifying information removed by the interviewer before other team members view the files. Recordings of the interview will be transcribed using a service that provides a high level of security and confidentiality (these services have procedures in place to meet HIPAA requirements). The media used to record the interviews and contact information will be stored in a locked file cabinet. To prevent unauthorized access (including access by theft), electronic copies of the originals kept on computers will be password protected and encrypted using the AES 128 security standard (the highest available to the public).

This study adheres to the regulations and ethical standards in the "common rule" and "Belmont report" as adopted by the Department of Health and Human Services (DHHS). Before interviews take place this study will be reviewed and approved by both the dissertation committee *and* the Institutional Review Board, Ph.D. in Leadership & Change, Antioch University, Dr. Carolyn Kenny, IRB Chair, ckenny@phd.antioch.edu, 805-565-7535.

Please contact me with any questions or to discuss the protocol you want me to follow.

(203) 270-0444 cfoster@phd.antioch.edu

My committee chairperson is Jon Wergin Ph.D. (804) 269-3826 jwergin@phd.antioch.edu

Thank you for considering my request, a copy of the invitation & informed consent is attached.

Charles A. Foster

Doctoral Candidate Antioch University

* Social support & containment for the challenges individuals face during difficult transitions.

After Interview Leave Behind Information

Thank you for participating, I truly appreciate your time and willingness to share your story. In the next few days I will call you to see if you have any questions. If I have further questions I will contact you to set up a time to talk. When I have started summarizing, I may contact you to get your feedback.

If you have any questions or want to add anything contact me at:
Office (203) 270-0444 Cell (203) 417-7550 Email*: cfoster@phd.antioch.edu
*Email messages are not secure, do not send any private information by email.

Resources

24-hour Breast Cancer Network of Strength™ Hotline 800-221-2141 (English)* 800-986-9505 (Spanish)
www.networkofstrength.org The mission of the Breast Cancer Network of Strength™ Organization is to ensure, through information, empowerment and peer support, that no one faces breast cancer alone. Breast Cancer Network of Strength™ provides information and support free of charge at www.y-me.org and through the 24-hour Breast Cancer Network of Strength™ Hotline, which is staffed entirely by trained peer counselors who are breast cancer survivors. *Interpreters available in 150 languages

Ann's Place (203) 790-6568 www.annsplace.org Cancer support in Western Connecticut & Eastern New York

OncoChat www.oncochat.org Online peer support for cancer survivors, families, and friends

BreastCancer.org www.breastcancer.org Information and discussion groups (including families and friends)

Well Spouse Foundation 1-800-838-0879 www.wellspouse.org Support for spousal caregivers

Cancer Information Service (NCI) 800-4-CANCER (1-800-422-6237) http://cis.nci.nih.gov
A national information and education network in English and Spanish

Breast Cancer Network of Strength Men's Match Program 800-221-2141

To talk with a man who understands your concerns, call the Breast Cancer Network of Strength Hotline and ask to be matched with a male volunteer. You'll receive a return call at the time and place you request.

Men Against Breast Cancer (866) 547-MABC (866-547-6222) www.menagainstbreastcancer.org
National non-profit organization designed to provide targeted support services to educate and empower men to be effective caregivers when breast cancer strikes a female loved one; as well as, target and mobilize men to be active participants in the fight to eradicate breast cancer as a life threatening disease.

Appendix B

Breast Cancer Transition Literature Search

Topic area refinement began with a broad pool of literature, about 2,700 articles and dissertations (1997 to 2007) focused on the breast cancer experience. RefViz™ software was used to view and understand this larger pool of studies, to look for groupings, and fine-tune the search terms. Because the holding environment concept is not broadly used outside of the object relations and social work fields, it was expanded to include psychosocial constructs. Terms such as "social support," "culture," "quality of life," "caring," and "coach" identified those studies that fell within the broadly defined concept of holding environment in the large set of records. This produced the search string below.

