CHEMOTHERAPEUTIC TREATMENT OF CANCER: AN ECOSYSTEMIC STUDY OF HYPNOSIS AND ATTRIBUTIONS OF MEANING

by

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submitted in accordance with the requirements for the degree of

DOCTOR OF PHILOSOPHY

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

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NOVEMBER 1997

I declare that "Chemotherapeutic treatment of cancer: An ecosystemic study of hypnosis and attributions of meaning" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

P. LEVY 1997-11-30

ACKNOWLEDGEMENTS

It is with much gratitude and appreciation that I acknowledge the invaluable assistance and support given to me by the following people in the process of bringing this thesis to fruition:

Prof. David Fourie for infusing life into this work, for sharing his knowledge, for his patience, his guidance and his encouragement.

Prof. Bezwoda and Staff of the Oncology and Haematology Unit at the Johannesburg General Hospital, for their willing co-operation and availabiltiy, in particular Sisters Ward and Franken. The Wits Ethics Board for sanctioning the research.
The patients who co-operated in this research project, and gave so generously of their time.

The Staff of the Unisa Library for the exceptionally professional and efficient service rendered to me throughout the research work. Particular thanks to Mr James Kitching of the Reference Library.

The academicians and clinicians who provided me with valuable input, clarification and encouragement: Prof. August Cluver; Prof. Gillian Straker; Dr. Louise Olivier and Mr. Gus Coetzee.

Colleagues, friends and family members who were not only consistently supportive throughout, but who also came to the rescue in times of need. In particular: Wendy and Steve, Janet, Doron, Linda, Melanie, my sister Jean and my mother.

My husband, Wally, for his encouragement and support, his generous assistance, his proof reading of the final material and for being there when I needed him.

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SUMMARY

The word "cancer" has different meanings for different people. In general, it is synonymous with fatality, either imminent or in the forseeable future. How each person perceives and attributes meaning to this personal experience, varies according to idiosyncratic factors. These factors are constituted by each individual's unique internal make up and by external influences and it is the combination of the multiplicity of factors that bring about the personal attributions of meaning for each individual.

The thesis examines the attributions of meaning of a sample of 42 women with breast cancer, through administration of a semi-structured interview and questionnaire, with follow up interviews. The theoretical concepts which are explored, examine the shift away from the traditional, Newtonian, linear-causal, neutral observer model (as in the traditional medical model), towards an ecosystemic, a-causal, contextual, holistic stance.

Ecosystemic thinking is utilised in this research work, and this way of thinking is applied to the findings. In addition, a qualitative, descriptive approach is adopted, so that an in depth emphasis rather than a quantitative, empirical view of the patients in the sample, is undertaken. The applied questionaire focuses on the patient's experience of cancer diagnosis, with more specific reference to the side effects of the chemotherapy. The emphasis is towards the issue of anticipatory nausea and emesis and the possible use of hypnosis in relation to these effects. Each patient's attribution of meaning to these aspects forms the core of the thesis.

The study discloses the wide variety of attributions of meaning held by different women in a similar predicament towards different aspects of that predicament. Concomitantly, the study highlights the limitations of the traditional, medical model which contribute to

diminishing the personal understanding of each patient, and the impact of this on both treatment and outcome for each patient.

KEYWORDS

Anticipatory nausea and emesis; Attribution of meaning; Cancer; Chemotherapy side effects; Ecosystemic; Hypnosis; Qualitative research.

CHAPTER 1

INTRODUCTION

Despite advanced 20th Century medicine, cancer remains a prevalent disease, with predominantly serious and malevolent outcome for the person diagnosed with the illness. The serious consequences and side effects of the treatments which are presently available to treat cancer, also often militate against a positive perspective.

Perhaps as a result of the inherent attitude of fatality which is attributed to cancer, it is not an illness about which the lay person speaks easily or openly. There is secrecy, fear, even shame as well as anger, helplessness and often strong dependency on the medical figures (who may be seen as controlling, authoritarian and possibly healing parental figures). The emotions and beliefs surrounding cancer and the diagnosis of cancer in a patient are often suppressed or denied by the patient and/or the family, resulting in feelings of isolation and depression.

In general, cancer is seen as fatal unless treated medically (and even then it is often seen as fatal despite medical intervention), and a particular reality is constructed around this disease. As Capra (1987, p. 388) states: "The popular image of cancer has been conditioned by the fragmented world view of our culture, the reductionist approach of our science, and the technology-oriented practice of medicine."

Based on medical research, techniques and ideas, (including the realities constructed by the people concerned), the doctor will devise and prescribe a treatment plan, and if the patient is cooperative and in agreement, the plan will be instigated. This usually involves surgery, chemotherapy or radiation or a combination thereof, in order to possibly halt and/or reverse the progress of the illness to prolong life. The treatment often causes the patient to feel worse than the illness itself and it may incur moderate to

severe side effects. With regard to the chosen treatment, the beliefs of the doctor and the patient usually are directed towards the expectation or hope of amelioration of the illness (Weinberg, Louw & Schomer, 1994). The construction of this reality as described, is idiosyncratic for each individual, and the doctor and patient may construct their own different realities about the patient's cancer. The selected treatment plan is based on a constellation of ideas, past experience, future expectations and attributions of meaning on the part of both the doctor and the patient.

The present study explores the perceptions of individual breast cancer patients in the research sample, in relation to each individual's illness and her treatment, together with her attributions of meaning over the course and duration of the treatment. This perception involves the patient's beliefs together with the meaning she attributes to the procedure. This attribution of meaning includes her perceptions of the possibility of unwanted side effects of treatment as well as the end result of the treatment. What she believes she is able to do for herself around her illness, if anything, is also important and is taken into account in this study.

1.1 Towards a Holistic Approach

An important aspect of the treatment of cancer (and the field of medical treatment in general) is the dichotomy between the assessment and treatment of the physiological or organic aspect of the illness, and the addressing or ignoring of the psychogenic or psychological makeup of the person.

From a traditional point of view, cancer and any side effects of cancer treatment are seen in terms of the medical or biomedical model which may be described as linear-causal and reductionistic in outlook and approach. As Bloch (1983) points out, such a focus has resulted in further decontextualization of the patient (from a more specific viewpoint), and an associated fragmentation of the health care process (in general). As

a result, there is a general reduction in the responsibility of all concerned with the health care process and this includes the patient and his/her own level of responsibility for his/her illness/wellness.

This narrowed viewpoint which is utilised by the specialised medical model, precludes the holistic approach to the individual patient. As a consequence, the disease rather than the person becomes the focus of treatment. Thus, the treatment often becomes a dehumanising and not always a beneficial experience for the patient, both physically and psychologically.

The awareness of the need for a shift towards a holistic model from this linear-causal, restrictive Newtonian stance, must of necessity, give way to a wider outlook. Such a holistic model would need to take an interdependent, interrelated and interconnected stance. In taking such a stance, ideas, beliefs, perceptions, feelings and the physiological processes of the patient would be included in the treatment approach, as well as an inclusion of the people involved in the patient's world (Griffith & Griffith, 1992; Onnis, 1993). The process of medical data collecting would thus give emphasis to dialogue between patient and clinician (Hewstone, 1983) and as Engel (1992) states: *"...dialogue is truly foundational to scientific work in the clinical realm"* (p. 8, italics in original). This outlook would include a biopsychosocial approach with recursive cycles and structures of meaning (Schwartz & Wiggins, 1986), rather than, or in conjunction with, the present day approach which incorporates increased medical specialization with a consequent focus on specific body parts and diseases of those body parts (Dym, 1987).

1.1.1 A Brief Statement on the Ecosystemic Stance

An ecosystemic approach to the treatment of the individual with cancer encompasses not only the diagnosis and illness of the person, but also a functionally meaningful unit

involving the contextual awareness, together with the interrelatedness of that person with his/her environment and with the people in the world around her/him (Bloch, 1983). This approach is a move towards a holistic, integrational viewpoint of disease where treatment of the disease means treatment and involvement of the totality of the person.

1.1.2 The Medical Approach

1.1.2.1 The Medical View of Chemotherapy

From a medical point of view, the chemotherapeutic treatment of many cancer cases often results in numerous moderate to severe side effects which frequently cause patients excessive distress and paradoxically, for a time, worsens the quality of life while the treatment is in progress.

Cytotoxic drugs act at the cellular level to directly destroy tumour cells (cytocidal) or to induce local adverse conditions so that tumour cells are unable to replicate (cytostatic). The cytocidal mechanism inhibits protein synthesis so that a depletion of essential enzymes causes cells to become incapable of being self-sustaining and they therefore die. Desoxyribonucleic acid (DNA) synthesis is inhibited via cytostatic mechanisms so that normal cellular replication consequently cannot occur (Golden, 1975).

1.1.2.2 The Physiological Side Effects of Chemotherapy

Unfortunately chemotherapy affects not only the tumour cells but also healthy cells, resulting in unwanted side effects. These side effects, even in successful chemotherapy treatments, may include alopecia, stomatitis, diarrhoea, anaemia, immunosuppression, temporary or permanent frigidity or impotence, anxiety, depression, anorexia, changes in liver enzymes and not least, nausea and emesis (Burish & Lyles, 1981; Carey &

Burish, 1988; Golden, 1975; Golden, Horwich & Lokich, undated publication; Laszlo, 1983; Lyles, Burish, Krozely & Oldham, 1982; Morrow & Dobkin, 1988; Penta, Poster & Bruno, 1983). The nausea and vomiting can at times be so severe and debilitating, causing amongst other problems, marked electrolyte imbalance, dehydration and weight loss, (Frytak & Moertel, 1981; Glaxo Holdings, 1991), that some patients decide to refuse further chemotherapy preferring to deal with the ensuing consequences rather than suffer the alternative consequences of the severe disability of the side effects (Burish & Carey, 1986; Andrykowski, Redd & Hatfield, 1985; Frytak & Moertel, 1981; Laszlo & Lucas, 1981; Morrow, 1986; Morrow & Dobkin, 1988; Odansetron Technical Monograph, 1991; Penta et al, 1983; Whitehead, 1975).

The antiemetic medication available at present, including two potent and costly new drugs, Zofran and Kytril, is not always effective or adequate in curtailing or reducing the nausea and/or emesis and in turn has its own set of unpleasant side effects e.g. sedation and dystonic reactions (Borison & McCarthy, 1983; Glaxo Holdings, 1991; Morrow, Arseneau, Asbury, Bennet & Boros, 1982; Weddington, Blindt & McCracken, 1983).

1.1.3 The Psychological View

1.1.3.1 Psychological Side Effects of Chemotherapy

One of the psychological side effects of chemotherapy, an interesting phenomenon termed anticipatory nausea and vomiting (ANV), has been documented by many research workers (Ahles, Cohen, Little, Balducci, Dubbert & Keane, 1984; Andrykowski, 1986; Andrykowski et al, 1985; Burish & Carey, 1984, 1986; Burish & Lyles, 1981; Burish, Redd & Carey, 1985; Carey & Burish, 1988; Cohen, Blanchard, Ruckdeschel & Smolen, 1986; Contach, 1983; DeVita, Hellman & Rosenberg, 1985; Dobkin, Zeichner & Dickson-Parnell, 1985; Kellerman, 1980;

Laszlo & Lucas, 1981; Lyles et al, 1982; Nicholas, 1982; Redd & Andrykowski, 1982; Redd, Rosenberger & Hendler, 1983).

Anticipatory nausea and emesis often occurs in patients who have experienced marked posttreatment nausea and/or vomiting from the chemotherapy treatments. When present, it usually occurs only after the fourth or fifth administration and is reported in the literature to occur in 8% to 57% of the patients (Andrykowski, 1986; Morrow & Dobkin, 1988). Since it occurs prior to the actual treatment event (but usually only after several previous treatments associated with severe nausea and/or vomiting) and often in association with stimuli or thoughts connected to the hospital or treatment environment, this phenomenon has been attributed to conditioning and is assumed to be a conditioned response (CR) (Andrykowski et al, 1985; Burish & Carey, 1984; Burish & Lyles, 1981; Carey & Burish, 1988; Dobkin, Zeichner & Dickson-Parnell, 1985; Lyles et al, 1982). When ANV manifests, it is a particularly troublesome and unpleasant indirect side effect of certain chemotherapies and obviously creates additional distress in the sufferer. It is mostly unresponsive to and thus not alleviated by antiemetic medication (Laszlo, 1982; Laszlo & Lucas, 1981; Morrow et al, 1982).

1.1.4 An Altered Perspective of Anticipatory Nausea and Vomiting

1.1.4.1 Attribution of Meaning as Opposed to Conditioning

An aspect of ANV which has not been clearly implicated or researched, is the possibility that it may be the result of the patients' particular attributions of meaning to the illness and/or to the treatment, rather than being simply a conditioned response. That an attribution of meaning or a belief could have powerful effects on the physiology (and behaviours) of an individual is well documented (Andreychuk & Skriver, 1975; Ajzen & Fishbein, 1980; Bramwell, 1956; Carey & Burish, 1988; Cohen Sachs, 1987;

Fishbein, 1967; Fourie & Lifschitz, 1985; Frank, Gliedman, Imber, Stone & Nash, 1959; Friedman, 1963; Girodo & Wood, 1979; Glass, Singer, Leonard, Krantz, Cohen & Cummings, 1973; Goulding & Goulding, 1979; Honigfeld, 1964; Jones, 1977; Kirsch, 1985, 1991; LaClave & Blix, 1989; Lyles et al, 1982; Margolis, 1983; Matthews, Simonton & Shook, 1984; Nerenz, Leventhal & Love, 1982; Pattison, Lapins & Doerr, 1973; Peck & Boland, 1977; Redd, Rosenberger & Hendler, 1983; Rosenthal & Frank, 1956; Sacerdote, 1970; Simonton & Simonton, 1975; Simonton, Matthews-Simonton & Creighton, 1978; Timko & Janoff-Bulman, 1985).

In the work of the Simontons (1975; 1978), the relationship of this particular aspect of healing i.e. patient beliefs, is seen to be so important and so profound that it forms the basis of the Simontons' treatment of cancer (Simonton & Simonton, 1975; Simonton et al, 1978).

1.1.5 The Use of Hypnosis in Dealing with Anticipatory Nausea and Vomiting

Because hypnosis has been used successfully in the treatment of nausea and vomiting and other side effects in cancer treatment, part of this study also set out investigate the patients' attributions of meaning surrounding hypnosis.

There is an abundance of documented research describing traditional approaches to hypnosis, relaxation techniques, desensitisation, guided imagery and biofeedback methods which have been found to be highly effective in ameliorating not only ANV, but in some instances, posttreatment nausea and emesis as well (Bowers & Kelly, 1979; Burish & Carey, 1984; Burish, Carey, Krozely & Greco, 1987; Burish & Lyles, 1981; Burish, Redd & Carey, 1985; Butler, 1955; Carey & Burish, 1985, 1987, 1988; Cohen Sachs, 1987, Contach, 1983; Dash, 1980; Dempster, Balson & Whalen, 1976; DeVita, Hellman & Rosenberg, 1985; Dreifuss-Kattan, 1990; Hendler & Redd, 1986; Hilgard & Hilgard, 1975; Hoffman, 1983; Kellerman, 1980; Kennedy, Packard, Grant

& Padilla, 1981; LaClave & Blix, 1989; Lyles, Burish, Krozely & Oldham, 1982; Marcia, Rubin & Efran, 1969; Margolis, 1983; Milne, 1982; Morrow, 1984, 1986; Morrow & Morrell, 1982; Redd, 1981, 1986; Redd & Hendler, 1984; Redd, Rosenberger & Hendler, 1983; Sacerdote, 1970; Siegel & Longo, 1981; Simonton, Matthews-Simonton & Creighton, 1978; Stam, 1969; Zeltzer, LeBaron & Zeltzer, 1984). Since these techniques work relatively rapidly, are free of side effects, cost-effective (Carey and Burish (1988) believe otherwise) and allow the patient a degree of control over the discomfort, many research workers have made valuable and creative use of these methods. An in-depth description of these techniques is not considered relevant in this study.

An individual's attribution of meaning relating to hypnosis is an important determinant as to how that person views hypnosis and whether or not that person would value hypnosis. This in turn, would be likely to influence whether or not that individual would be inclined to accept and to learn to use hypnosis as a possibly beneficial tool in assisting with the control of the illness and its associated problems. Whether attributions of meaning and belief systems, when taken into account with illnesses such as breast cancer and its chemotherapeutic treatment, dictate or influence associated occurrences such as side effects, (in particular ANV), is undocumented. It thus appears that this is an area that has not been well researched. This observation stands in contrast to the well-researched and documented use of hypnosis in the treatment of ANV.

1.1.6 Attribution of Meaning and Beliefs

1.1.6.1 The Relationship of this Aspect to the Present Study

Attribution of meaning and belief systems are embedded in an individual's idiosyncratically constructed 'knowledge'. This in turn is based upon each individual's internal makeup, together with that individual's perception of experiences and his/her

interrelatedness with the world and the people in the world around him/her. A major part of the focus of this research project is to ascertain whether or not patients have any prior knowledge of the side effects of chemotherapy and how they consequently construct this knowledge to form personal attributions of meaning relating to their illness, treatment and side effects. In addition each individual's attribution of meaning relating to hypnosis is also extracted and forms an integral part of the research. Because each person's attribution of meaning will be idiosyncratically constructed and idiosyncratically different, the personal impact on each particular individual will be specific for that individual. This research concerns itself with all of these issues.

1.1.7 The Rationale Dictating the Research Project

An individual's positive, negative, indifferent (or unknown) attributions of meaning associated with cancer and the side effects of chemotherapy, and with hypnosis,may influence each individual's behaviour, coping, outlook and even the outcome of that individual's illness. In addition, should ANV occur, the individual's attribution of meaning may also influence the advent of ANV, as opposed to simply labelling the ANV as a conditioned response. With regard to hypnosis and attributions of meaning, the rationale suggests that a negative awareness of hypnosis will probably cause the patient to reject anything pertaining to hypnosis and, conversely, a positive view of and belief in hypnosis may mediate towards an acceptance of and involvement in hypnosis for whatever purpose the person sees fit. In addition, perturbations of existing ideas and attributions of meaning may occur at any stage of the patient's treatment, and may manifest as a shift in the patient's thinking and belief systems. Equally, indifference or lack of knowledge in a person may change during the course of treatment. Any such changes are noted when and if they occur during the course of this study.

1.1.7.1 The Partnership of an Ecosystemic Approach and Attributions of Meaning

With the emphasis on attributions of meaning in this research work, an ecosystemically orientated approach lends itself admirably to incorporating individual belief systems as well as each person's contextual interaction, both intrapersonally and interpersonally within the world around him/her. An ecosystemic approach involves the interpersonal and interactional flow of ideas in context between the people involved, in that context, (in this case, researcher, subjects and the people in the subjects' world), and consequently incorporates all members' atributions of meaning pertaining to the issues which arise. The outcome is the creation of a functionally meaningful unit (Bloch, 1983). Such an approach has clearly moved away from the restrictive and limiting, traditional Newtonian outlook with its linear-causal postulates and the medical model which is based on these postulates. Consequently, an ecosystemic approach also differs markedly from the more traditional approaches to hypnosis, both in concept and in research methodology. The linear-causal view moves into the background in such an approach, and the focus is heavily on an ecology of ideas (Bateson, 1972), incorporating attributions of meaning and perturbations of ideas.