Main search string:

Main topic area: ("breast cancer" OR "breast neoplasm*") *in subject heading only* **AND** *sub topic area:* ("social support" OR support OR qol OR "quality of life" OR partner OR husband OR "significant other" OR holding OR environment OR "holding environment" OR care* OR caring OR psychosocial OR cultur* OR coach* OR navigat* OR mentor* OR Coordinat* OR "peer counselor") *anywhere in record* **AND** *phenomenon topic area:* (experience OR transition OR adjustment OR transformat* OR positive OR negative OR growth OR cope OR coping OR benefit OR "posttraumatic growth" OR ptg) *anywhere in record* **AND** *empirical study limiters:* (empirical OR qualitative OR quantitative OR study OR survey* OR questionnaire* OR grounded theory OR phenomenolog* OR ethnograph* OR autoethnograph* OR hermeneut* OR critical OR action OR discourse OR feminis* OR heuristic OR "focus group" OR case study OR narrative OR participa* OR analysis OR history OR measurement OR sampling OR respondent OR subject) *anywhere in record*

Limiter strings:

To exclude clinical trials, and medical or pharmaceutical or psychiatric treatment studies: NOT (trial OR genetic OR cells OR tumor* OR tumour* OR screening OR lesions OR "magnetic resonance imaging" OR mri OR diagnostic OR detect* OR mamogra* OR protein* OR protocol* OR dosage OR dissection OR therap*) *anywhere in record*

Additional limiters: if available in an index only peer reviewed articles included, in MEDLINE the sub category of "cancer" was selected.

Indexes: The entire PsychINFO database, and within the EBSCO database: *Alt HealthWatch, CINAHL Plus with Full Text, Communication & Mass Media Complete, Education Research Complete, Health Source - Consumer Edition, Health Source: Nursing/Academic Edition, MEDLINE with Full Text, SocINDEX with Full Text, Women's Studies International, Academic Search Premier*

Because the initial search was restricted to concepts similar or related to the holding environment concept, that body of literature was seen as a starting point from which to expand on. Additional literature was uncovered through "mining" reference lists in the initial studies of interest and reviews of psychosocial breast cancer literature.

Permissions

Permission was obtained to reproduce figures used in this dissertation. Following is the correspondence granting permission for each figure.

Figure 1 permission: Productive range of distress, (Heifetz & Linsky, 2002)

From Permissions IS5820_12897@is.instantservice.com
To Charles Foster <cfoster@antioch.edu>
Date Tue, Sep 20, 2011 at 9:06 AM
Subject RE: Request to use one figure in a PhD dissertation (#8095-252774486-6985)

Dear Charles Foster,

Thank you for your email. As long as the HBP material is only being used to fulfill the class assignment in the pursuit of your degree, permission would be granted at no charge as long as the material is fully cited (as you have already done below).

If the thesis is later published or distributed as training material, however, then there would be a royalty charge for use of the HBP material that would be based on how much material is used and the print run.

Sincerely,

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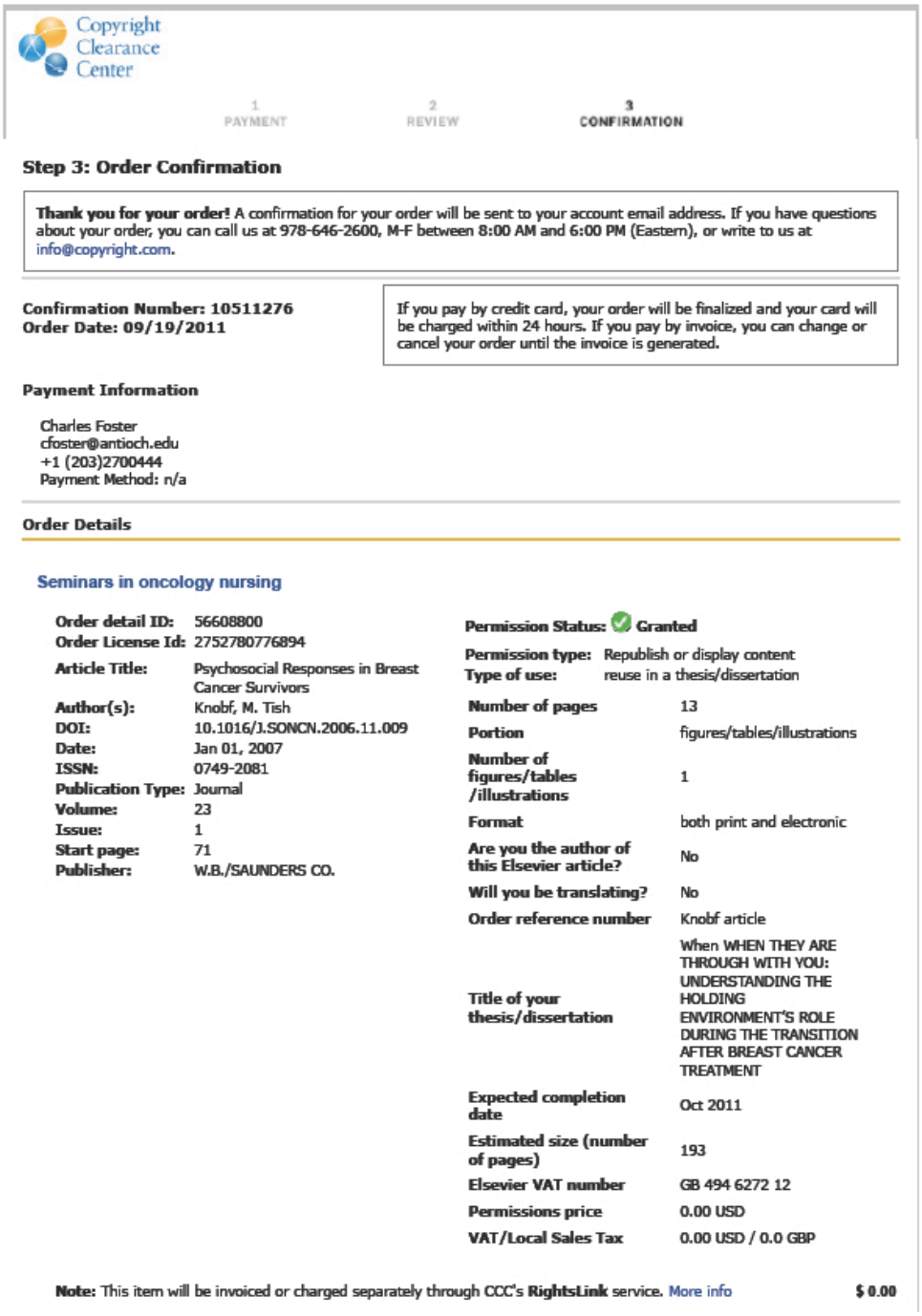