1.1.8 Purpose of the Present Study

Because the traditional and still currently fashionable medical model diagnoses and treats the cancer in the patient i.e. inflicts a linear-causal approach (doctor to patient, treatment to illness), the patient is seen in the role of the recipient or receptacle of the doctor's training, attributions of meaning, diagnosis and resultant choice of treatment. This role given to the patient often carries with it the patient's unexpressed submissiveness and acceptance, where the doctor is seen as the observing authority figure, who "knows" the "facts" and can treat the problem/illness. What the patient "knows", thinks or feels about his/her illness or attributes meaning to about his/her illness, is usually given minimal, if any recognition or importance. The disease is

targeted and treated by the medical professional(s), and the unique, idiosyncratic manner in which each person views his/her illness in relation to him/herself and the way in which this could affect the process of healing or deterioration in each individual, is undervalued.

This study aims to explore the idiosyncratic attributions of meaning of patients with regard to their illness and their pending treatment, including an ongoing follow-up during the treatment process. Consequently, each individual's unique and personal creations of realities in his/her particular disease situation, is highlighted. More specifically, the present study sets out to investigate the cognitions and the associated attributions of meaning and beliefs held by a sample of females with breast cancer. The area of research focuses on each patient's beliefs and attributions of meaning relating not only to cancer as an illness affecting that individual, but more specifically towards each individual's beliefs about and expectations regarding the possible side effects of her chemotherapy treatment, specifically ANV. In addition, each person's attributions of meaning relating to hypnosis was explored. Whether or not that person has a belief that hypnosis could be of assistance to her in dealing with unwanted side effects i.e. whether or not she could help herself via hypnosis also formed part of the investigation. Influences which may have affected or created each person's beliefs in this area were included.

1.1.9 In Summary

(a) Cancer patients often experience unwanted, detrimental side effects to the treatment of their disease -- the side effects chosen for the purpose of this investigation are those of nausea and vomiting (N & V) and anticipatory nausea and vomiting (ANV).

(b) The unchallenged opinion expressed in a survey of the extensive literature, describes the ANV as a conditioned response to the associated environment, experiences and thoughts.

(c) This research explores the possibility that ANV may be the result of individual attributions of meaning rather than simply a result of conditioning. Attributions of meaning may be seen as personal constructions or beliefs created and held by each individual relating to the world around him/her, to the people in his/her world, and how he or she is influenced by both of these aspects.

(d) In addition, the literature clearly indicates that hypnosis is useful in alleviating the chemotherapy side effects of nausea and vomiting. This research also examines patients' attributions of meaning relating to hypnosis and attributions of meaning to the use of hypnosis for ANV.

(e) The approach adopted for such explorations in this research work eschews traditional Newtonian ways of thinking in favour of an ecosystemic approach. Such an approach avoids linear causality and reductionism (Newtonian concepts) and in particular, utilises contextual interactions, second-order cybernetic thinking and a constructivist stance.

(f) An ecosystemic approach is utilised in this research with a focus on attribution of meaning and hypnosis.

The main thrust of this research work involves exploration and revelation of individual patients' attributions of meaning and beliefs. The medical model description of ANV assumes it to be directly caused by chemotherapy, and the psychological explanation is based on the concept of conditioning. Depending on the findings of this research, if attributions of meaning are seen to play any role in the process (a possibility suggested by the literature in other fields), the unchallenged acceptance of ANV as a direct result of chemotherapy and as a conditioned consequence of nausea and vomiting, may have to be re-evaluated. Equally, and more specifically, if a belief in or positive attribution of meaning to hypnosis results in a person's acceptance and use of hypnosis and any

consequent benefit, such as amelioration of unwanted side effects, the traditional medical model utilising its external observer, linear-causal approach, may have to be reassessed, with a conseqent widening of the traditional, limited view. Potentially, this may offer a new way of thinking about medical treatment and about the people involved in both the giving and receiving of the particular treatment.

A move in this direction has been made by the Simontons (1975, 1978, to be discussed in Chapter 5), and by the "I can cope" programs offered by some cancer treatment units. In these approaches, the patient is not just a passive receptacle treated by 'observers', but is seen as possessing input/output 'power' with regard to her/his illness, treatment and healing. This approach may have the potential to become a powerful addition to and ally of medicine of the present time. A broader range of application could be envisaged if the patient's beliefs and attributions of meaning could be investigated and understood in advance of the treatment, so that these beliefs could be utilised, and if necessary, reframed to assist in the outcome. Instead of putting a treatment plan onto or into the patient, recursive and interactive mutual cooperation could be utilised to enhance, broaden and deepen the traditional medical approach with the possibility of increased benefits to the patient. Such an approach would utilise ecosystemic principles with particular emphasis on attribution of meaning.

The following chapter explores the move from Newtonian thinking to ecosystemic thinking, with a description of the intervening concepts utilised to create a different approach and a different viewpoint. A clarification of ecosystemic thinking is offered.

CHAPTER 2

THE ECOSYSTEMIC PERSPECTIVE

2.1 Introduction

During the last 50 to 60 years, as a result of new concepts and ideas developed in the domain of physics, there has been a profound change in our view of the world. Scientists found that they could no longer use their traditional basic concepts, language and way of thinking, based on a Newtonian linear-causal, reductionistic and objectivist stance to describe atomic phenomena. Therefore, theoretical change and movement was inevitable, manifesting in growing criticism levelled at Newtonian epistemology for its limitations and impediments (Bateson, 1972; Capra, 1983; Fourie, 1990, 1991a; Fourie & Lifschitz, 1989; Keeney, 1979, 1983; Keeney & Morris, 1985; Lifschitz, 1986; Lifschitz & Fourie, 1990; Prigogine & Stengers, 1984; Tomm, 1983; Zukav, 1979).

This criticism was followed by an alteration to scientific thinking and epistemology which resulted in a major shift in outlook. In this shift, the mechanistic conception of Descartes and Newton began to be circumvented and in its place, a perspective encompassing a holistic and ecological outlook evolved (Capra, 1983). (It is important to note that in this context the term 'mechanistic' is used to describe the reduction of complex living processes to machine analogies, after Auerswald (1987), and not, as Keeney (1983) suggests, to focus on explanations of pattern and structure). Capra (1983) adds weight to this shift away from a Cartesian-Newtonian outlook by stating that: "We live today in a globally interconnected world, in which biological, psychological, social and environmental phenomena are all interdependent" (p. xviii). He calls this shift a 'paradigm shift' towards an ecological perspective which is needed

to describe this world of today appropriately. Interestingly, and in contrast to the pragmatic viewpoint just described, Capra (1983) equates the holistic, ecological view with the views of mystics of all ages and traditions.

This change of direction in thinking takes its course through concepts which cover interactional or systemic concepts (von Bertalanffy, 1968), cybernetics and ecology (Bateson, 1978; Hoffman, 1981; Keeney, 1982, 1983) and the concept of constructivist thinking (Dell, 1985; Gergen, 1985; Hoffman, 1990a; Speed, 1991; Watzlawick, 1984) and social constructionist thinking (Carpenter, 1991; Hoffman, 1990b;). In turn, these concepts are closely allied to postmodernism (Hare-Mustin & Maracek, 1988; Michael, 1991). This shift, and the resultant shift in concepts, thoughts and theories which involve the way the world is currently seen (in particular in the world of science and the humanities), has profound implications for research in psychotherapy.

The ecosystemic, constructivist, postmodern way of thinking not only challenges traditional, scientific Newtonian thinking, where discussion and acceptance of 'facts', 'neutral observers', linear causality, reductionism, objectivity and similar limiting concepts have determined the method and style of research, but it also offers a different way of viewing the world. The shift dictates an approach which may loosely be described as all-encompassing -- it is interpersonal, intrapersonal, contextual and flexible. In the research methodology based on this approach, boundaries lose their traditional rigidity and tend to become blurred, and factual stability is no longer of ultimate importance -- phenomenology, experiential content and personal and social constructs/ideas/ beliefs dominate and give meaning to studies, to concepts and to theories.

In order to trace and understand the movement from the traditional Newtonian epistemology towards an ecosystemic theory, a brief overview of Newtonian

epistemology follows.

2.2 Assumptions Underlying Newtonian Epistemology

Newtonian thinking reached its peak in the mid 1800's. It seemed that all phenomena could be explained in terms of mechanical models based on long established principles (Zukav, 1979) which could be described using the following terminology:

1) Reductionism or atomism: This pertains to the reducing of a phenomenon or object to its most basic elements or building blocks in order to comprehend, and if necessary, measure the phenomenon or object (Schwartzman, 1984). As a result of knowing these characteristics, the whole can then be understood and attained by recombination of these elements.

2) Linear causality: Cause and effect is assumed to be the linking factor of the elements in Newtonian epistemology. Not only can the causal trains be short, direct and clear-cut, but there can also be long, causal trains as in the case of complex phenomena (Fourie, 1990; 1991a; Hoffman, 1981).

3) Neutral objectivity: In order to arrive at the truth, observation must, of necessity, be objective i.e. the observer must not influence the object or phenomenon. In this way only, can one know what the object or phenomenon is really like (Colapinto, 1979; Fourie, 1990; 1991a).

As scientists began to explore different ways of thinking, Newtonian theory was questioned and challenged with the emergence of new ideas and concepts. The following section extrapolates.

2.2.1 The Outmoding of Newtonian Epistemology

In the century that followed the birth and establishment of Newtonian thinking, the emergence of quantum mechanics and Einstein's theory of relativity added different

dimensions to the way of viewing the world. These dimensions did not necessarily negate Newtonian ideas, but certainly highlighted the limitations of Newtonian thinking. In a simple and clear definition, Zukav (1979, p. 46) states that: "Newton's laws are based upon observations of the everyday world. They predict events...which pertain to real things...and which are simple to understand and easy to picture." As Zukav succintly states: "The physics of Newton remains valid within its limits" (1979, p.45). The observation that the Newtonian approach no longer presents a comprehensive enough way of explaining all that exists and/or can be observed, has led to the creation of less restrictive approaches. This evolution in the world of physics is an example of Kelly's (1955, 1970) concept of constructive alternativism -- a concept which is related to the interpretation of events. The same events may be explained differently by Newton and Einstein, but Einstein's theory is able to anticipate more events than the Newtonian models. This is not necessarily because Einstein's theory is more correct or true, but because it has a broader range of application or convenience (Kelly, 1955; Landfield & Leitner, 1980). Along similar lines, Zukav (1979) discusses quantum mechanics as another example of theoretical progress in advance of Newtonian thinking in the field of physics.

Comparing quantum mechanics to Newtonian thinking, Zukav (1979, p. 46) writes: "Quantum mechanics depicts the probabilities of phenomena which defy conceptualization and are impossible to visualize", as opposed to Newtonian laws which are based on observations of the everyday world and which predict events. "Therefore, these phenomena must be understood in a way that is not more difficult than our usual (Newtonian) way of understanding, but different from it" (Zukav, 1979, p. 46).

Newtonian thinking describes laws which govern and understand phenomena, but which are limited in creating a reality of the universe, a flaw which is highlighted not only by quantum mechanics, but also by Einstein's theory of relativity. In contrast,

quantum mechanics and ecosystemic concepts have in common "the idea of minimal knowledge of future phenomena" (Zukav, 1979, p. 54) which suggests that each person's reality is what he/she chooses to make it and it is thus individually created or constructed. As Zukav states: "All that the mind can ponder is its *ideas* about reality" (1979, p. 63). As a result, one cannot accept an objective reality apart from one's experience -- this is connected with the concepts of constructivism and attribution of meaning which form an integral part of this thesis and which will be discussed later in this chapter, and in Chapters 3 and 5.

In terms of what has been described as reality, a Newtonian epistemology "assumes that there is an external world which exists apart from us" (Zukav, 1979, p. 54) and which can be observed, measured and speculated upon without it being changed. It is thus seen to be indifferent to us and to our needs and exists "out there" with no reference to "I" (Zukav, 1979). In a pivotal conceptual shift, quantum mechanics introduces the concept of "participator" (Zukav, 1979) associated with the concept of participation. Stated differently, and in line with cybernetic epistemology, "We are not as separate from the rest of the world as we once thought" (Zukav, 1979, p.42). This is an important departure from the traditional Newtonian concept of the "observer" who observes without partaking or participating. Ecosystemic theory is in agreement with this postulate in recognising that the so-called observer is not able to be totally objective and without participation in the world i.e. is involved as a participator. Consequently, "we cannot observe something without changing it" (Zukav, 1979, p. 134).

Quantum mechanics and ecosystemic theories both imply that "all of the things in our universe (including us) that appear to exist independently are actually parts of one all-encompassing organic pattern, and that no parts of that pattern are ever really separate from it or from each other" (Zukav, 1979, p. 73). Consequently, in the field of human sciences, the move towards an ecosystemic perspective encompasses a wider, deeper,

less constricted approach than in Newtonian thinking, with an emphasis on environmental, interpersonal and contextual interrelatedness.

2.2.2 Ecosystemic Thinking as Opposed to Newtonian Thinking in the Human Sciences

The importance of the shift from a mechanistic, Newtonian outlook, through quantum mechanics towards an ecosystemic approach, particularly with relevance to psychotherapeutic progress, may be summed up as follows:

The traditional approach of the clinician, (in this case, the psychologist or doctor) as the 'expert observer and diagnostician' is one in which the 'client or patient' is viewed as a separate entity with a 'disease or emotional problem'. As a result of this linear-causal, objective approach, using analytic reductionism as a tool, a diagnosis or decision regarding therapeutic action is made by the clinician, independent of any decision-making by the client/patient. To create a shift in this uni-dimensional approach, the idea, taken from quantum mechanics, of the observer as a 'participator' rather than an outsider, opens up new vistas in the medical field of diagnosis and treatment. The shift leads to the substitution of the notion of 'probabilities' in terms of outcomes, rather than, as in the present medical model, Newtonian 'predictions of events' which are dependent upon 'objective observations'. The outcome of such an approach is likely to offer greater scope for the doctor and patient to form a functionally meaningful unit together. This would incorporate a greater flexibility around mutual, recursive interactions and thus a wider spectrum for probability of outcomes (rather than a predestined and often limiting 'prediction'). This view incorporates ecosystemic thinking with its relationship to cybernetics of cybernetics (to be discussed later in this chapter).

2.2.3 Use of Ecosystemic Thinking in the Present Study

Based on the above way of thinking, this research project utilised an ecosystemic approach in order to highlight the importance of the effects of the recursive, interpersonal flow of ideas in an interpersonal matrix consisting of patient and researcher, patient and medical staff, patient and family and friends, and patient and environment (hospital and external, including the media). This flow of ideas within the interpersonal context at a cognitive level and a communicative level, would automatically fuel each patients' attributions of meaning and beliefs. These in turn, would be influenced and coloured by each patient's idiosyncratic constructions (Hoffman, 1990b), together with the patient's internal, structure-determined physiological makeup (Maturana, 1975). Thus, each patient would create personal attributions of meaning utilising this information, so that she (all patients in this research are female), would have beliefs and ideas about many areas of her illness, about herself personally and about the more specific areas relating to the research project i.e. ANV and hypnosis. In this way, each person would create her own reality and her own idiosyncratic perception of what she was experiencing.

In order to further clarify and to widen the perspective on the nature of ecosystemic thinking, the basic concepts constituting this approach, need to be highlighted and described. The following section deals with the relevant issues.

2.3 The Ecosystemic Approach

2.3.1 Description and Conceptual Framework

Without a lengthy and not necessarily relevant reiteration of the literature pertaining to the terminology used, the term 'ecosystemic' can briefly be described as a hybrid of the terms 'ecology' and 'systems' (Capra, 1983; Keeney, 1983; 1984). The latter is taken from von Bertalanffy's (1968) general systems theory and the former from

Bateson's (1972) and Bogdan's (1984) view of a system as an 'ecology of ideas'. An ecology may be described as: "The broadest possible view for looking at all systems and interrelations among systems" (Keeney, 1983, p.135; 1984, p. 34). The essence of an ecologic viewpoint can be described as encompassing the interrelatedness of the parts of an indivisible, whole universe in which the understanding of patterns of an ongoing process predominate (Fourie, 1990). In defining a system, Capra (1983, p. 226) describes it as "....an integrated whole whose properties cannot be reduced to those of its parts." Inherent in this description is the assumption that a system must be viewed in a holistic way, with all parts of the system manifesting interdependence, and this applies both to the scientific world and to the human sciences. Golann (1987) states that to understand what he terms 'interactional systems', a system has "to be described rather than explained" (p. 331). These views necessitate the incorporation of cybernetic epistemology (Capra, 1987; Dym, 1987; Fourie, 1995; Hoffman, 1985; Jasnoski, 1984; Keeney, 1979; 1982; 1983; Loos & Epstein, 1989; Prigogine & Stengers, 1984; von Foerster, 1984; von Glasersfeld, 1988; Wiener, 1954), and the way of thinking expressed in these views, becomes the precursor of ecosystemic thinking.

2.3.2 Description of an Ecosystemic Approach

As with the concept of postmodernism, there seems to be no clear-cut, single definition of an ecosystemic stance. Stachowiak and Briggs (1984) in an oversimplified definition, suggest that an ecosystemic approach is one which is "focused on the context of interaction among individuals and their environment" (p. 7). Keeney's (1983) description of an ecosystemic approach suggests that it is: "...an epistemological framework representing cybernetics, ecology, and system theory" (p. 16). Fourie (1991a, p. 475) expands on this by explaining that: "...an ecosystemic approach focuses on people's interlinked ideas, beliefs, and attributions." Perhaps ecosystemic thinking can best be understood by descriptions of what does and does not

constitute an ecosystemic stance, rather than by a definition. Such descriptions will unfold in the following sections.

2.3.3 The Application of Ecosystemic Thinking

The emerging concept of ecosystemic thinking (affiliated to Bateson's (1972) term 'ecology of ideas' and Keeney's (1979) term 'ecosystemic epistemology'), initially manifested in family therapy, with a consequent shift in the psychotherapeutic approach to the family and its patterns of behaviour. This move from a problem-identifying, linear-causal view of the family by the clinician, to a holistic, acausal and constructivist way of thinking, which is ecological in its approach (Fourie & Lifschitz, 1989), constitutes the basis of the ecosystemic model. The relevance of this change is that the clinician, the family members, the patterns of behaviour organization, individual ideas and attributions of meaning all contribute to the formation of a consensual domain involving an interconnected, cohesive way of thinking. This consensual domain forms the core of the therapeutic process and all participants are seen as part of the co-evolutionary ecosystem (Auerswald, 1987). All members of this system contribute to the psychotherapeutic work and all contributions are relevant to and influential in the final outcome of the meeting. This approach utilises Bogdan's (1984) concept of "ecology", and views with importance "how ideas in human systems are complexly interwoven and how these ideas continually influence one another in mutual and reciprocal ways" (Fourie, 1991a, p. 468).

An important progression occurred when this conceptual view was applied to the field of hypnosis, and also to selected medical domains such as psychosomatic medicine (Fourie, 1991a; 1995; 1996a; Fourie & Lifschitz, 1989). The use of an ecosystemic approach in these fields was not necessarily to replace the traditional methods, but to invoke a new perspective with regard to the thinking about, and working in these domains.

2.3.4 Attribution of Meaning Embedded in Ecosystemic Thinking

During the 1980's, when the range of ecosystemic thinking was extended from the domain of family therapy to the field of hypnosis, a significant outcome was the subsequent alteration to the way of thinking about and describing hypnosis (Fourie & de Beer, 1986; Fourie & Lifschitz, 1985, 1988, 1989; Lifschitz & Fourie, 1985). The concept of attribution of meaning is inherent in this shift. It implicates the notion that interwoven ideas in human relationship systems involve not only society and the family, but also each individual and the idiosyncratic way he/she thinks and attributes meaning to ideas and information obtained from others and the environment. Fourie (1991b) states that attribution of meaning "...encompasses all ideas of all participants regarding one another, regarding the specific situation and its definition, regarding the particular problem and regarding specific behaviours in the situation" (p.66). The idiosyncratic way each individual thinks encompasses Maturana's (1975) theory of structure determinism and the concepts of constructivist thinking. These particular concepts, together with additional relevant concepts relating to this field, such as systems theory, cybernetics and second-order cybernetics, have been clearly described, discussed and criticised in the literature and an elaborate regurgitation and repetition of the documentation has therefore been avoided in this thesis. However, in order to clarify the move toward ecosystemic thinking, a brief highlighting of the terms used in these fields, and how these concepts relate to ecosystemic thinking, follows under the relevant headings (together with the pertinent references).

2.4 Towards an Understanding of the Epistemology Involved in the Development of Ecosystemic Thinking

2.4.1 Systems Theory and Cybernetics in a Process Towards Ecosystemic Thinking

2.4.1.1 Systems Theory

As stated briefly, earlier in this chapter, the foundation of ecosystemic thinking is systems theory, originally engineered as general systems theory by von Bertalanffy (1968). General systems theory emphasises a shift of the focus on parts to a focus on the whole. This shift is the basis of Capra's aforementioned description of a system as "... an integrated whole whose properties cannot be reduced to those of its parts" (Capra, 1983, p. 266). Systems theory may be seen as having pioneered the move towards an integrated, interrelated, holistic approach in contrast to the reductionistic stance which involves explanations and proof. The integrated approach lends itself to the style used in this research with regard to the way the researcher understands each individual's ideas and attribution of meaning relating to her illness, her treatment, the use/non-use of hypnosis,as well as the interrelationship between the researcher, patient and others involved. The traditional cause and effect model plays no part in the description of this research.

As briefly mentioned, in the humanistic field, the major impact of the systems approach was in family therapy where the instigation of a new and different framework for family therapy was created, paving the way for an emerging and evolving ecosystemic style. Such a framework entails the family and its members being seen as interdependent, mutually defining, interwoven with the environment and "located in evolutionary timespace" (Auerswald, 1987, p.322). This viewpoint is compatible with the ideas of Maturana (1975), Keeney, (1983) and Prigogine & Stengers (1984) and necessitates a brief overview of cybernetic concepts.

2.4.1.2 Cybernetics

"Cybernetics" a term first used by Wiener (1954), is described as "the science of control and information feedback in systems" (Loos & Epstein, 1989, p. 153). The concept refers to a shift away from general systems theory where the focus is the change of emphasis from parts to wholes, towards patterns of organization where the focus on the patterns of organization, overshadow the importance of the 'object' (Keeney, 1982, 1983). As Keeney so elegantly clarifies: "An encounter with cybernetics is somewhat analogous to a Japanese landscape, where pattern rather than objects, is primary. The objects fade into the background while pattern is brought into focus" (Keeney, 1983, p. 64). Living systems adjust to internal and external changes in an ongoing basis with the purpose of maintaining and conserving their essential structure. There is a complementary relationship between stability and change -- the basis of cybernetics (Capra, 1987; Dym, 1987; Keeney, 1982; 1983; Hoffman, 1986; Jasnoski, 1984; Prigogine & Stengers, 1984; von Foerster, 1984). In this respect, cybernetic thinking may thus be seen as a transitional move between general systems theory and the shift to ecosystemic thinking with its affiliation to second-order cybernetics.

There is a clear distinction between first-order and second-order cybernetics and this distinction may loosely be seen in parallel to the contrast between Newtonian thinking and the concept of quantum mechanics. In first-order cybernetics (as in the Newtonian model), the controller or observer resides outside the system, observing the system but separate and therefore neither influencing nor affecting the system (termed observer-independent by Hoffman (1985)). In second-order thinking (allied to the concept of quantum mechanics), there is a recognition that the observer exists as an included and integral part of the system rather than external to it, and therefore cannot be seen as neutral or non-participant. A discussion of this idea follows.

2.4.1.3 Cybernetics of Cybernetics or Second-Order Cybernetics

The fundamental concept of second-order cybernetics dictates that the observer must be included in any description of the system. As a result, the observer then becomes part of the system being observed and inextricably, the act of observation changes what is being observed (Keeney, 1979). This results in what has been termed "observation of observation" (a higher order of observation), and constitutes the domain of second-order cybernetics (cybernetics of cybernetics) (Fourie, 1995; Golann, 1987; Hoffman, 1985; Keeney, 1983; Lewis, 1989; Loos & Epstein, 1989; von Foerster, 1984).

An important aspect of second-order cybernetics is the perspective of the autonomy of whole systems, the distinctive wholeness or identity of a system (Keeney, 1983; Loos & Epstein, 1989; von Foerster, 1984). This is opposed to the interaction in informationally open systems of general systems theory (which can be linearly affected by outside influence). In other words, a system which is autonomous is a system which will regulate and conserve itself and thus is impervious to linear influence from the outside (Fourie, 1993, 1995; Keeney, 1983). In this respect, it can however, only do this within the limitations of its internal structure. Should the system lose its autonomy, it no longer functions as a system. The idea of conservation of autonomy can be applied to both individuals and to family systems, bearing in mind that both are interrelated at various levels (Fourie, 1993).

Along similar lines, ecosystemic thinking suggests that the behaviour of people under observation is necessarily influenced by the act of observation, which is neither neutral nor an act in isolation. The act of observation is also influenced by the observer's inherent bias resulting from his/her idiosyncratic way of observing and thinking., In this approach, (e.g. as in its application to the field of family therapy, and to hypnosis), the system and the observer function in a recursively interactional matrix wherein the ideas

in this inclusive matrix constantly influence each other and interweave in all aspects relative to the individuals within the matrix (Hoffman, 1985; Keeney, 1983; Leyland, 1988).

2.5 Conclusion

The move away from the Newtonian stance not only takes direction towards the concepts and ideas describing systems and cybernetics, but also involves a questioning of the accepted Newtonian notion of reality. This shift introduces the concept of the construction of ideas. Consequently, constructivist thinking with its inherent ramifications may be seen to be directly related to the ideas, concepts and perspectives which emerged in the move away from Newtonian thinking. A discussion of different viewpoints on constructivism and the relationship of constructivist thinking to ecosystemic thinking and to attribution of meaning follows.

CHAPTER 3

THE RELATIONSHIP OF CONSTRUCTIVISM TO ECOSYSTEMIC CONCEPTS

3.1 Introduction

In order to understand the general impact of constructivist thinking, it is necessary to bear in mind the aforementioned traditional ideas that the world and reality can be assessed and described objectively by an independently observing observer. When this viewpoint was challenged by Einstein's theory of relativity and by the theory of quantum mechanics, (Deikman, 1982; Heisenberg, 1989; Zukav, 1979),one of the outcomes was the idea of the observer as a participant (second-order cybernetic thinking). With this emphasis on the importance of the interrelationship between observer and observed, the concept of "objective knowledge" was eschewed. A major outcome was the reassessment and redefinition of the perception of reality.

Bateson (1972) and Maturana (1975) describe reality in terms of cognitive constructions allied to a consensual domain amongst participators. As Hoffman (1985) states: "....ideas about the world are shared ideas, consensually arrived at and mediated through givens like language and culture" (p. 384). Inherent in such a change of perspective is the development of constructivist concepts.

3.2 The Constructivist Viewpoint

In making a link between cybernetics and constructivism, Keeney (1983) states that the cybernetic epistemologist participates in the construction of a world of experience -- this is both relevant and important in the domain of therapeutic realities, as in psychotherapy, family therapy and hypnotherapy. In clarifying his terms, Keeney (1983, p. 13) explains 'epistemology' in the sociocultural domain as "a study of how

people or systems of people know things and how they think they know things." Auerswald (1987, p. 321) expresses the definition slightly differently by stating that epistemology denotes "a set of rules used by a specific group of people to define" what he terms "*universal* reality" (p. 321, italics in original). More generally defined, epistemology recognises and describes how people construct their habits of cognition and how people maintain these constructs (Keeney, 1983).

Carpenter (1991) defines constructivist thinking as follows: "...because what we think of as reality is always filtered through the eyes of observers, it is therefore constructed or invented" (p. 347). This is a direct challenge to the idea that knowledge is obtained through objective observation of occurrences in the world around us and so casts doubt on previously accepted traditional scientific assumptions.

Extrapolating on this view, Keeney (1983) describes and clarifies a distinction between traditional, lineal (atomistic, reductionistic and anti-contextual) epistemology and non-lineal epistemology. In contrast to the former, the latter is described as emphasising ecology, relationship and whole systems -- this attunes non-lineal epistemology to interrelation, complexity and context. In psychotherapy, the therapist's choice to work either in a lineal or non-lineal epistemological framework, will result in the therapist constructing, maintaining and experiencing a particular world view (or paradigm) (Keeney, 1983). Therapists who choose a non-lineal therapeutic stance will "view their relationship with clients as part of the process of change, learning and evolution" (Keeney, 1983, p. 14). This supports the view that an observer-free description of a situation which can be objectively assessed and evaluated can not exist, nor can it make sense (Gerhardt & Beyerle, 1997). In this respect, ".....what one knows leads to a construction and what one constructs leads to knowing" (Keeney, 1983, p. 108).

The basis of constructivism (Effran, Lukens & Lukens, 1988; Gergen, 1985), rests on the idea that knowledge and understanding are the result of participatory invention

involving language and linguistic conventions (Anderson & Goolishian, 1988; Goolishian & Anderson, 1987). Relating to this and offering a different angle, is Maturana's explanation that it is the structure of our physiology that determines what we see, rather than the reality of what is really in the environment (Dell, 1985; Effran & Lukens, 1985; Leyland, 1988; Maturana, 1975). (Maturana's structure-determined theory will be discussed later in this chapter). Gergen (1985) echoes and clarifies the constructivist viewpoint by suggesting that humans have inherent tendencies "to think, categorize or process information, and it is these tendencies (rather than features of the world in itself) that are of paramount importance in fashioning knowledge" (p. 269). As a matter of interest, Capra (1987) and Young-Eisendrath and Hall (1991) contend that Jung was ahead of his time in that his outlook and way of thinking had adopted constructivist concepts and had already moved away from the traditionally accepted Newtonian limitations of the time.

Constructivist concepts are an inherent part of attributions of meaning and in this study, this approach is pertinent to understanding the way each cancer patient constructs her reality and creates her attributions of meaning to all aspects of her illness and to the idea of hypnosis.

In the large body of literature on constructivist thinking, selected theorists, important in elaborating the approach undertaken in this research, have been highlighted. This is consequently a limited and discriminated viewpoint of constructivism -- the scope of this thesis precludes full coverage.

3.2.1 Maturana's Biological Bias: Towards Constructivism

A brief mention of aspects of Maturana's theory, which aligns with constructivist thinking, is presented. The essence of Maturana's theory may be stated as follows: "social systems and all human endeavor must be understood in the light of our existence

as biological entities that are coupled to a medium" (Dell, 1985, p. 1). In adopting this approach, Maturana (1975) eschews the mechanistic Newtonian concept which holds that forces and impacts causally determine an organism's behaviour. In its place, he favours the idea that forces and impacts are "merely the historic occasion for the system to continue its structure-determined behaviour" (Dell, 1985, p. 7). Maturana (1975) explains structure-determined behaviour by suggesting that all living systems, and inanimate objects as well, have their behaviour determined by their structure or components. This includes the relationships between those components (Dell, 1985). Consequently, systems can only act in accordance with their structures (Maturana, 1975) i.e. in ways allowed by their structures so that the structures allow what an observer may perceive (Dell, 1985). Inherent in this concept is the viewpoint that structure i.e. the components and the relations between the components in living systems, can and do alter with each interaction that occurs. This indicates that structure is not static and can change and shift from moment to moment (Dell, 1985) and these individual differences in an individual's internal structures offer an explanation as to why each person will respond idiosyncratically and thus uniquely, to the same external information. It is this aspect which is explored in the attempt to understand each cancer patient's personal representation of her world.

In the light of this concept, it becomes apparent that it is the system which specifies the individual's behaviour, not the interaction with or information impinging on the individual (Dell, 1985). "The information has no existence or meaning apart from that given to it by the system with which it interacts (Dell, 1985, p. 6). Fourie (1995) dds that a person's structure encompasses his or her present or current knowledge. Since an attribution of meaning for an individual is based on that individual's prior knowledge, the combination of that knowledge together with person's individual internal structure (Maturana, 1975), forms the basis for the construction of each attribution of meaning. This, and not the perceived object or event, determines the behaviour or reaction. In addition, if an individual perceives an object, that object can

only be represented in the brain by ideas about the object (Maturana, 1975). Inherent in this view, is the idea of perturbations or disturbances (Maturana, 1978). Maturana (1978) uses this concept to assist in explaining and describing the shift of ideas and beliefs within an individual which align with the shifting world around that individual. As Andersen (1995) explains: "We need to be 'disturbed' since disturbances keep us alive and make us able to change in correspondence with the shifting world around us. But if the disturbances are too different from what our repertoire is able to integrate, we disintegrate if we include them" (p. 59).

These points focus on the essence of Maturana's concept of structure-determinism and as a result of this viewpoint, Maturana claims that objective knowledge is not possible and, equally, that objective information is impossible (Bateson, 1972; Maturana, 1975; 1988). As Dell (1985) suggests, much of the way we think about the nature of causality consequently has to be re-examined as a result of Maturana's concept of structure-determinism. The essence of Maturana's theory links well with the broader concept of constructivism to form a compatible way of explaining attributions of meaning.

3.2.2 Watzlawick's and von Glasersfeld's Constructivist Views

In line with Maturana's description of reality, Watzlawick (1984) allies himself with the contention that because constructivism does not support the assumption that a reality exists, it is incompatible with traditional thinking. For Watzlawick (1984), constructivism is the "invention" of reality (p. 10) and as an example of this definition, he suggests that the mystics who examined the world by using "the language of the great symbols governing their era" (i.e. religion, mythology, philosophy and the like) may be described as "...captives of the particular reality constructed through the use of these symbols" (p. 329).

Watzlawick (1984) questions how the world would be for a person who was able to "accept reality fully and totally as his or her own construction" (p. 326). He believes that such a person would be tolerant and responsible, would experience total freedom and would thus have the ability to experience the choice of constructing his/her own reality one way or another. Watzlawick (1984, p. 330) suggests that: "Constructivism does not create or explain any reality "out there"; it shows that there is no inside and no outside, no objective world facing the subjective....." All meaning and naming is influenced by relativity and subjective origin and "....all attribution of sense and significance creates a particular reality" (p. 330). In creating that reality, the individual must create a world "in his own image" (p. 330), unaware of creating this particular world. The individual would then experience that created world "out there" as existing independently of him/herself. As a result, the individual would then construct him/herself in a self-reflexive manner, "in relation to the "suchness" of this supposedly objective world" (p. 330). Watzlawick concluded that "The inevitability of this quest makes its senselessness meaningful" (1984, p.330). He emphasises that it is the subject or the individual and not constructivism per se, which creates the reality in the world "out there."

Von Glasersfeld (1984, p.30) sums this up by stating that "the world we experience is, and must be, as it is, because we have put it together that way." This is an elaboration of what von Glasersfeld describes as "the most fundamental trait of constructivist epistemology" (p. 29) which he explains as being an experiential world consisting of experiences -- this is the world which is constructed. He clearly states that this experiential world makes no claim at all about "truth" in relation to an ontological reality (von Glasersfeld, 1988). For von Glasersfeld (1984, p. 40), "knowledge" is seen as being invariances in the individual's or organism's experiences, rather than being ascribed to the actual realities "in an independently existing world" . This pertains directly to the aspects of attributions of meaning and beliefs in the present research project, in that each patient's beliefs relate directly to her "knowledge" obtained from

various sources, together with her own idiosyncratic interpretations of that "knowledge", arising from her unique internal makeup or structures (Kenny, 1988; Maturana, 1975).

An additional component which is relevant to the constructivist approach, is the importance of the role of language (Anderson & Goolishian, 1988; Goolishian & Anderson, 1987) in creating the "web of meanings" (Griffith, Griffith & Slovik, 1990, p. 23) which arise as a result of dialogue and conversation about the problem (illness) by the relevant people in the ill person's life. The importance of the role of language in the creation of meaning implicates the concept of discourse analysis where "language is viewed as the centre of the production of meaning rather than a transparent rendering of some preexisting reality " (Kaminer & Dixon, 1995, p. 169). The scope of this thesis precludes a full discussion of discourse analysis.

3.2.3 Hoffman's Constructivist View

In her constructivist thinking with regard to family therapy, Hoffman (1990a; 1990b; 1993), holds that: "There is no assumption of objectivity or truth" (1990a, p.28) and offers the following definition: "Constructivism holds that the structure of our nervous systems dictates that we can never know our own construction of others and the world" -- an "observing system" reality (p. 4). This idea fits with and supports Maturana's (1975) premises (Dell, 1985; Effran & Lukens, 1985; Leyland, 1988) as well as the belief systems alluded to in Transactional Analysis which are mentioned in section 5.6 in Chapter 5.

In eschewing the idea of an objectively perceived reality, Hoffman shifts towards what she terms the "template theories": "....the notion that people, tribes, nations or whatever, build up constructs (embodied in myths, premises, concepts or belief systems) about the world and then operate according to them" (Hoffman, 1990a, p. 9-

10). Hoffman (1990a) holds that the templates controlling attitudes in individuals usually remain out of consciousness, are difficult to extract and they often have explanatory powers in certain problem situations. She states: "....the kind of abstract premises that have to do with survival are laid down at a deep-structure level" (Hoffman, 1990a, p. 20). In addition, Hoffman (1990a, p. 23). contends that: "....problems do exist, but only in the realm of meanings." In other words, each individual's idiosyncratic belief systems and ways of thinking, are brought into play in order to deal with the way a specific problem is perceived by that individual and in order to create idiosyncratic meaning for that individual. This tallies with to the concept of attribution of meaning where each individual attributes his/her uniquely constructed meaning (and beliefs) to the presenting problem and consequently creates his/her idiosyncratic experience of his/her presenting problem (in this case, illness), incorporating all that relates or pertains to it.