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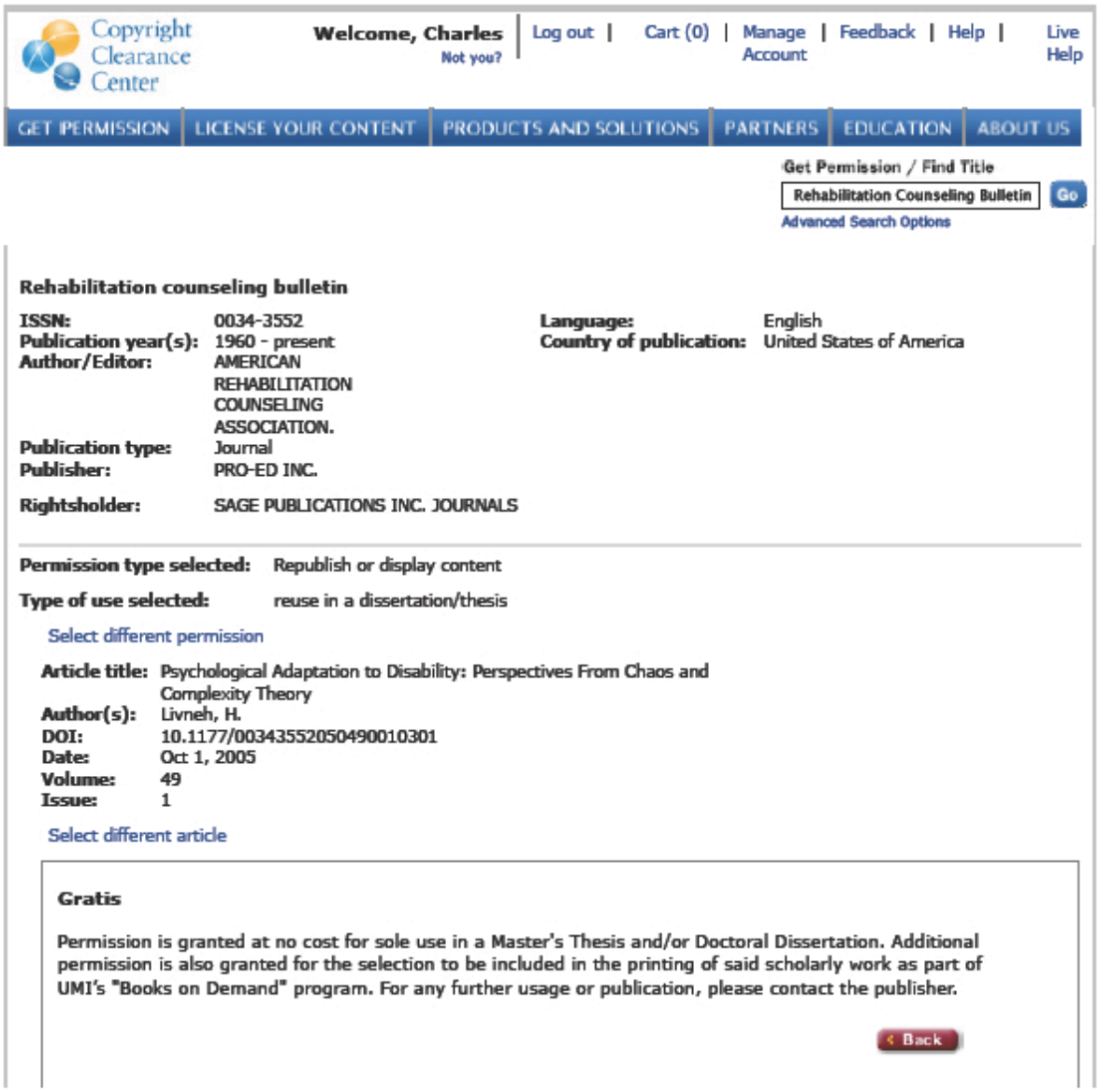