Hoffman (1990a) describes interventions and tasks in therapy as actually being "ideas about" interventions and tasks, and reframings in therapy as being believable opinions. As she says: "The world is the same and yet it is not" (Hoffman, 1990a, p. 24), a concept which was already emerging in the writing of Watzlawick in 1984.

In the field of family therapy and in the family environment, this perspective places emphasis on cognitions and on ideas i.e. beliefs, premises and myths, rather than on manoeuvres, coalitions and games. This rethinking of the perceived patterns in a family results in a focus on the governing ideas affecting attitudes and behaviours in the family. This is a shift away from the traditional focus of changing family structures and interacting patterns. In other words, the power and effects of the beliefs in family systems, which create the differing "realities" in each individual within each particular family system and also in the family system holistically and interactively, have become the dominant area of focus for effective change. This approach manifests a shift

wherein emphasis is on the power of attribution of meaning and beliefs, as opposed to the emphasis on behavioural changes.

3.2.4 Speed's Co-constructivist Position

Speed's definition and description of constructivism (1991) states that: "...the view that what we know is determined by our ideas, so that our view of reality is only that, a view, something constructed in our heads, invented by us. We can never know reality, we can only ever have views of reality. In a nutshell, *our ideas determine what we know* " (p. 396, italics in original). In a succint manner, Speed (1991, p. 407) elaborates this concept by stating "Just because reality is filtered through our perceptions does not mean it does not exist and does not affect those perceptions." Realism may be seen as "....the position that reality exists, can be discovered by people in an objective way and thus strongly determines what we know. Knowledge can therefore directly reflect this reality and will be valid, i.e. true. In a nutshell, *reality determines what we know*" (Speed, 1991, p. 396, italics in original).

In effect, Speed (1991) is in agreement with constructivist thinking (as proposed by Hoffman (1990a; 1990b) and by Watzlawick (1976)), as well as with social constructionist thinking, by suggesting that knowledge is dependent on our ideas and the ideas of others. However, she does not accept the proposal that reality has no relevance to what we know (Speed, 1994) and places emphasis on her premise that reality has its own level of importance. For Speed (1991), there is an ongoing interaction between the ideas each individual has, which creates that individual's personal reality and actual reality itself. Speed's (1991) co-constructivist stance appears to be a more balanced, less extreme approach than radical constructivism.

Speed's (1991, 1994) co-constructivist view has relevance for the present research work where each patient in the sample has experienced a particular reality of being

diagnosed with cancer. Each patient then perceives, understands and attributes meaning to her diagnosis, in terms of her unique internal structure and her idiosyncratic ability to construct her personal reality (Bannister, 1970; Bruner, 1987; Fischer, 1987; Maturana, 1975; Viney, 1988). Basically, an individual's ideas and/or constructions of reality create that individual's beliefs and associated attributions of meaning (Berger & Luckmann, 1976; Goudsmit, 1989; Reiss, 1981). Language is the vehicle through which these meanings are expressed (Anderson & Goolishian, 1988; Goolishian & Anderson, 1987).

This concept can be extended to encompass groups in society, where "other people's ideas determine what we know" (Speed, 1991, p. 400) and this in turn influences our beliefs (Griffith et al, 1990; Hamilton, 1993). Thus, according to Speed (1991; 1994), a co-constructivist stance encompasses ideas as well as reality in defining knowledge.

If this viewpoint is related to the present research project, it can be postulated that each patient's own reality about her illness, would be personally created or constructed, and could also be perturbed through ideas and information from other people and the media in the world around her (Speed, 1991). Her interpretation of all these aspects would be dependent on her own unique internal structure to create or construct her idiosyncratic belief systems and associated attributions of meaning (Goudsmit, 1989). This would be based not only on her internal structures as described by Maturana (1975), but also on her subjective style of cognitive functioning and her past experiences (Gheorghiu, Netter et al, 1989). The co-constructivist stance dictates that the combination of the reality of the patient's diagnosis of cancer, the patient's idiosyncratic use of her internal makeup, and the particular external matrix which is relevant to her at the present time, will offer a co-constructed reality for that patient. This is inclusive of the concept of attributions of meaning, which is interwoven with the idea of constructivism and (co-constructivism) in an ecosystemic matrix and which creates each individual's perception of his/her own experience of reality.

Although constructivism and co-constructivist thinking adopt somewhat differering views, the common thread which runs through both concepts is the opposition to "the modernist idea that a real world exists that can be known with objective certainty" (Hoffman, 1995, p 8). Constructivist thinking and co-constructivist thinking commonly suggest that the individual's construction of reality results in idiosyncratic beliefs based on the individual's ideas, the ideas of others in the individual's world, and to this, the co-constructivist view includes the additional factor of the external reality (Speed, 1991; 1994). Because of the implication of this statement that individual beliefs are not independent of external, social influences, it is relevant to briefly mention the concept of social constructionism (Woolfolk, 1992).

3.2.5 Social Constructionism

Social constructionism rejects theorising about the 'interiority' of the individual and chooses to explore the texts and the relations between the texts, used by individuals and through which individuals are presumably socially constituted, as being the basis of knowledge (Michael, 1991). In other words, social construction theory emphasises external components by postulating that: "....ideas, concepts, and memories arising from social interchange and mediated through language" (Hoffman, 1995, p. 8) are relevant factors in deriving knowledge. As a result, the social constructionists suggest that all knowledge "evolves in the space between people" (Hoffman, 1995, p. 8). This is in contrast to cognitive social psychology which focuses on highlighting the internal psychological processes that direct social behaviour (Michael, 1991). Viewed ecosystemically, a description and understanding of attribution of meaning will necessarily encompass both of these concepts -- cognitive social psychology and social constructionism, with both having relevance in the way each patient constructs a set of ideas, beliefs and a personal reality about her experience of her illness.

3.3 Conclusion

In concluding this section, it is suggested that constructivism allies itself with the postmodern movement in that both challenge the idea of a single or unitary meaning of reality (Hare-Mustin & Maracek, 1988). The common thread between constructivism and the postmodern movement is the concern with the way meaning is represented. As Hare-Mustin (1994, p. 33) suggests: "A postmodern orientation reminds us that all realities are constructions, and some are more influential than others." A discusion of postmodernism ensues in order to illustrate the connections inherent in constructivism and the postmodern movement, and to highlight a connecting link with ecosystemic thinking.

CHAPTER 4

ECOSYSTEMIC THINKING AND THE POSTMODERN ERA

4.1 Introduction

Ecosystemic thinking shows an affinity to the postmodern movement in its similar move away from linear-causal, as well as first-order cybernetic thinking,. This parallel move may be described and explained and clarified in the following way: In the field of family therapy, Hoffman (1990) delineates a distinction between first-order and second-order approaches to therapy. The former includes objective descriptions of the family system and encompasses terms such as circularity and homeostasis. A second-order approach eschews the position of the therapist as an observer of the family system i.e. outside the system,which is a first-order view, and emphasises the evolution of new ideas and narratives resulting from the communication and conversation of therapy (de Shazer, 1982). Extrapolating on this dichotomy, it is possible to postulate, (albeit perhaps in a somewhat exiguous fashion), that the first-order approach has a parallel with modernism and the second-order, postmodernism (Pocock, 1995). Pocock does, however, suggest that this division may not be fully tenable. He reasons that therapies which are delineated as modernist may not be pursuing absolute truth while "therapies characterized as postmodern may become absurd when testing of stories becomes possible" (Pocock, 1995, p. 151) Consequently, both should probably play a role in the field of family therapy.

In order that the parallel between postmodern and ecosystemic thinking becomes apparent, it is relevant at this point to introduce the concept of modernism and the subsequent emergence of the postmodern movement.

4.2 Modernism

4.2.1 Introduction

In a somewhat confusing way, Madison (1988) states that there is no clarity on the meaning of the words modernism and postmodernism and that "They mean, it appears, whatever we want them to mean" (p. x). (As a result of this loose interpretation or description, it may be relevant to note that such a statement may be partially responsible for promoting or colluding with this attempt to reconcile ecosystemic thinking with postmodernism). Nevertheless, modernism commonly (and perhaps simplistically), seen to be the precursor of postmodernism, surfaced during the Age of Enlightenment, an era associated with the Renaissance (Featherstone, 1988; Pocock, 1995). In this respect, Kvale (1990) rhetorically questions whether or not postmodernism is actually a continuation of modernism or whether it is really a break with modernism. Lather's view (1990, p. 80) suggests that "...postmodernism is a process of modernity, an epochal turning point in how the world and the possibilities of human agency are conceived." Lash (1988) clarifies this somewhat, by suggesting that 'early' modernity, (which he attributes to the era of the Renaissance), is involved with the differentiation of cultural from religious realism and the aesthetic from the social realm. This early Renaissance modernity era is followed by 'late' or later modernity with the subsequent rise of aesthetic modernism (Lash, 1988), equated by Lyotard (1988) to postmodernism.

4.2.2 Tracing Modernity to Postmodernity

The foundations of modernity are based on the importance of rational knowledge, positivism and the scientific method (Leary, 1994). The philosophy of modernity suggested that "The world was understood as something that could be deduced,

evaluated, and known on its own terms" and the self was conceptualised "as a distinct, stable entity" (Leary, 1994, p. 440-441), a way of thinking with strong Newtonian influence. In the theme of modernity, man is placed at the centre and is seen as a rational being where reason leads to progress (Kvale, 1990).

Modernity is characterised by the important theme (which changes radically in postmodern thinking) of "the *dichotomy of the universal and the individual*, between society and the unique person, where the rootedness of human activity and language in a given social and historical context is overlooked" (Kvale, 1990, p. 37; italics in original) -- the individual is an object for general laws of history and nature. In other words, in modernity, the world is seen as a picture or representation, and man as a representing subject in the midst of mere objects (Madison, 1988). The notions of subjectivity and a fully objective, determinate world are the theoretical by-products of modernism. Man is the "knowing subject" who forms true "representations" of so-called objective reality (Madison, 1988) (as in Newtonian thinking and in first-order cybernetics). The movement away from modernism means a move away from what modernism understood by "the subject" and "the objective world." This then brings to an end the concept of the cognizing subject as an outsider who forms a "mental representation" of a world, the world being fully what it is in itself (Gergen, 1991; Madison, 1988) -- this is reminiscent of the movement from first-order cybernetic thinking to second-order cybernetics. Consequently, as a result of the "demise of the epistemological subject and the objective world" and the demise of ideas of "knowledge" and "truth", the age of modernism began to draw to a close with the emergence of postmodernism as an attempt to examine and understand the consequence of this demise of the modernist subject-object split (Madison, 1988, p. x).

4.3 The Rise of Postmodernism

Disillusionment and disappointment with modernism followed. The science and technology aspect of modernism failed in its promise to lead to greater emancipation by progress and to solve all human problems. Concomitantly, when presupposed rationality often failed to exist in reality, a different reality had to be constructed to account for the worldly disorder and the exigencies of contemporary cultural life (Kvale, 1990; Leary, 1994). The limited concept of rationality in modernism, which needed formality and technicality, with an emphasis on method, calculation, prediction and control -- a functional, means-end rationality --gave rise to an evolving postmodernity (Leary, 1994). This placed emphasis on an expansion of rationality, and an eschewing of appeals to formal logic, thus increasing the "focus on the values and the ethical responsibility of the acting persons" (Kvale, 1990, p. 39). Postmodernism embraces a communal network or interaction: "... the universal laws and the unique individual selves are seen as abstractions from man's being in the world" (Kvale, 1990, p. 37). This gives rise to interpretations of meaning and truth being made by individuals who share decisions and the consequences of their decision-making -- this way of thinking is different to equating objectivity to universal laws, and subjective and/or relative aspects to the person (Kvale, 1990). The interpretation of meaning and truth by individuals who share decisions, is in common with ecosystemic thinking (and attribution of meaning). Both viewpoints incorporate aspects of Maturana's (1975) concept of consensual domain as well as aspects of constructivist and social constructionist thinking in the quest for whatever reality is seen to be.

4.3.1 A Description of Postmodernism: Facets of Similarity to Ecosystemic Thinking

Both postmodernism and ecosystemic thinking may loosely be described as the "contemporary historical moment" (Michael, 1991, p. 204). Both appear to epitomise the emergent cultural and psychological style (characteristics) of the present era. Michael (1991, p. 204) states that a definitive characterization of postmodernism would

"contradict the fragmentary, ironic, essentially unsummarizeable nature of postmodernism" (and the same could apply to ecosystemic thinking).

Consequently, despite the amount of literature on postmodernism, Featherstone (1988, p. 20), in agreement with Madison (1988), writes that "there is as yet no agreed meaning to the term postmodern." He states: "... the term postmodern is more strongly based on a negation of the modern, a perceived, abandonment, break with or shift away from the definitive features of the modern with the emphasis firmly on the sense of the relational move away" (Featherstone, 1988, p. 197). In 1988, Featherstone stated that postmodernism was presently only at the beginning of this alleged shift and as yet was not a fully fledged positivity with its own comprehensive definition. Kvale (1990) elaborates on this when he suggests that there is no "systematic theory or a comprehensive philosophy (of postmodernism), but rather a diagnosis and interpretation of the current culture, a depiction of a multitude of interrelated phenomena" (p. 36). More recently, Gergen (1991) suggests that its value exists in that it highlights historical changes occurring in contemporary culture, involving more specific fields such as the academic, intellectual and artistic worlds, as well as wider cultural and sociological spheres, particularly in western, developed countries. This description also loosely fits to an ecosystemic way of seeing the world.

Postmodernity can be said to be associated with 'the loss of a sense of historical past', 'the replacement of reality by images' and 'simulations' (Featherstone, 1988, p. 207). It is this direction of change that shows similarity with ecosystemic principles and attribution of meaning, in a movement away from traditional structuring to the flow of the here-and-now moment. As Featherstone (1988, p. 205) states: a postmodern sociology "focuses attention on the ways in which theories are built up, their hidden assumptions, and questions the theorists' authority to speak for 'the Other', who as many researchers are finding out, is now often actively disputing both the account and the authority of the academic theorist." In order to make sense of the emergence of

postmodernism and its associated changes (in the culture of contemporary western societies), "we need to move beyond the false oppositions of foundationalism and relativism, of single epistemology and plural ontogeny, and investigate specific social and cultural processes and the dynamics of the production of particular funds of knowledge" (Featherstone, 1988, p. 205).

4.3.1.1 Legitimacy in Postmodernism

An additional aspect of postmodern thinking which is relevant to the ecosystemic stance, is the question of legitimacy -- what is valid and legal, whether an action is correct and justifiable (Lyotard, 1988). Lyotard (1988) suggests an intrinsic legitimation utilizing narrative knowledge. This legitimation does not need recourse to argumentation of proof, but certifies itself in the pragmatics of its own transmission. This perspective moves beyond the influence of Cartesian-Newtonian linear-causality, and supports ecosystemic thinking. Legitimation of action will take place through communicative and linguistic action and this may be described as contextual relativism (based on the shared decision-making as mentioned by Kvale (1990) and with similarity to the concept of consensual domain (Maturana, 1975)). Consequently, with the dissolution of universal systems of knowledge and global narrative, a shift occurs where local context and local knowledge predominate (Kvale, 1990). Kvale (1990, p. 38) clarifies: "The emphasis upon the local is not merely a retreat from the global system of modernity, but surpasses the modern polarity of the universal and the individual, of the objective and the subjective." Stated slightly differently, if knowledge is arrived at socially, (rather than being described purely in terms of universal systems of knowledge), then the postmodern view sees knowledge as changing and renewing itself in each moment of social interaction (Hoffman, 1995). Within this concept, emphasis is given to the facets of local interaction and local meaning, together with changing language games, comparable to the interactional interplay described in ecosystemic thinking.

Ecosystemic perspectives have developed along a relatively similar route to the point where individual meanings and shared ideas or ideas within a consensual domain are the way of viewing and being in the world, in opposition to observer-based Newtonian perspective. Postmodernism has further similarities with ecosystemic thinking: the postmodern world exhibits continual change of perspectives which do not necessarily have an underlying common frame of reference, with a tendency to a variety of changing horizons. What has become important is the emphasis on the local and personal responsibility for here and now actions, rather than the search for utopias. As Kvale (1990, p. 41) states: "A postmodern attitude to the world relates to what is given, rather than what has been or could be."

4.3.1.2 The Postmodern Condition: Three Dynamics

In a further exploration and description of postmodernism, Michael (1991) proposes three dynamics that characterize the postmodern condition:

4.3.1.2.1 Transgression

Transgression which is the breaking down or blurring of established, discrete boundaries or categories (such as art, culture and reality). This is contrasted with the idea of clarification which also involves delineation and which belongs to the historically more traditional style. Michael (1991) makes the point that clarification is involved in the concepts of cognitive and social constructionist social psychologies. Paradoxically, however, because social constructionism straddles traditional disciplinary boundaries, it not only exemplifies postmodern transgression, but also retains the processes of clarification as its emphasis in relating to inquiry (Michael, 1991).

4.3.1.2.2 Accelerated Turnover

Accelerated turnover which relates to the increased tempo of change (or hectic throughput) in the images, texts and categories in various aspects of social and individual life. Michael (1991) gives the example of youth fashion, where accelerated turnover of styles occurs so that the time period between the fashionable and the passe decreases.

4.3.1.2.3 The Consumption of Spectacle

The consumption of spectacle (and the fun ethic) -- Michael (1991) describes this aspect of postmodernism as "the motive force behind transgression and accelerated turnover" (p. 205), wherein "the experience of change, novelty and spectacle becomes an end in itself" (p. 206), a sort of 'ecstacy' resulting from transgression and accelerated turnover, although there is not necessarily a practical utility associated with these aspects of postmodernism.

Michael (1991) parallels Featherstone's (1988) postulate in suggesting that in postmodernism, "The boundary between the cultural and real life, the image and the real, is being increasingly transgressed" (p. 208). Traditional culture is constantly being challenged: "To the extent that the postmodern era is characterised by transgression and accelerated turnover, the representations, categories, texts and so on, that have been used to structure the social world in a number of domains -- the self, the meanings of cultural artifacts, the social group -- no longer fulfill this function" (Michael, 1991, p. 211). In this respect, Michael (1991) suggests that postmodernism tends to oppose cognitivism and constructivism which utilise the processes of clarification and stabilization to furnish practical gains in all spheres of life, individual and social.

In line with the postmodern view, ecosystemic concepts also manifest transgressions of boundaries and categories, and thus challenge traditional scientific approaches which have pursued the course of clarification, delineation and stabilization. Phenomenological research methods, often used in ecosystemic studies, reflect the postmodern approach, in that they differ markedly from the traditional dictate of large subject samples and the associated statistical procedures required for "meaningful", scientific outcome. This latter (traditional) approach ignores the individual, personal and interactional aspects of the subjects in the samples and reduces the individual to a series of significant or non-significant statistical data. A breakaway from these established boundaries and categories (Michael's (1991) concept of transgression) to a more flexible, individualised approach, is in line with both postmodern and ecosystemic conceptualisations.

4.3.1.3 Fragmentation

Lyotard (1988) and postmodernists in general, emphasise fragmentation -- relating to language, time, the human subject and society itself (Sarup, 1988). There is a rejection of organic unity. In leaving behind a premodern or traditional society, postmodernism has created an individualistic and fragmented society. This echoes Michael's (1991) concept of transgression and shows a similarity with ecosystemic thinking. In this respect, in the present study, the impact of the media -- radio, television, computers, lectures, shows, reading material, cannot be seen as separated off from each individual's way of thinking, seeing the world and attributing meaning to life experience. The individual cannot be viewed in isolation -- the impact and effect of the media, together with information which is culturally acquired from person to person, are taken into account in examining the idiosyncratic creations of beliefs and attributions of meaning in the women interviewed. The relevance of each woman's attribution of meaning to her circumstance, her beliefs about the treatment and its

outcome, becomes the narrative and the substance of this thesis -- this is in contrast to the traditional scientific and statistical approach and reflects the ecosystemic approach with its postmodern flavour. In this respect, the postmodern viewpoint, like the ecosystemic approach, gives the impression of encompassing aspects of the concepts of cognitive social psychology, constructivism (Hoffman, 1993) and social constructionism. Even though there are differences and contrasts within these viewpoints, the common denominators are the break with traditional thinking and the blurring of traditional boundaries in one way or another.

4.3.1.4 Performance and Imagination

Sarup (1988), predating Michael's (1991) propositions, suggested that: "The goal of science is no longer truth, but performativity -- that is the best possible input/output equation" (p. 124). Because the ability to produce proof is increased by performativity, the ability to be right is also increased and "...the technical criterion cannot fail to influence the truth criterion" (p. 124).

The shift from a traditional organization of knowledge, which keeps fields of knowledge "jealously guarded from one another" (Sarup, 1988, p. 125), to procedures that increase an individual's ability to connect these fields, is in accordance with postmodern dictum. This shift is assisted by modern day computer data banks which allow the relevant data to be organized into an efficient strategy for problem solving in the here and now -- the data can thus be arranged in a new way. This "capacity to articulate what used to be separate can be called imagination" (Sarup, 1988, p. 125) and it is this imagination which can result in a new move or new argument governed by established rules, or can invent new rules or a new frame. Not only is this a postmodern view of knowledge, science, 'facts', but also coincides with an ecosystemic approach in that it encourages the destabilization of the narrower, limiting, traditional style and of scientific boundaries. This approach encourages contextualisation and the

encompassing of all available data, input and information in order to discover meaning in the data.

4.3.2 The Technological Transformation:

4.3.2.1 Knowledge and Narrative

It is interesting that an earlier birth of postmodernism seems to have been negated and denied, probably because it arose prior to its 'appropriate' time in history. Many past scientists have had their invention of new rules ignored or repressed because their work destabilised the accepted traditional positions in the scientific hierarchy and in the discipline itself -- the rules of the game would have to be changed for adequate consensus to take place and this is often too threatening. Hence refutation occurs. The advent of technological transformations e.g. computerisation, may have promoted the emergence and acceptance of postmodern thinking.

Lyotard (1988) states that in the last four decades, the technologies and science have become more involved with language and obviously, these technological transformations (involving computers and their language, data banks with information storage and problems of communication and cybernetics), have a major impact on knowledge and the way in which learning is acquired, classified and made available. Thus, according to Lyotard (1988), the nature of knowledge has no choice but to change in this context of transformation. He believes the postmodern age is bound to alter the status of knowledge, and that knowledge is already ceasing to be an end in itself. As he states: "Knowledge [*savoir*] in general cannot be reduced to science, nor even to learning [*connaissance*] (Lyotard, 1988, p. 18, italics in the original). "Knowledge, then, is a question of competence that goes beyond the simple determination and application of the criterion of truth...." (Lyotard, 1988, p. 18)

Sarup suggests: "Scientific knowledge does not represent the totality of knowledge; it has always existed in competition and conflict with another kind of knowledge" called narrative. In addition, "In traditional societies there is a pre-eminence of the narrative form" (Sarup, 1988, p. 120). Narratives may be explained as popular stories, legends, myths and tales and apart from defining "what has the right to be said and done in the culture in question" (Sarup, 1988, p. 120), they most probably play an important role in the concept of attribution of meaning. In this respect, narratives form a background of influence for each individual's personal experience and belief systems, which would then impact on that individual's idiosyncratic way of seeing the world, and this view would become the individual's personal "story" (Leary, 1994).

In the science language game, proof has to be provided by the scientist for what is said or postulated. There must be the ability to refute opposition or contradiction by others concerning the same referent. This is different to the story-telling knowledge associated with narrative. In the science language game, consensus between partners is important, but not every consensus is a sign of truth -- it is assumed, however, that the truth of a statement necessarily draws consensus. Again there is a parallel with the ecosystemic concept of mutual consensus within the context of individuals in a particular situation e.g. the hypnotic situation where 'truth' is not the issue, the mutual agreement defines the situation and the condition.

Lyotard (1988) makes the point that one cannot judge the validity of narrative knowledge on the basis of scientific knowledge or vice versa because the relevant criteria are different and are both equally necessary. Scientific knowledge insists that one language game or denotation be utilised to the exclusion of all others -- this is the main difference between scientific narrative and narrative knowledge. Narrative knowledge does not need scientific proof and argumentation to validate itself and fits with the concept of legitimacy (Kvale, 1990; Lyotard, 1988), although this view is questioned by scientists (Pocock, 1995; Sarup, 1988). Interestingly, Lyotard (1988)

suggests the paradox that scientific knowledge has to resort to narrative knowledge in order to know and make known that it is the true knowledge, even though it gives no credence to narrative knowledge e.g. physicists 'tell stories' about subatomic particles (Sarup, 1988, p. 141). In this respect, Lyotard (1988) suggests that there is a recurrence of the narrative in the scientific. He also suggests that postmodernity signals a crisis in the legitimizing function of narrative, that is, in its ability to compel consensus.

Sarup (1988) suggests that a narrative always demands interpretation and thus a distinction must be made between manifest meaning and latent content. Importantly, "every narrative simultaneously presents and represents a world" i.e. "creates or makes up a reality and asserts that it stands independent of that same reality" (p. 142) and in so doing, both reveals and illuminates a world as well as hiding or distorting it. Narrative is "the contentless form of our most basic experience of reality" (Sarup, 1988, p. 142). He suggests: "...it is a specific mechanism through which the collective consciousness represses historical contradictions" (p. 142). This view is confluent and consistent with the concept of attribution of meaning. Similar language and viewpoints could be expressed with regard to attributions of meaning, and these views which collaborate and fit with ecosystemic thinking.

4.4 Aspects of Difference Between Postmodernism and Ecosystemic Thinking

An aspect of difference between postmodernism and ecosystemic thinking may be seen in the motive in each i.e. "people of the postmodern era can shift from text to text at random -- the primary 'motive' being the search for spectacle" (Michael, 1991, p. 217), which is not the case in an ecosystemic perspective. However, where similarity surfaces is in the idea that "Under such circumstances there is constant shifting of meaning in process -- texts have fluid meanings and multiple, burgeoning connections" (Michael, 1991, p.217). Ecosystemic concepts and attribution of meaning show

similarities with this outlook in that they utilise the concept of perturbation of ideas as an explanation or description for the shifting of meaning in process. Michael (1991) writes: "Thus, the postmodern individual is not socially delimited by the use and content of particular texts. Rather, he/she emerges in the turnover and transgression of texts. For some analysts of postmodernism, this has been a cause for celebration insofar as the playfulness entailed in the transgression and turnover is seen as a good thing, both in its own right and as a form of resistance to those texts that in some way constrain people" (p.217). This is reminiscent of the turning away from limiting Newtonian constraints towards the emergence of a stance which has a looser, more flexible and encompassing style as adopted in ecosystemic thinking.

4.5 Conclusion

The structure, confines and limitations inherent in the "old", traditional, Newtonian way of representing science and scientific theories including research, have been critically appraised and evaluated by many theorists and researchers in the field and have been found to be deficient -- too narrow, limiting, and constraining. As a result, an array of new concepts has surfaced, resulting in a serious break away from more conservative viewpoints. These new concepts have not necessarily negated the traditional views, but have widely expanded not only the way of viewing the world, but have caused a shift in the approach to research and studies in the scientific field, and particularly in the humanities. Man is no longer seen as an external "observer" of the world. There is a fluidity, a flexibility and a wider encompassing of all variables which opposes the rigidity and narrowness of traditionality, and which opens up a new way of perceiving 'facts' and 'knowledge'. Postmodern dynamics involves a loosening, undermining, replacing and fragmenting of social representations not only over extended historical periods, but also in quick, accelerated succession. The processes of continuing change are the issue. As Michael (1991) states: "... postmodernism

comprises an historical juncture in which people perceive or experience texts as 'self deconstructing'; texts are seen to be enmeshed in a whole array of other texts and derive their multiple meanings from these relations" (p. 217).

In a broad manner, this description parallels the concept of context in ecosystemic thinking and encompasses the notion of each individual's idiosyncratic interpretation and attributions of meaning pertaining to the texts. The interplay and interconnectedness of Maturana's (1975) structure-determined, internal world, second-order cybernetic thinking, the concepts of constructivism and social constructionist thinking and attribution of meaning, are inherent in both ecosystemic viewpoints and postmodern thinking, (although the latter is described with different languaging), and there are levels of merging similarity in the concepts.

It is difficult to separate into discrete entities the concepts discussed in this chapter -- they clearly interweave with each other at the same time as complementing and extending one another. Nevertheless, an attempt to extract and extrapolate the concept of attribution of meaning (incorporating beliefs and expectations), which is consistent with this way of thinking, is offered in the following chapter.

CHAPTER 5

AN HOLISTIC PERSPECTIVE ON ATTRIBUTION OF MEANING

5.1 Introduction

An individual who is diagnosed with a life threatening disease is likely to experience more feelings of helplessness, fear and anxiety than in any other situation which does not involve threat to life. At such time, the individual may be more vulnerable and hence more available and receptive to outside influences in the form of other people's advice, opinions, general hearsay, literature, media programmes and medical support. Alternatively an individual may become more withdrawn, defensive and closed, and thus more dependent on internal structure and self-support, than under non-threatening conditions. In both instances, how each individual perceives and interprets the available information is dependent on personal, idiosyncratic style. How the individual reacts, what behaviour he/she manifests, is based on his/her internal structure or makeup (Maturana, 1975), his/her cognitions, and his/her personally constructed ideas, beliefs and attributions of meaning about the prevailing life-threatening situation, and in the context of the life-threatening situation. The combination of the uniqueness of these factors is likely to influence and direct the individual's way of dealing with the illness, the individual's behaviour and coping mechanisms and possibly even the outcome of the ordeal. A life-threatening experience will probably be somewhat different for each individual, depending on that individual's internal structures (Maturana, 1975) and accumulated 'knowledge' which is based on past experiences, the individual's ways of perceiving the world and the resultant idiosyncratic ideas, constructed beliefs and attributions of meaning associated with the unity of these aspects in a holistic framework.

This chapter presents a perspective on attribution of meaning including beliefs and expectations, and of necessity has to involve the theories, concepts and ideas presented up to this point, because of the inextricably interwoven nature of these issues. Of particular note is the associated influence and involvement of constructivist concepts.

5.2 Attribution of Meaning

5.2.1 Working Definition and Description of Attribution of Meaning

Attribution of meaning "encompasses all ideas of all participants regarding one another, regarding the specific situation and its definition, regarding the particular problem and regarding specific behaviours in the situation" (Fourie, 1991b, p. 66). Fourie (1991b) points out that this concept is different to attribution of personality traits as described by Jones and Davis (1965), which relates to the perception of other people, or causal attribution which relates to the causes of peoples' behaviour (Kelly & Michela, 1980). Verbal (and non-verbal) language i.e. the utilization of linguistic processes, is necessary for the co-evolution of these attributive meanings into a domain of consensus -- this includes the ongoing co-evolution of such a consensus, and implies interaction between people (Anderson & Goolishian, 1988; Fourie, 1991b).

This viewpoint adopts a wider,different perspective than does the one-dimensional, cognitive aspect of ideas, which relates to the intrapsychic functioning of each individual. This 'wider system' consequently incorporates the interaction of people with each other and their environment, as well as the constant evolution of ideas in that system (Fourie, 1991b, p. 67). As Fourie (1991b, p. 63) explains: "Whatever is perceived by anybody in this system can only be interpreted by reference to that individual's existing ideas". The evolution of a particular set of ideas is the result of the process of continual intepretation. The influence of any perception on any one idea is not seen as lineal in such a system, but with the evolution of the system, there occurs a parallel development of a consensual domain (Fourie, 1991b; Maturana, 1975). In

this way, the system becomes mutually defined whether by agreement or disagreement between the members of the system -- this is a way of being together (Fourie, 1991b; Fourie & Lifschitz, 1985). "Whatever is perceived is attributed with particular meaning by each individual on the basis of their own set of ideas at the particular moment, in interplay with the consensual domain at that time. Every verbal or non-verbal action performed by anybody in the system (including the therapist) is imbued with meaning by everybody else in the system" (Fourie, 1991b, p. 63-64). The set of ideas held by one member of the system will influence the specific meaning which that person attributes to that action -- each individual's idiosyncratic set of ideas is related to the particular consensual domain of that moment. An expressed idea may be seen to be a perturbation either of another idea or of the consensual domain within the system, rather than being able to cause any particular linear influence.

Viewed this way, all therapeutic models can be described as being an exchange of ideas between the participants in a complicated and recursive process (Fourie, 1991b). If the ideas of the members in the system simultaneously link in a meaningful manner, the (client's or therapist's) ideas may then alter as part of a co-evolutionary process.

This perspective of attribution of meaning offers a holistic and constructivist view of psychotherapy inherent in which is an a-causal view of the psychotherapeutic process. In such a perspective, individual attributions of meaning lead to the construction or co-evolution of a shared meaning which then becomes embedded in a consensual domain. This consensual domain is the result of each person's idiosyncratic, and thus different, attributions, ideas, concepts and beliefs which perturb one another within the particular system, in an ongoing process. Languaging is the vehicle enabling the evolution of a consensual domain (Anderson & Goolishian, 1988). The outcome of such perturbations within the psychotherapeutic framework, the consensual domain, results in a shared meaning which sees the original behaviours and/or problems as having disappeared or having lost their problematic status. Thus, as a result of the individual

attributions of meaning, a shared meaning is constructed (Effran, Lukens & Lukens, 1988; Fourie, 1991b; von Glasersfeld, 1984). Psychotherapeutic (and hypnotic) techniques are consequently seen as methods or ways of perturbing ideas and beliefs or attributions in this constructivist view of psychotherapy and hypnosis (Fourie, 1991b).

5.2.2 The 'Truth/Reality' Aspects of Attribution of Meaning

Inherent in this view of attribution of meaning, is the assumption that, attribution of meaning can refer to an individual's or system's beliefs or assumptions about an issue which does not necessarily imply a truth about that issue. An attribution of meaning is an individual's or system's idiosyncratic way of creating his/her/their own reality about a particular issue in the world around him/herself/themselves. It is the meaning that a person attributes to an event that determines resultant behaviour (Speed, 1991; White & Epston, 1989) and, conversely: "The active structuring of experience results in a frame of reference or point of view from which the person assigns meaning to the new experiences" (Young-Eisendrath & Hall, 1991, p. 14).

Attributions of meaning may also be understood by a broad synthesis of Einstein's general theory of relativity which "shows us that our minds follow different rules than the real world does" (Zukav, 1979, p. 181) and Maturana's structure-determined theory "which tries to superimpose on the real world its own version of what must be" (Zukav, 1979, p. 181). This view is based on a similarity of ideas that the structures of the rational mind determine what it will and will not accept freely. It suggests that attributions of meaning do not necessarily come from the real world, but from each person's idiosyncratically, structure-determined mind. If the concept of attributions of meaning is described as a mental creation, then it is important to note that there is no correctness or incorrectness and no way to determine such issues. As Zukav, (1979, p. 328) writes: "Reality is what we take to be true. What we take to be true is what we believe. What we believe is based on our perceptions. What we perceive depends on

what we look for" and this in turn depends on what we think, which depends on what we perceive. "What we perceive determines what we believe" which determines what we take to be true and this "is our reality" ."

5.3 A Move Towards Attribution of Meaning:

5.3.1 Beliefs, Expectations and Anticipations

The following section provides a background which leads towards the present view of attributions of meaning. Aspects of historical ideas and definitions which describe beliefs, expectations and anticipations are outlined. These concepts, not identical to attributions of meaning but with some similarity, hold a narrower perspective than the later concept of attributions of meaning and also manifest with certain discrepancies.

A description of the term "belief" is offered by Stolzenberg (in Watzlawick, 1984) as a "system in which all acts of observation and judgement are made solely from within and in which all other considerations are subordinated to the maintenance of the system itself" (p. 272).

Rokeach (1968) describes a belief system as "having represented within it, in some organised psychological but not necessarily logical form, each and every one of a person's countless beliefs about physical and social reality" (p. 2). He writes that the total number of beliefs possessed by the adult involves tens, possibly thousands of beliefs concerning what is true or not true, beautiful and good in relationship to the physical and social world in which we live. He suggests that man's beliefs -- "like the physicist's electrons and protons, like the astronomer's moons and planets and suns, like the geneticist's chromosomes and genes -- become somehow organised into architectural systems having describable and measurable structural properties, which, in turn, have observable behavioral consequences" (p. 1). Rokeach (1968) describes

beliefs not necessarily as verbal reports taken at face value, but as inferences made by an observer about underlying states of expectancy.

If it is accepted that beliefs, assumptions and expectancies are all allied to attributions, then Rokeach (1968) and Goldstein (1962) express similar viewpoints. Goldstein (1962) states that the expectancy usually relates to past experience in similar circumstances and the arousal of central cognitive motivational processes. He suggests that the greater the strength of the expectancy, the greater will be the probability of arousal in a particular situation. In addition, if the strength of the expectancy is great, then the amount of appropriate information needed to confirm it will be less and the amount of information needed to infirm it, increases. The more often an expectancy has been confirmed in the past, the greater its strength will be. Goldstein (1962) also suggests that with reference to any particular issue, the fewer alternative expectancies there are in the repertoire of the individual around that issue, the greater the strength of those expectancies will be. In addition, the cognitive field is provisionally organised according to the expectations of the subject and the expectations which survive are those which best correspond with 'reality'.