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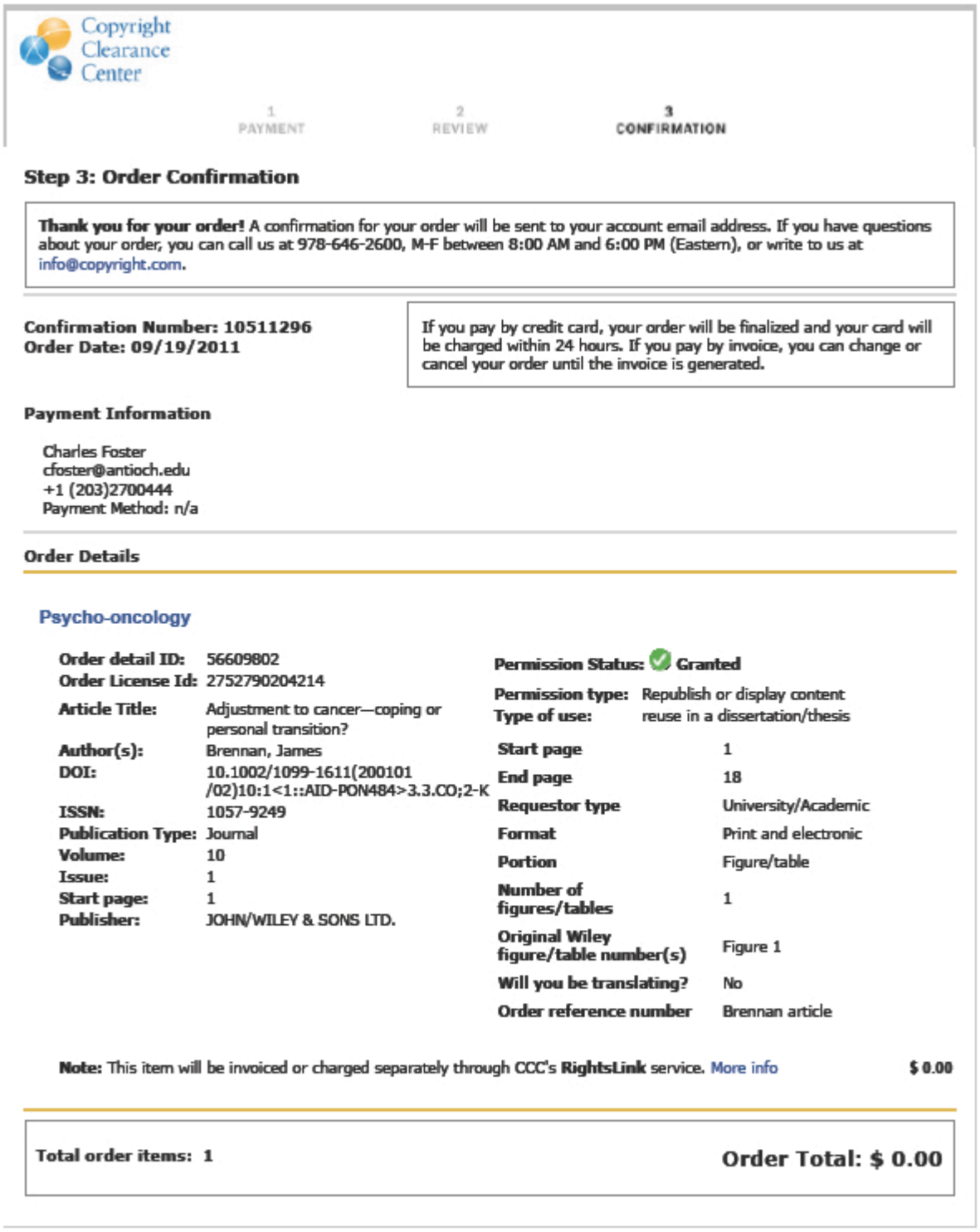