Stated differently, but in support of Goldstein's views, Kelly (1970) puts forward a postulate which is basic to the psychology of personal constructs and suggests that : "*A person's processes are psychologically channelized by the ways in which he anticipates events*" (p. 9, italics in original). Behaviour may thus be viewed as anticipatory rather than as reactive (Goldstein, 1962; Kelly, 1955). If this is seen as the directive referent for understanding and explaining human processes, then Kelly (1970) is clearly eschewing the stimulus-response ideation of earlier scientific determinism. In its place, he and others (Goldstein, 1962; Kelly, 1955; 1970; Rotter, 1954) credit anticipations and attributional processes with playing a major role in determining the outcome of behaviour. Goldstein and Shipman (1961) and Rosen (1976) suggest that behaviour is regarded as a function of the subject and one of the

major predictors of behaviour is the subject's expectancy regarding the outcome of his/her behaviour in a given situation). In addition to this view, Landfield and Leitner (1980) describe anticipation as a pivotal assumption in constructivist theory. They state: "The essential nature of *or* reason for construing is *anticipation*" (p. 5, italics in original). An important extrapolation of this view is that the occurrence of a behaviour is strongly determined by the person's anticipation or expectancy that certain goals or responses will occur, and not just by the nature or importance of the actual goals or reinforcements (Barber, Spanos & Chaves, 1974; Goldstein, 1962; Rotter, 1954). That expectancies formed in certain situations are likely to generalize to other situations is well known (Kelly, 1970; Kirsch, 1990) and thus, in the present study, an important factor is the subjects' generalization of expectancy with regard to ANV and cancer in general (what they know about it and whether or not they expect it will happen to them) and with regard to hypnosis (whether or not they have positive or negative beliefs about hypnosis and also concerning the efficacy and usefulness of hypnosis). In this respect, expectations (and attitudes) based on direct rather than vicarious experience are more potent and thus have a greater impact on behaviour (Goldstein, 1962; Kirsch, 1990), but the latter also have influence and impact.

5.4 Attribution of Meaning in the Therapeutic World

In a broad sense, people view their world around themselves and the manner in which it impinges on them as a 'given reality'. In contrast, constructivist viewpoints suggest that what is perceived as reality is created by each individual's personal beliefs and attribution of meaning, which in turn, are dependent on past experiences, on internalised information, on ideas and cognitions and on the physiological structure of the nervous system (Fourie, 1991b; Keeney, 1982; 1983; Maturana, 1975; Rokeach, 1968; Simonton & Simonton, 1975; Speed, 1991; Zukav, 1979). This suggests that each individual has an idiosyncratic and personalised way of experiencing and viewing the world around him/herself. Equally, each individual would have an idiosyncratic way

of interpreting and thus attributing meaning to how he or she can be affected by, or in turn, can affect this world. Bowers (1973, p. 227) describes attribution theory as being concerned with "how we know something about ourselves and others."

5.4.1 In Psychotherapy

The ramifications and pervasiveness of attributions of meaning are inherent in the field of psychotherapy. Individuals often react potently to and are often heavily influenced by their internal beliefs which in turn colours each individual's perception of the so-called different 'realities' of everyday occurrences and interactions. These beliefs and attributions of meaning frequently dictate the pattern or flow of the individual's lifestyle and influence that individual's perception of 'reality' in everyday issues. Equally, the therapy is subtly governed by the therapist's theoretical and personal belief systems interacting with and often influencing and influenced by, the personal belief systems of the client. The therapy will be strongly influenced by the collusions and/or contradictions resulting from similar, dissimilar or innovative belief systems and attributions of meaning being introduced by both parties in the ongoing therapeutic process.

5.4.2 In Psychoanalytic Psychotherapy

In psychoanalytic psychotherapy, the intrapsychic, linear-causal stance still dominates, (although it is showing a shift towards intersubjective, interactional, constructivist thinking and practice). In psychoanalytic parlance, the playing out or enacting on the part of the patient/client of the reified, traditional psychoanalytic concepts of transference and the unconscious may be described as attributions of meaning on the part of the patient/client towards the therapist within the therapeutic situation. This particular aspect of attribution of meaning is itself attributed to the patient's/client's past experiences of relationships with important people in his/her life, and this is believed to

influence the present day interaction and relationship with the therapist, regardless of what is actually happening in the particular moment in the therapeutic situation. Equally, all of this may be seen as the therapist's attribution of meaning to the therapeutic situation and relationship. In this respect, Gill (1985), Schwaber (1985) and Michels (1985), each writing from a different perspective on the transference, are collectively clear on the interactional, observer/participator roles of therapist and patient/client in the therapeutic relationship, where the views and beliefs of each affect the other, recursively and in a co-evolutionary manner. The issue of each participator's perception of reality is also highlighted. How these beliefs and ideas perturb other beliefs and ideas during the recursiveness of the therapeutic process will result in a consensual domain shared by patient/client and therapist, and will affect and dictate the perceived views and outcome of the therapy. ("Patient/client" is used in this context, because psychoanalysis views analysands as "patients" and cognitive and ecosystemic therapies use the term "client").

5.4.3 Transactional Analysis

Although the term 'attribution of meaning' is not used in the psychotherapeutic theory of Transactional Analysis (TA) as evolved and described by Eric Berne (Berne, 1961; 1964; Kadis, 1985; Stewart & Joines, 1987), TA extensively incorporates the beliefs of the individual which are based on past experiences and on perceived transactions between parent and child (and significant others in the child's life). The Gouldings (Goulding & Goulding, 1979) have developed an extension of Berne's therapy in their "redecision" work which is also strongly associated with childhood beliefs -- based on experiences in the child's life, the child often makes a "decision" about him/herself, others and the world around him/her and then acts according to that perception or attribution of meaning, or in avoidance of it. The 'reality' of the original situation/environment, together with the child's perception and personal interpretation of that reality, amalgamate to form the child's belief. This can colour the individual's

life in a multitude of ways, in an ongoing capacity, often negatively and with personal and idiosyncratic distortions of reality which are non-beneficial to the individual. (In a sense, the Gouldings have created their own personal belief systems or attributions of meaning about other people's personal childhood beliefs).

5.5 The Influence of Experimenter Bias

Related to this view but stated differently, Rosenthal, Fode, Friedman and Vikan (1960), Goldstein (1962) and Frank (1959) suggest that "experimenter bias clearly illustrates that an experimenter's expectations may covertly influence a subject's performance under a variety of motivational states and situational characteristics." Taken one step further, Frank, Gliedman, Imber, Stone and Nash (1959, p. 967) suggest that ".... any form of activity by a person culturally defined as a healer may activate a patient's belief that he is being helped." Consequently, professional attention paid to the patient in the form of the initial interview, questionnaires, general interest etc., while not intentionally therapeutic, will be given personally constructed meaning by each patient, and may function positively to activate favourable expectancies. Parental, familial and peer group attitudes play a crucial role in influencing subjects with their expectations regarding the situation (Simmons & Freeman, 1959). Rosenthal and Frank (1956) argue that patients entering psychotherapy have varying degrees of belief in its efficacy and this belief or set of expectations may be an important determinant of the results of the therapy. Cartwright and Cartwright (1958) extrapolate this concept, predicting that a patient's expectation of improvement is the result of believing that certain effects will result together with the belief that the therapist is the major source of help. In addition, there are beliefs in the techniques and procedures which are seen as an important aspect of the help, as is belief in oneself (the patient/client) as playing a large part in the therapy. This is supported by Frank et al (1959). Wilkins (1979) suggests that "even when superiority over control procedures is demonstrated, nonspecific events, in general, and expectancy factors, in particular,

have been presented as possible interpretive contaminants that account for this superiority." Wilkins (1979) adds that clients with greater expectancy levels improve more than clients with lower expectancies (in psychotherapy) and that the reliable correlation between client expectancy and therapy outcome indicates that clients are accurate predictors of future events (Rosen, 1976; Wilkins, 1973). However, it is important to note that not all therapeutic gain is caused by expectancies (Kazdin & Wilcoxon, 1976; Lick & Bootzin, 1975) and measures used to infer expectancies are, themselves, reactive to interpretive artifacts.

5.6 Attribution of Meaning in:

5.6.1 The Advertising World

In a different context, the world of advertising is notably dependent on the influence of attribution of meaning. Watzlawick (1984) asserts that mind manipulations occur in the field of advertising wherein a deliberate attempt is made "...to bring about attitudes, assumptions, prejudices, and the like, whose realization then seems to follow naturally and logically. Thanks to this brainwashing, the world is then "seen as "thus" and therefore *is* "thus" " (Watzlawick, 1984, p. 112, italics in original). Watzlawick (1984) connects this viewpoint of advertising to the emergence of constructivist theory, where constructivism is seen as rejecting "objectively knowable truth" (Hoffman, 1990a; 1990b). In addition, the ensuing theory suggests that an individual's beliefs about the world are 'social inventions' (social construction) and are the result of environmental cues and experiences. This phenomenon applies equally to propoganda, for example in Nazism, where the Nazi doctrine was "To totally saturate the person .... with the ideas of the propoganda , without him even noticing that he is being saturated" (Watzlawick, 1984, p. 112). Consequently, "the invented reality will become "actual" reality only if the invention is believed" (p. 112). "Where the element of faith, of blind conviction, is absent, there will be no effect" (Watzlawick, 1984, p. 113).

5.6.2 In Religion

In religious thinking, all religions have their foundations and bases connected to attributions of meaning and belief systems. This aspect of religions forms the generalised commonality of all religions, with the specific details of each religion giving rise to the differences. Religious members of society may be described as prescribing to the beliefs and attributions of their chosen religion. Atheists, agnostics and anti-religious individuals prescribe to a different set of beliefs. As Berger and Luckmann (1976, p. 133) suggest, "...the devil unwittingly glorifies God, that all unbelief is but unconscious dishonesty, even that the atheist is really a believer."

5.6.3 In Cancer

In 1978, the Simontons, regarded as pioneers in the field of mind-body control and research in cancer treatment, published their work on a technique for dealing with patients diagnosed with cancer. The basis of the work incorporates the belief systems and expectations of patients and doctors relating to the treatment, prognosis and cure of cancer. The book contains numerous examples of patients whose powerful, positive beliefs around the attainment of wellness resulted in positive outcomes, regardless of the medical diagnosis and prognosis of their cancer. Equally, there are descriptions of patients' negative beliefs and expectations surrounding their cancer diagnoses, which resulted in seemingly premature death for these patients. The Simontons state: "....without beliefs -- those of the patient and of the medical team -- to support the treatment and create an expectancy of health, the physical treatment is incomplete" (Simonton, Matthews-Simonton & Creighton, 1978, p.30). They state that it is not sufficient for a patient simply to go to a doctor who will "fix him up." They clearly

indicate that: "Each person can assume responsibility for examining, even altering, beliefs and feelings that do not support the treatment, that do not move in the direction of affirming life and health" (p. 30).

The basic technique involved in their philosophy is that of working with a patient's positive beliefs towards regaining health. They do this by supplementing the conventional medical treatment (surgery, chemotherapy or radiation wherever necessary) with visualisation techniques akin to techniques used in traditional hypnosis. After deep relaxation has been attained by the patient, he/she is required to use mental imagery in order to visualise his/her body internally mobilising an attack mode to destroy the cancer cells in the body. The patient can choose any style of cancer-cell destruction which feels personally suitable. The Simontons offer no rigid direction in the visualisation technique. Their work shows levels of commonality to the concepts of attribution of meaning and ecosystemic thinking. They are strongly aware of the influential and recursive interactions and ideational exchanges between doctor, patient and relevant others, which can affect (perturb), or even create (construct) beliefs in the patient, (and which can result in a mutual domain of consensus). The beliefs, in a sense, create a personal reality for each patient, regardless of what is perceived by others to be a reality at that moment in time.

The Simontons' innovative approach to cancer opened new doors in the treatment and conceptualisation of the illness -- the patient is seen holistically, mind and body interconnected, rather than simply as a body with a malignant tumour which, in linear-causal fashion, needs to be eradicated (Bloch, 1983; Simonton, Matthews-Simonton & Creighton, 1978; Simonton & Simonton, 1975; Watzlawick, 1984).

A criticism levelled at the Simontons' concept is that in offering techniques and teachings to patients to assist them with responsibility-taking for wellness, a lack of improvement in the patient's illness could lead to an attribution of meaning of personal

failure for that patient. The possible, additional negativity of these beliefs and associated feelings to the serious problem of having to deal with his/her cancer, may exacerbate the patient's plight, and may preclude some researchers and oncologists from offering this technique and some patients from choosing to use this approach.

5.7 Attribution of Meaning Related to Hypnosis

Returning to the concept of beliefs and attributions of meaning from an historical and more traditional view, and relating this view to hypnosis, Ellenberger (1970) puts forward the idea that it is hardly likely that one could 'induce' a hypnotic condition in a subject (linear-causal, intrapsychic stance), who has no prior awareness of hypnotism -- it would be necessary for the "hypnotist" to give an explanation of what is expected and thus create a role expectation in the subject. This stance could loosely be described as a precursor of the idea that attribution of meaning concerning hypnosis is necessary in order that hypnosis can be seen to be taking place. Ellenberger (1970) elaborates further by suggesting that if a subject has in the past experienced a spontaneous, somnambulistic state or a convulsive crisis associated with an hypnotic exprience, it is likely that the subject would repeat this previous occurrence in any further hypnotic situation, unless what is expected of him/her under hypnosis is explained by the "hypnotist" (i.e. the original belief is perturbed).

Bradley (1978) suggests that attributions are probably determined by motivational and cognitive factors. In a similar way to Ellenberger (1970), he postulates that information and knowledge about behaviour or performance in previous similar situations or in previous similar tasks will affect a subject's expectations for the forthcoming related issues (Bernstein, Stephan & Davis, 1979; Goldstein, 1962; Nerenz, Leventhal & Love, 1982; Redd, Rosenberger & Hendler, 1983). This links with the hypothesis in the present study, that subjects who have prior knowledge or information regarding hypnosis, and prior knowledge and information regarding side effects of chemotherapy,

knowledge obtained from other people's proffered information, other's experiences, books, magazines, TV and radio talks, electronic media and general environmental information, may be biased in either a positive or a negative manner as a result of this prior knowledge.

Consequently, although hypnosis has traditionally been described as a reified entity, a set of intrapsychic phenomena occurring in the hypnotized subject, ecosystemic epistemology has shifted the emphasis so that hypnosis is described as a concept. This view of hypnosis as a concept utilises a holistic, interconnected and contextual perspective in order to reframe and explain hypnosis and associated phenomena (Fourie, 1990; Radtke & Spanos, 1981). This perspective places emphasis on the context in which the hypnosis takes place, as well as the interconnections between the beliefs, expectations, opinions and ideas of the participants in the hypnotic situation (Fourie, 1991b). Hypnosis is defined by the fit of ideas into a consensual domain and the meaning that is attributed to the behaviour of the participating subject(s) in the hypnotic situation (Fourie, 1991b; Sheehan & Perry, 1976). Where subjects (and families) attribute inherent power to hypnosis, they often attribute to it the ability, possibility and potency of eliminating or overcoming problems (Fourie, 1991b).

Ecosystemic postulates and Newtonian perspectives are "irreconcilable and mutually exclusive" (Fourie, 1991b, p. 61). This statement is equally applicable in the more specific field of hypnosis and the conflicts between these two perspectives in the field of hypnosis, is highlighted in the following section.

5.8 In the Contexts of Hypnosis and Attribution of Meaning

5.8.1 The Conflict Between Newtonian and Ecosystemic Epistemologies

As previously mentioned, the ecosystemic stance with regard to hypnosis shows a radical movement away from the linear-causal, a-contextual, Newtonian view, and in

contrast, incorporates a heavy emphasis on attributions of meaning. The following points summarise these issues:

(1) Ecosystemic thinking "does not reduce the hypnotic circumstance into elements or parts" (Fourie, 1990, p. 4), nor does it reify the parts. Importantly, hypnosis is not viewed "...as an entity, such as a state of consciousness, existing inside the subject" (Fourie, 1990, p. 4). Rather, hypnosis is seen in the context of a situation or environment wherein all the ideas of the people involved, play a part in the outcome. As Fourie (1990, p. 4) states: "All participants have opinions and expectations about the situation and these form the basis on which everybody attributes meaning to whatever occurs in the situation" with different situations resulting in the attribution of different meanings to whatever occurs.

(2) The issue of causal factors differs radically in the two approaches in that "Ecosystemically seen, hypnotic behaviour is not caused by anything" (Fourie, 1990, p. 4). Fourie (1990) suggests that "hypnotic" behaviour is mutually qualified by the participants in the situation when they regard it (or attribute such meaning to it) as hypnosis, or expect and anticipate, hypnosis. This relates to Maturana's (1975) 'domain of consensus' which is his descriptive term for an ongoing, intricate, co-evolving network of expectations, attributions and opinions which create the "reality" for the participant's in a particular situation. This mutual qualification may be clearly expressed in languaging, but may often be subtle and may take the form of respectful silence and/or a maintenance of focus on the subject, on the part of the onlookers, if present (Fourie, 1990).

In this framework, the traditional hypnotic induction, based on Newtonian premises, is not seen as either necessary or relevant to "cause the hypnosis" (Fourie, 1990, p. 4). It is simply seen as having "two functions: it serves as a vehicle for the process of mutual qualification, and it punctuates the flow of events in such a way as to indicate that

behaviours during and subsequent to induction could be seen as "hypnotic"" (Fourie, 1990, p. 5). Providing the witnessed behaviour fits with the expectations (and attributions of meaning) of the people in the particular situation, that behaviour, (whatever its nature), "can be mutually qualified as "hypnotic"" (Fourie, 1990, p. 5).

(3) Because, in ecosystemic epistemology, all participants in the "hypnotic" situation are observers and thus participators, they are all part of the system and therefore cannot be objective, and this is contradictory to Newtonian epistemology (Fourie, 1990; Leyland, 1988; Maturana, 1975). This concept relates to Dell's (1985) writing, that different individuals interpret differently the same incoming information and therefore respond differently. The basis for this view is Maturana's (Maturana & Varela, 1980) conclusion that information has no objective existence because all living systems are organizationally closed and each is dependent on its internal structure for its behaviour. According to Maturana (1975) the world is structure-determined and "structure is not a static thing" (Dell, 1985, p. 7) -- it changes with each interaction in which it is involved. "Forces and impacts cannot and do not determine, specify or instruct the behavior of an object" (Dell, 1985, p. 7) -- a concept which is in opposition to the linear causality of Newtonian theory. The outcome of this stance with regard to hypnosis, is that the hypnotic situation becomes described as "a co-constructed one, meaning that everybody partakes in its construction ... it is constructed by the interplay of the participants' idiosyncratic ideas and attributions; there is nothing "real" or "objective" about it" (Fourie, 1990, p. 7). (This use of the concept "co-constructed" differs to Speed's (1991, 1994) view as described in Chapter 3).

This ecosystemic approach defines the concept of hypnosis as one which is involved with participants' attributions of meaning, ideas and interpretations relating to the particular situation and includes the behavioural and interpersonal occurrences in that situation. Consequently, hypnosis is seen as a concept and not as an entity and is not reified. There are no actual, inherent characteristics of hypnosis, only individuals' ideas,

attributions of meaning or creations which suggest or define hypnosis. Thus, whatever is believed to 'fit' is hypnosis -- there can, in essence, be no misconceptions related to hypnosis when hypnosis is viewed from an ecosystemic standpoint. Whatever cognitions the individual brings into the situation and whatever he/she believes about hypnosis, constitutes what hypnosis is for that person. As Fourie (1991b, p.63) suggests: "...whatever is perceived by anybody in this system can only be interpreted by reference to that individual's existing ideas." Carpenter (1991, p. 347).) supports this by stating: "...knowledge is what we and others agree we know rather than being a direct reflection of any reality."

This involvement and emphasis on attributions of meaning is an important facet of an ecosystemic way of thinking. Such a way of thinking has relevance not only for hypnosis as described above, but also for the way people personally conceptualise illness and the associated treatment modalities.

5.9 Relationship of Attribution of Meaning to the Present Study

In adopting the aforementioned stance, it is anticipated in the present study, participants' beliefs and attributions of meaning associated with hypnosis, are likely to affect the way the individual responds or reacts to the idea of hypnosis. In other words, it is suggested that it is not hypnosis which carries any particular power, but the meaning attributed to it by each person as a result of his/her idiosyncratic perception of the concept of hypnosis. If a patient in this research work chose to use hypnosis for whatever reason, during the course of her cancer treatment, ".....hypnosis would be used to perturb the ecology of ideas in which the particular problem is seen to exist" (Fourie, 1991, p. 475).

Inherent in the exploration of subjects' attribution of meaning in relation to their illness and to the issues of ANV and hypnosis, in the present study, is the underlying notion or

assumption that as a result of each person's idiosyncratic attribution of meaning, each person will have an individualised set of ideas and experiences related to her illness, her treatment and her use/non-use of hypnosis. This notion in itself is an attribution of meaning to the attribution of meaning and may, at a subtle level, affect the recursively interactional relationship between the researcher and each subject.

This view is corroborated by Rosenthal et al (1960) who discuss the influence which the research worker's (or experimenter's) bias (which is in turn related to the research work) will unwittingly or subtly have on the subjects' expectancies and so possibly affect the outcome of the research results. There is a substantial number of corroborating studies in this field (Cartwright & Cartwright, 1958; Frank, 1959; Frank, 1968a; 1968b; Frank et al, 1959; Friedman, 1963; Goldstein, 1960; Goldstein, 1962; Goldstein & Shipman, 1961; Kelly, 1955; Kraines, 1943; Krause, Fitzsimmons & Wolf, 1969; Rosen, 1976; Rosenthal & Frank, 1956; Simmons & Freeman, 1959; Wilkins, 1973). Similarly, professional attention paid to the patient in the form of the initial interview, questionnaires and general interest, while not intentionally therapeutic, may function positively and thus activate favourable expectancies in the patient (Frank, 1968a, 1968b; Frank et al, 1959; Friedman, 1963; Goldstein, 1960; Goldstein & Shipman, 1961). Also, familial, peer group and societal attitudes play a crucial role in influencing subjects' expectancies regarding the situation (Simmons & Freeman, 1959).

In the present research, the aforementioned experimenter bias assumes a different role. The presentation of even a seemingly relatively neutral, set questionnaire to each subject, will be perceived differently by each individual patient. For some it will be neutral and for others possibly provocative, intrusive or distressing, depending on each individual's idiosyncratic attribution of meaning to the questions. People often ask questions of the researcher and it is also likely that the subtle effects of attribution of meaning (when seen in an ecosystemic perspective of recursive interaction between

patient and researcher), may occur in the answers to these questions and as a result of answers to these questions. It is perhaps impossible (and in the present research involving ecosystemic thinking, even unnecessary) to control for this. As an additional thought, even refusal to answer a subject's questions could create an additional attribution (based on the patient's perception and interpretation of this refusal). Holistically and contextually viewed, every interaction between the people involved in the situation, languaged or non-verbal, has the potential to perturb and co-create the ideas of those individuals.

Related to the issue of utilising a relatively neutral, set questionnaire devised in research programs, the comments of Wilkins (1979) are pertinent. Wilkins (1979, p. 840) suggests that "even when superiority of control procedures is demonstrated, nonspecific events, in general, and expectancy factors, in particular, have been presented as possible interpretive contaminants that account for this superiority." Wilkins (1979) adds that clients with greater expectancy levels (in psychotherapy) improve more than clients with lower expectancies and that the reliable correlation between client expectancy and therapy outcome indicates that clients are accurate predictors of future events (Bednar, 1970; Rosen, 1976; Wilkins, 1973). However, it is important to note that not all therapeutic gain is caused by expectancies (Kazdin & Wilcoxon, 1976; Lick & Bootzin, 1975) and measures used to infer expectancies are, themselves, reactive to interpretive artifacts.

5.10 Attribution of Meaning and Self-fulfilling Prophesies

Jones (1977, p.127) suggested that "..... people make their choices in many ways which appear to them to extend the system they have found useful for anticipating events." This can be interpreted as the individual constantly making an effort at controlling or imposing order and coherence in his/her life and by so doing, being able to understand, anticipate and consequently control ongoing events in his or her life and

environment. Jones (1977) attributes the individual's ability to make choices as his/her way of coping and dealing with or defining a course of action. Jones (1977, p.127) poses the important questions: "What determines the perceived probabilities? What are some of the variables that influence our perception that one outcome is more or less likely than another?" He states that: ".... the outcome that follows a particular choice is, at least in part, a function of the expectations or perceived probability that the outcome in question will result from the choice" (p.127). In order to reduce anxiety, an individual needs to attend to the disconcerting uncertainty in his/her life and environment and in order to attend to the uncertainty, it is often necessary to "compare ourselves with others whom we have reason to believe will be similar to ourselves with respect to the ability in question" (Jones, 1977, p. 130). This would be the choice of the individual when his/her beliefs, opinions and abilities could not be adequately validated or corroborated by physical 'reality' or personal past experience. This is a different way of describing ecosystemic concepts and issues of attribution of meaning and relates directly to the present research work. Jones (1977, p. 145) maintains that ".... the outcome which follows a particular choice is in part a function of the expectation or perceived probability that the outcome in question will result from the choice." This relates to the assumption of the self-fulfilling prophesy which is in turn related to the question of whether or not expectations, attributions and beliefs will result in an outcome which fulfills the belief, bearing in mind that a self-fulfilling prophesy is defined by Jones (1977, p. 166) as "an expectation that leads to its own fulfillment." All of these issues may be seen to be included as facets of attributions of meaning.

An interesting concept which fits with attribution theory is postulated by Heider (1958). He suggests that whether or not a person believes that he/she can influence the course of events is directly related to the individual's perception of personal power as well as his/her personal ability to cause the event to happen. How influential the individual believes the associated environmental forces to be, will also affect outcome and is a

pertinent factor in the present research programme. Jones (1977) in his summary of the chapter on "Expectations, Health and Disease" states that ".... expectancies produce effects ranging from pain relief to an increase in one's general susceptibility to illness and may even influence death itself" (p. 237). This fascinating concept is also used to explain the phenomenon of "voodoo" death (Cannon, 1942).

5.11 The Relationship Between Attribution Theory, Constructivism and Social Constructionism

Constructivism and social constructionism commonly share banishment of the concept of objectively knowable truth (Hoffman, 1990b). However, they dichotomise in emphasis. As Hoffman (1990b, p. 2) clearly explains: ".... social constructionists place far more emphasis on social interpretation and the intersubjective influence of language, family, and culture, and much less on the operations of the nervous system as it feels its way along" (which contrasts with Maturana's (1975) biological viewpoint). In other words 'social inventions' is the term that best describes an individual's beliefs about the world and is attributed to the theory of social construction. This concept parallels the thinking relating to attributions of meaning where the social context together with the individual's past experiences and awareness of other's experiences combine to create that individual's idiosyncratic attribution or belief or expectation in a particular situation. This process is assisted and broadened by our conversation with other people (Patterson & Garwick, 1994; Gergen, 1985; Schwartz & Wiggins, 1986) and new realities, "compatible with our human tendencies to attribute meaning to our experience with each other" may be explored (Anderson & Goolishian, 1988, p. 391).

That a constructivist view incorporates beliefs and attributions of meaning and is idiosyncratic for each individual becomes clearer and more consolidated by the writing of Scarr (1986, p. 44) who states: "Knowledge of all kinds, including scientific knowledge, is a construction of the human mind." Scarr (1986) supports the view that

scientific facts are invented, not discovered and, in concordance with Maturana (1975), that consensual validation highlights the usefulness of these 'facts' and is dependent on shared perceptions.

This way of describing knowledge and facts incorporates the ideas of ecosystemic thinking with its dependence on mutual qualification of participants in a situation (Fourie, 1990) together with the attribution of particular meaning to what is occurring in that situation. This is in contrast to linear-causal thinking and "discovering facts." In order for persons to perceive or process knowledge, Scarr (1986) states that the constraints of beliefs are necessary and that an individual's prejudices and emotions construe, create and colour their perception of events (as in eyewitness accounts of crime). "Thus," states Scarr (1986, p. 45), "each of us is biased by the human tendency to seek 'facts' that are congruent with our prior beliefs." Maturana (1975) sees this as "structure-determined" which renders each individual's interpretation of information to be a personal viewpoint, dependent upon idiosyncratic attribution of meaning for each individual, and thus making for the differences in individuals' belief systems.

In the scientific world, preference for one theoretical perspective rather than another is the result of social and cultural biases dictating the beliefs or attributions of meaning towards the 'facts'. That members of the scientific community share and agree upon the beliefs around 'facts' gives these 'facts' a status in reality that they do not actually possess and supports the viewpoint that science is constructed knowledge (Scarr, 1986). If, however, this perspective is viewed ecosystemically, it could be expressed as mutual agreement and qualification by members of the scientific community (for example), resulting in an agreed upon attribution of meaning or, as in constructivist thinking, an 'invention of facts' rather than a 'discovering of facts'.

Scarr (1986) makes the interesting and effective point that in the formation and formulation of theories, using in particular, psychology as an example, if different views

and beliefs had been constructed or created around the different observations and problems in various spheres, totally different theories, approaches and outcomes may have been the result, with far reaching effects.

From a constructivist perspective, "A constructivist view frees us to think the unthinkable, because our view of "reality" is constrained only by imagination and a few precious rules of the scientific game" (Scarr, 1986, p. 67). Similarly, Lazarus (1993, p. 675), suggests: "...theories do not measure or try to make sense of observations; rather it is our theories that decide what we can observe in the first place." Thus, "we do not discover what is intrinsic in nature, but we invent our theories and divisions and view the world through them" (p. 675). This viewpoint concurs with that of Gergen's (1985), and pertains to social constructionist views -- the observer creates realities and truth can never be known with certainty. Lazarus (1993) contends that people respond to their perceived environment rather than to some real environment. However, he questions whether all truths are totally dependent on and biased by subjective inference (Lazarus, 1993; Shontz & Rosenak, 1988). In his discussion of theories and observations, Lazarus (1993) makes the point that our viewpoints influence our observations (bearing in mind that observations do not occur in a vacuum) -- in other words, it could be said that depending on a person's attributions of meaning, so will that person's observations be influenced (Thompson & Janigian, 1988). As Berger and Luckman's (1976) often quoted statement suggests "...if 'the person constructs reality', then so also does 'reality construct the person' " (Atwood & Ruiz, 1993; Stenner & Eccleston, 1994, p. 89).

When attribution of meaning is related to the concept of social constructionist thinking, several aspects emerge. Atwood and Ruiz (1993, p.11) state: "Social constructionist places emphasis on social interpretation and the intersubjective influences of language, family and culture." The underlying supposition put forward by social construction theory is thus that social interactions continually give rise to an evolving set of

meanings and that constantly changing narratives in society give rise to these meanings. Socially constructed meanings are the result of socialization and are internalised by each individual. Psychological meanings and scripts for behaviour are dependent on and flow from these socially constructed meanings (Atwood & Ruiz, 1993). Atwood & Ruiz (1993, p. 12) clarify: "A person attempts to match his/her experience with the available meaning and scripts." Hoffman (1990b, p. 3) suggests that: "Problems are stories people have agreed to tell themselves " and that "the findings of their conversations have no other reality than that bestowed by mutual consent" (p. 4). Thus each person develops his/her idiosyncratic identity, script and personal meanings, in and of the world, based on and embedded in the dominant culture. The individual's meaning system allows each individual to make sense of experiences and to construct a reality for him/herself (Atwood & Ruiz, 1993; Thompson & Janigian, 1988) -- another way of defining attribution of meaning and of viewing Maturana's (1975) structure-determined theory.

5.12 Conclusion

Attributions of meaning are the personal meanings each individual gives to his/her way of experiencing and interpreting the world. These meanings are idiosyncratically constructed and, additionally, are influenced and moulded by the people and the environment around the individual. This includes the information and stories which emanate from these sources and which may perturb each individual's personal set of ideas. Attributions of meaning incorporate constructivist and social construcionist thinking, and inherent in these concepts is the lack of possibility to accurately describe and pinpoint 'truth' and 'facts' in a definite 'reality'.

In a further progression of the epistemology presented to this point, the following chapter discusses different views of hypnosis and explores the influence of ecosystemic thinking and attributions of meaning to hypnosis.

CHAPTER 6

AN ECOSYSTEMIC PERSPECTIVE ON HYPNOSIS

6.1 General Introduction: A Brief Historical Overview of Hypnosis

Hypnosis has been a much revered, much maligned concept throughout its history. The literature (Bramwell, 1956; Butler, 1955a; Conn, 1957; Crasilnick & Hall, 1975; Diamond, 1984; Fromm, 1987; Gorton, 1949; Gravitz, 1991; Sheehan & Perry, 1976; Sutcliffe, 1960; Wolberg, 1948) has extensively and elaborately detailed and described hypnosis from the 1700's through to the 20th century, including its introduction into the realms of psychoanalysis during the 19th century. Because of this, except for a short mention of its initial emergence, a history of hypnosis will be bypassed in the present thesis. This is also in agreement with and support of Spanos and Chaves' (1991) viewpoint which questions the relevance of a historical study of hypnosis in the light of a constructivist perspective. Spanos and Chaves (1991) suggest that on the one hand, historians should continue with studies of the "idea of hypnosis" and "the manner in which that idea evolved" (p. 44), as well as all the associated issues relating to that idea. On the other hand, and particularly from a contextualist and ecosystemic perspective, "....it is misleading and counterproductive to view hypnosis as an entity or condition that can be traced from one historical era to another" (Spanos & Chaves, 1991, p. 44). However, despite Spanos and Chaves's pertinent viewpoint, a brief introduction leading up to the present day stance on hypnosis will be presented simply for the sake of completeness.

Any brief introduction on hypnosis must make mention of Franz Anton Mesmer who is generally credited with the discovery of hypnosis during the 1770's. Mesmer based his theory of animal magnetism on Father Maximillian Hell's original theory of magnetism.

Father Hell, a Jesuit professor of astronomy at the University of Vienna, held the belief that all bodies were influenced by a universal magnetic fluid, which in turn was influenced by the planets. If there was magnetic disharmony in human beings (created by an imbalance which was influenced by the planets), there would be illness. (This theory, as with all theories, is a perfect example of an attribution of meaning as discussed in Chapter 3). Mesmer's approach was to restore harmony to the magnetic fluids of the individual. His technique is well-documented and will not be discussed (Ellenberger, 1970; Gravitz, 1991; Spanos & Chaves, 1991; Wagstaff, 1981).

However, it was not until 1841 that the term 'hypnosis' was used to describe such demonstrations of magnetism. This use of the term 'hypnosis' was attributed to James Braid, the surgeon, and was said to be derived from the Greek 'hypnos' (to sleep). He used this term to describe the state of apparent nervous sleep which he witnessed in subjects. Despite the above, it seems that the term 'hypnosis' was apparently first employed by d'Henin de Cuvillers in 1820, several decades before Braid's usage. d'Henin de Cuvillers was a contemporary French mesmerist, who utilised the words 'hypnotist' and 'hypnotism' (based on the Greek God of sleep Hypnos) in his writings (Gravitz, 1991). Gravitz (1991) suggests that even before d'Henin de Cuvillers' writings, similar terms had been used in several French dictionaries. James Braid believed hypnosis to be a sleep-like state of increased concentration wherein belief, expectancy and magnetism were greater than in the 'waking' state (Sheehan & Perry, 1976). Although present day theorists have discarded the (archaic and reified) concept of magnetism, belief and expectancy are still an integral part of the majority (if not all) of the theories pertaining to hypnosis.

It is interesting that in the transition period between the early, historical approaches to hypnosis and a 1990's ecosystemic viewpoint, White, in 1941, seems to have adopted in part, a transitional view which could be postulated to be a mini-precursor of the ecosystemic approach. He was the first of the modern writers to clearly reject a

mechanistic approach to hypnotic behaviour (Spanos & Chaves, 1991), and emphasised the subject's expectations together with the subject's wish to behave like a hypnotized person (Bowers, 1973). He suggested that the subject uses goal-directed strivings and has a wish to offer the hypnotist what is demanded or expected of him/her -- this idea of hypnosis seems to encompass attribution of meaning and, roughly speaking, a consensual domain. White(1941) does, however, retain the notion of an altered state which is eschewed in ecosystemic thinking (Fourie, 1991a, 1995; Spanos & Chaves, 1991). Van der Walde (1965) also challenges the stereotype of hypnosis as a "unique and tangible entity" (p. 445) and suggests that the presence of hypnosis in a subject has no objective criteria for its definition, nor is it an unique phenomenon, but that the basis of hypnosis can be seen as "a specific attitude" (p. 440; italics in original). This concurs with similar viewpoints put forward by Gill and Brenman (1961) and Barber and Calverley (1962).

Whatever hypnosis is (Editorial, 1985), the concepts of its healing and its power have been kept alive by a myriad of ingenious and imaginative beliefs. Over the centuries these have involved beliefs in incantations, the occult and exorcism, touch, mineral and animal magnetism, fluids, planetary forces and somnambulism to mention several (Gravitz, 1991). The point here is the importance and power of the attributions of meaning in relation to the concept of hypnosis. Also, since no single, clear-cut, acceptable-to-all theory of hypnosis has emerged over the years, and clearly, each theorist believes his/her theory has something valid to offer, it must be concluded that there cannot yet exist a non-controversial, clear-cut definition, description or understanding of hypnosis and what hypnosis is -- perhaps, as Hilgard suggests (1973) an area of possible agreement may be seen in the common topics pursued in hypnotic research and that these topics may be defined as "the domain of hypnosis" (p. 972; italics in original).

In the shift towards refining the theories and understanding of hypnosis, present day theorists have adopted a language and epistemology which basically describes four particular ways of viewing hypnosis. These are typically referred to as the neodissociative or 'state' theory (as proposed by Hilgard, 1991), 'non-state' theory (Barber, 1979), Ericksonian hypnosis (Lankton, 1985; Zeig, 1982) and Haley's (1963) 'interactional' theory. All four perspectives have their respective followers and critics. A brief explanation of the differences (and certain levels of overlap) ensues, together with a description of the movement towards ecosystemic thinking with regard to hypnosis (encompassing the interrelationship of attributions of meaning).