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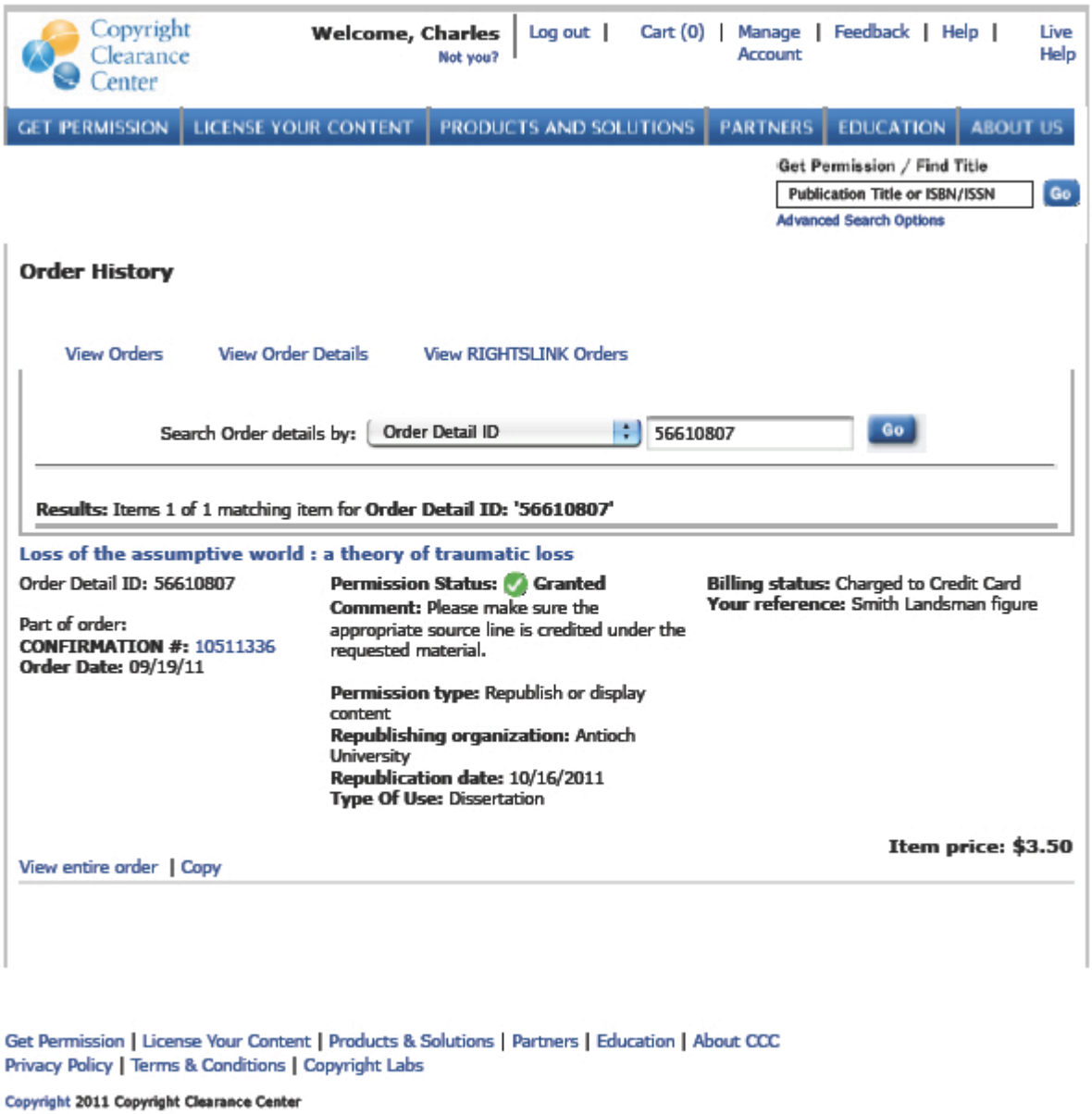

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Endnotes

[i] While Donald had been developing his ideas for some time, and benefiting from the intellectual and creative stimulation in his relationship with Clare, the actual use of the terms "holding" and "environment" in the context I refer to in this study was by Clare (Britton-Winnicott, 1955/2004), in an article she wrote about social work with children. " 'The Theory of the Parent-Infant Relationship' (1960) is a nineteen page tour de force entirely worthy of its rather grand title. It shows the maturing of thoughts that were first broached in 'Primitive Emotional Development' (1945). At the forefront in the paper are the terms 'holding' and 'the holding environment' which, at the very end of the paper, in a footnote, Winnicott attributes to his wife Clare with reference to a 1954 [1955] paper of hers on casework" (Rodman, 2003, p. 267).

[ii] There is a potential incongruence here with Heifetz's (1994) ideas of the use of authority to create a holding environment. "If [the leader] has authority in the social system, then he has some leverage over the holding environment. He can reduce the distress by being an authoritative and hopeful presence, providing clear direction and protection, orienting people with the reasons for undergoing hardship, adding internal structures, controlling conflict, and framing the debate in less challenging ways. Conversely, he elevates distress when he puts pressure on stakeholders, unleashes conflict, includes provocative voices, and frames the debate more starkly" (Heifetz, 1994, p. 243). It seems that Heifetz may be focusing on the adaptive task of the organization, not the development of individuals as Winnicott does. The leader, doctor, nurse, counselor, or other change agent may need to consider which is their more important objective, and to be cautious when balancing dependence and development. Schein (1988, 1999a, 2003) considers it part of the change agents task to develop the individual or organization so that their dependence becomes less over time.

[iii] There is a dual nature to classic grounded theory because it has both positivist and interpretivist roots (Charmaz, 2003; Dey, 1999; Goulding, 2002b; Locke, 2001). Prasad and Prasad (2002) would label classic grounded theory as *qualitative positivism*:

> For the most part, qualitative positivism adopts a relatively commonsensical and realist approach toward ontological and epistemological matters. Reality is assumed to be concrete, separate from the researcher, and cognizable through the use of so-called objective methods of data collection (p. 6).

In part this is because of the coming together of Glaser's quantitative training at Columbia University and Strauss' training in symbolic interactionism at the University of Chicago (Birks, Chapman, & Francis, 2006; Charmaz, 2006; Dey, 1999; Goulding, 1998, 2002b; Heath & Cowley,

2004; Henwood & Pidgeon, 2003; Locke, 2001), and the influence from that era of sociological, psychological, and social psychology research.

Denzin and Lincoln (Denzin & Lincoln, 2000) have labeled this time period as, "…the golden age of rigorous qualitative analysis…" (p. 14), and indicate that *The Discovery of Grounded Theory* (Glaser & Strauss, 1967) was an important marker. Glaser and Strauss – building upon qualitative methodology that was mostly passed on through mentoring and lecture at the time – made explicit procedures and strategies that broadened the appeal of qualitative research at a time (mid 1960's) when quantitative methods were dominant (Birks et al., 2006; Charmaz, 2003; Goulding, 1998).

[iv] Glaser (2002) has spoken out against constructed grounded theory and states that only his version is true to the original, his is the only variation that should be called grounded theory, and that all other variants "force the data" through preconceived ideas. Some see his argument as naïve because it assumes that qualitative research can be done under an objectivist epistemology and ignores the evolution of qualitative research (Bryant, 2007). Glaser's attack is somewhat ironic in that Charmaz's (2006) variation is an attempt to address just this issue through the use of a constructivist epistemology that brings a researcher's preconceived notions and influence on the data to the forefront and incorporates it into the analysis. Glaser would most likely respond that researcher memos should include any suspected preconception and those memos are part of the analysis anyway. In effect, Glaser feels that classic grounded theory procedures allow the researcher to be as "objective" as is possible in qualitative research, on the other hand, Charmaz and other proponents of constructed grounded theory feel that progress from the last 30 years of qualitative research methodology can be incorporated into grounded theory without "forcing the data." This ongoing debate makes it imperative that researchers using the method provide the reader with information about the variant of grounded theory being used and the theoretical perspective that guides the study. Each of the variations is a valid form of grounded theory, and it should be left to the reader to decide if the variation used is appropriate for the topic and properly implemented (e.g. consistent epistemology).