6.2 Approaching an Ecosystemic Perspective on Hypnosis

Over the years, the traditional approach to the understanding of hypnosis has been based on a cause and effect outlook as in Newtonian logic. Rather than giving rise to one particular, universally accepted explanation, it has resulted in numerous and varied explanations and beliefs. These evolved as an attempt to understand and describe what hypnosis is or seems to be. Stated differently, the history and the theories of hypnosis are all influenced and contaminated by the concept of attributions of meaning. These explanations are briefly presented in order to describe the evolution of the mode of thinking towards an ecosystemic approach.

6.2.1 State Theory

The theory pertaining to the state view of hypnosis holds that hypnosis is the result of an altered state of consciousness within the person (Fellows, 1990; Hilgard, 1991; Orne, 1959, 1971). In this altered, subjective state of awareness (residing within the person), the operation of dissociative mechanisms is postulated (Evans, 1968; Hilgard, 1991; Lankton & Lankton, 1983). This concept suggests that there is a dissociation

between the unconscious level of the subject and the subject's conscious functioning. This concurs and overlaps in part with the Ericksonian view which holds that an internal state of increased receptiveness and attention signify hypnosis (Lankton, 1985). Both state and Ericksonian views attempt to make sense of hypnosis in the absence of the context in which it is seen to occur (Lifschitz & Fourie, 1985). Both state and non-state theories view hypnotic susceptibility and depth as reified intrapsychic concepts. These approaches give rise to a description of hypnosis as an entity with a reality of its own (Lifschitz & Fourie, 1985) and is a view which is strongly challenged by ecosystemic thinkers.

6.2.2 Non-state Theory

The non-state view was an attempt at extrication from the confines of the intra-subjective state theory and criticises the notion of an altered state of consciousness as neither useful nor verifiable. The non-state theorists (Barber, 1979; Sarbin & Coe, 1972; Spanos, 1982) align their views with concepts generally applicable to social psychology (Fellows, 1990; Lifschitz & Fourie, 1990; Spanos & Chaves, 1991). The person is seen to be involved in role-expectations and role-skills i.e. to act according to his/her particular perception of situational demands as if he/she were hypnotised (Fourie, 1991a). In this non-state view it was implied that environmental and situational factors had a causal influence on the intrapsychic functioning of the person (Fourie, 1991a). Similarly, in state theory, hypnotic behaviour is seen to be the result of the so-called hypnotic induction imposed in a linear-causal manner, on the subject by the hypnotist, and this is postulated to cause or bring about the altered state of consciousness and dissociation within the subject.

To clarify, the non-state or sociocultural perspective (Barber, 1979; Colangelo, 1987; Sarbin, 1950) suggests that hypnosis may be seen as "experiences generated by subjects in response to the contextual clues" (Spanos & Chaves, 1991, p. 68), or as

Fourie (1991a, p. 477) suggests: "Non-state theory seems to conceptualize the intrapsychic strategies used by the subject as causally connected to hypnotic behavior."

6.2.3 Ericksonian View

Ericksonian hypnosis, as mentioned, also encompasses the notion of an altered state of consciousness (Lankton & Lankton, 1983), which is postulated to be caused by the technique used in the hypnotic process -- this way of thinking allies itself to the Newtonian concept of reductionism, where the whole is obscured as a result of the assumed importance of the elements (Fourie, 1991a). In Ericksonian hypnotherapy, the hypnotist is postulated to exert a direct or lineal influence on the person who is being hypnotized -- the hypnotist is seen to take control in establishing a rapport with and an influence on the subject, which causes the subject to focus his/her attention inward (Fourie, 1991b). This objectivity of observation, with outside intervention directed towards the client's system and constituting the therapeutic process, forms the basis of the Ericksonian way of thinking.

Erickson, however, did attempt to link the hypnotist and the subject through what can be described as 'an ecology of ideas', in which the subject's own attitudes, thinking, feeling and behaviour together with situational aspects were utilised (Erickson, 1959, 1964). This aspect of Ericksonian thinking may be seen as manifesting an ecosystemic flavour in its approach (Lifschitz & Fourie, 1990). Nevertheless, it is the linearity of focus in the technique, and aspects of the thinking, in the Ericksonian approach which is criticised by Fourie (1991b) and Matthews (1985). Matthews (1985) favours a cybernetic approach to hypnosis, and in this choice, is in line with the move away from the observer outside the system, towards the observer as a participant within the system, congruent with a shift towards an ecosystemic stance.

6.2.4 Interactional View

Haley's (1963) interactional view of hypnosis suggests an important paradigm shift away from an intrapsychic approach, in that he postulates that the establishment of a complementary, paradoxical relationship is necessary before hypnosis can occur. Diamond (1984) holds a similar view in his emphasis on the "dual phenomenon" of an interactive hypnotherapeutic relationship (p. 3). However, with these views of the importance of a specific type of relationship in hypnosis, Haley and Diamond still retains links with a causal conceptual model. Perhaps Haley's (1963) stance may be seen as a transitional movement from state, non-state and Ericksonian intrapsychic viewpoints of hypnosis, towards the second-order cybernetic approach of ecosystemic thought.

6.3 A Clarification of the Ecosystemic Stance in Relationship to Hypnosis

In the aforementioned perspectives, the emphasis is on a cause and effect linking of the different elements of hypnosis. It is assumed that intrapsychic states or strategies are the result of techniques (such as the induction) and these in turn result in or cause hypnotic behaviour (Fourie, 1991a).

In the field of hypnosis, the ecosystemic stance stresses an a-causal, contextually related perspective. This perspective may be seen as the outcome of an attempt to integrate systems theory, second-order cybernetic thinking, Maturana's concept of consensual domain, and concepts of constructivism, narrative and attribution of meaning. Consequently, from an ecosystemic perspective, it is suggested that "hypnotic behavior is not caused by anything" (Fourie, 1991a, p. 469). Such a statement is a direct challenge to Newtonian epistemology and opens up new vistas for hypnosis.

Fourie (1991a) extrapolates by explaining that hypnotic behaviours "...are ordinary behaviors designated as "hypnotic" by means of ongoing mutual qualification, which is based on the definition of the situation as one of hypnosis, and on the expectations and ideas of all the participants regarding such a situation" (p. 469; italics in original). Thus, hypnosis has no reality, and any behaviour can be consensually agreed upon to be labelled hypnotic behaviour, as long as that behaviour fits with the expectations of the people involved in the moment. Based on this view,as mentioned previously, there can be no misconceptions relating to hypnosis, only individual idiosyncratic conceptions, all of which may be seen as valid, and all of which can potentially be utilised in the hypnotic situation.

Fourie (1991a, p. 471) adds: "Behaviors are "hypnotic" only when they are mutually qualified as "hypnotic" within a particular ecology of ideas" and are not dependent on any particular ability of the subject. Hypnosis is thus postulated to occur not in a person, but in a situation (Fourie, 1991a). As a result, there is a shift away from an "intrapsychic emphasis on the individual to a consideration of the interconnectedness of behaviours and ideas between all participants in a whole situation defined as hypnosis" (Fourie & Lifschitz, 1989, p. 100). Clearly then, when hypnotic responsiveness is contextually specified and defined, the consequence is that the traditional and reified nomenclature of "hypnotic susceptibility" and "hypnotic depth" play no part and have no meaning in ecosystemic thinking (Fourie, 1991a; Fourie & Lifschitz, 1989).

This way of conceptualizing hypnosis refers to a situation in which the occurring behaviours are co-constructed, mutually agreed upon and then designated by the participants as hypnotic behaviours. The hypnosis per se is not seen as having inherent characteristics (such as depth), but may be described as an event which is given consensual meaning by the participants through their ideas and expectations relating to their perceptions and beliefs about hypnosis. "This interactional process through which a situation aquires a certain meaning, can be regarded as a co-evolutionary process

because everybody participates and the particular meaning of the context emerges from this mutual interaction" (Fourie & Lifschitz, 1989, p. 101) as befits an ecology of ideas.

Furthermore, hypnosis "is conceptualized as a ritualistic vehicle for ideas which could help clients and families to think differently about themselves and about their problems. Part of its potency lies in the belief generally held by clients and families that hypnosis is a powerful change agent and that, what is experienced and said by a subject in hypnosis is necessarily true" (Fourie & Lifschitz, 1989, p. 103). This description of hypnosis emphasises the concept that it is the ideas and connotations implied within the specific situation, which form the operative principle in hypnotherapy together with an emphasis on the attributions of meaning to the ritual of hypnosis (Fourie & Lifschitz, 1989).

As Fourie (1991a, p. 476) explains: "In ecosystemic hypnotherapy, there is (thus) no effort to persuade clients or families to view hypnosis or treatment in ecosystemic terms. Whatever the conceptions or attributions of the particular client or family may be, these can potentially be utilized in treatment." Consequently, although concepts such as the "unconscious" and "posthypnotic suggestions" are incompatible with ecosystemic thinking in relation to hypnosis, if a patient uses these terms as part of his/her attributions of meaning and expectations about hypnosis, these concepts would be included and utilised for the particular patient. However, they would not have the same meaning in this context as they would in the traditional approaches to hypnosis. They would be used in line with the ecosystemic style of utilising the patient's attributions of meaning and beliefs in order to perturb the patient's ideas and ways of thinking about the particular presenting problems. Although this way of thinking about hypnosis is clearly different to the more traditional approaches mentioned, Fourie & Lifschitz (1989, p. 105) point out that it is not necessarily " 'better' or more 'true' than any other perspective."

6.4 The Description of Hypnosis Through Ecosystemic Lenses

In order to further clarify the concept of a second-order or ecosystemic perspective on hypnosis, the following tenets are relevant (Fourie, 1995; Fourie & Lifschitz, 1989):

(1). Hypnosis is viewed as a concept and not as an entity in its own right.
"It is a meaning given to certain occurrences in certain circumstances" (Fourie, 1995, p.303). Idiosyncratic attributions of meaning about hypnosis, are constructed and created by each individual, based on the ideas each individual has about hypnosis with these ideas having been gleaned from various sources. This constitutes the personal way each individual perceives, understands and attributes meaning to "hypnosis" i.e. the individual's personal construction of his/her way of thinking about hypnosis.

(2). To be regarded as "hypnotic", behaviour needs to be mutually and consensually qualified as such.
As Fourie (1995, p.303) states: "No behavior is intrinsically hypnotic." There are no 'real' or 'true' hypnotic behaviours -- if behaviour occurs in a situation which has been consensually defined as a hypnotic situation, then that behaviour may be understood, accepted and/or described by the people involved as hypnotic behaviour (Fourie & Lifschitz, 1989). In other words, the individuals involved in that situation qualify the behaviour as "hypnotic" -- this occurs (albeit unwittingly), in a mutual and reciprocal or consensual manner. The occurrence is dependent on the ideas and attributions of meaning together with the verbal and non-verbal behaviour of the individuals concerned.

(3). Hypnosis is defined by mutual qualification rather than being caused by anything or any person.

Hypnosis may be described as the consequence of a process of consensual meaning which is attributed to a set of behaviours in a particular context. The internal structures of the individuals involved in the consensual domain dictate how these individuals and their ideas will couple with each other so that mutual qualification may take place. To clarify further, so-called hypnotic induction does not "cause" or "result in" hypnosis -- an induction may be viewed as an expected, punctuating ritual which people believe is necessary in order for hypnosis to occur (Fourie & Lifschitz, 1989). Fourie (1995, p. 303) states that the induction procedure "....serves as a vehicle for the process of mutual qualification, and it punctuates the flow of events in such a way that everybody expects behavior to be qualified as hypnotic from that point onwards." As a consequence, hypnosis (in that particular situation) is a concept which is constructed or created co-consensually.

(4). Hypnosis may be defined in terms of a constructed reality.

Particular meanings and expectations, held by individuals in a domain, construe a particular reality to any given circumstance or situation. Each reality is defined by the consensual name chosen to describe that reality and within that constructed framework, people hold certain expectations. To clarify, different realities are constructed when people come together and the names given to describe these realities come to be imbued with particular expectations and behaviours. For example, a funeral is imbued with different meaning and connotations to a sports meeting -- at a funeral, the people involved behave in ways expected at such a gathering and differently to the behaviour expected at a sports meeting. In this difference, each particular reality is constructed and maintained. The same way of thinking can be applied to the view of "hypnosis" as a constructed reality. Thus, within the reality defined as "hypnosis", all the individuals involved in the context of a particular situation consensually understand or attribute meaning to certain behaviours as being hypnotic (Fourie, 1995).

(5). Hypnotic reality is dependent on linguistic narrative.

Extrapolation of the previous point which states "Hypnosis may be defined in terms of a constructed reality", dictates that narrative is implicit in the statement. In this it is clear that ".... structural coupling between all the subsystems within the hypnotic system, ... can occur only by means of the exchange of ideas" (Fourie, 1995, p. 304). The mode of exchange is through dialogue and narrative i.e. via verbal and non-verbal language and this is also the manner in which the process of constructed or created reality defines hypnosis.

Closely associated with this perspective of hypnosis, is the concept of an individual's idiosyncratic attribution of meaning. In other words, how each individual views hypnosis will depend to a greater or lesser degree on the meaning he/she attributes to and the beliefs he/she holds in relation to hypnosis.

6.5 The Role of Attribution of Meaning in Hypnosis

Generally speaking, the lay person has no experience, either in training or education, pertaining to hypnosis. If he/she has any knowledge about hypnosis, it is usually gleaned from hearsay and/or the media in its various forms. Occasionally, an individual may have had a prior experience of hypnosis (therapeutic or as a demonstration e.g. stage hypnosis). Based on this information, on possible experience and the associated input, the person will create or construct ideas and meanings about hypnosis which will be dependent upon his/her internal "structure" at that moment (Fourie, 1995; Kenny, 1988; Maturana, 1975). The present or momentary perception of an object or concept, by the individual, is consequently dependent on the autonomously created and constructed ideas by that individual. Thus, the representation in the brain of the perceived object or concept, is based not on the object or concept itself, but on the ideas formulated about the object/concept. This applies equally to the concept of

hypnosis and how it is idiosyncratically perceived by each individual. The different perceptions different people have regarding hypnosis fit with this viewpoint and this also accounts for the possibility of individual delusions and distortions (Fourie, 1995).

This theoretical description offers a way of understanding the variety of responses different people show at the mention of the word "hypnosis." This variety of responses substantiates the idea or suggestion that hypnosis has different meanings i.e. different attributions of meaning for different individuals, and that each individual will utilise his/her knowledge and ideas pertaining to hypnosis at that moment, in the particular situation of the moment. The concept of 'an ecology of ideas' is descriptive of this way of thinking.

This variety of responses which individuals manifest in relation to hypnosis, is compounded by the history of hypnosis. Negative perceptions of the connections of hypnosis with Satanism, the devil, the occult (as mentioned earlier in this chapter) as well as the more benign and positive aspects (medical, curative and healing), have added to the lay person's ideas and possible confusion around hypnosis and what it means to each individual. As Fourie (1995, p.305) indicates: "The attribution of an almost mystical potency to hypnosis therefore gives it a ritualistic flavor and often leads people to entertain either exaggerated hopes or exaggerated fears about hypnosis. Even where clients' ideas about hypnosis are less extreme, there is often an element of hope or fear that hypnosis might prove to be very powerful." As Gruenewald (1982, p.47) stated in her description of the clinical situation: "Patients often openly or tacitly expect magical solutions to their problems... ." Associated with this expectation is the important role played by the patient's anticipated or peceived relationship with the therapist --this may also play a part in influencing the patients attributions of meaning about hypnosis.

In summary, when hypnosis is conceptualised from an ecosystemic perspective, the individual's attributions of meaning are incorporated and utilised as an important part of the hypnotic process. This approach allows the hypnotic process to link with the individual's ideas about him/herself (Fourie, 1995). The manifest variety of ideas and the variation of the degree of potency of the attributions of each individual, can be capitalized on and utilised therapeutically under the heading of "hypnosis.

6.6 The Application of Ecosystemic Hypnosis and Attributions of Meaning to the Present Study

6.6.1 Theoretical Description of the Personalised Approach

The present study involves an approach which attempts to explore, understand and appreciate each individual patient's attributions of meaning and consequent view of hypnosis in general, and in relation to her illness in particular, within the framework of ecosystemic thinking.

In this research, the more traditional view of hypnosis as an entity which entertains an inherent and inexplicable "power" to alter, to heal, to magically alleviate symptoms, and/or to explore archaic memories, has given way to an idiosyncratically focused, ecosystemically oriented approach. Using this approach, the description of hypnosis alters to become a "co-constructed definition in dialogue" (Fourie, 1995, p.312). As Keeney and Sprenkle suggest: there is "no emphasis on any part of the whole relationship system" in ecosystemic epistemology (1982, p. 15). An outcome of this is that the use and application of hypnosis has qualities of both adaptability and flexibility. As Fourie (1995) explains, the application and use of hypnosis occurs because "...such application is attributed with certain meanings by clients and families, attributions that are then capitalized on in order to perturb existing ideas in which the particular problem is seen as embedded" (p.312). Symptoms are then described as existing in ecologies of

ideas within systems rather than being seen as a product of intrapsychic pathology (Anderson & Goolishian, 1988; Efran & Lukens, 1985; Fourie, 1995; Griffith, Griffith & Slovik, 1990; Loos & Epstein, 1989).

The employment of hypnosis in such a framework then necessitates not only utilising the beliefs pertaining to hypnosis with whatever meaning it holds for the particular person, but also in such a way as to link with the person's ideas about his/her problems, situation and his/her needs in relation to these aspects. Dialogue plays an important role in achieving this end (Fourie, 1995). The use of hypnosis in this flexible and adaptive manner allows a fit with the expectations and ways of thinking of the people concerned, so that fulfilment of the expectations is more likely and more possible, and consequently it is also more likely and more possible that there will be a resultant benefit to the patient. This way of viewing hypnosis is congruent with Sacerdote's (1974) idea of "convergence of expectations" (p. 95), although his general outlook, being psychoanalytically based, is divergent from ecosystemic principles. In addition, such an approach allows the possibility of shifts in ideas, meanings and connotations so that individuals become able to think differently about themselves and about the way they perceive their problem(s).

6.6.2 Clinical Description

Owing to the time limits between medical consultations for each patient in the hospital setting, a personal interview was arranged with each suitable cancer patient, but was restricted to a fixed number of questions designed to extract individual patient beliefs. The questions opened up broader areas of each patient's beliefs around cancer in relationship to herself, with a narrowing down of the questions to beliefs about treatment side effects and hypnosis.

In an ecosystemic approach, each individual's attributions of meaning to hypnosis are taken into account. Where hypnosis is requested by the patient, these attributions of meaning are capitalised on and utilised to best fit with the patient's expectations. In this study, no attempt was made either to coerce any patient into using hypnosis nor to consciously perturb her existing ideas concerning hypnosis. The researcher accepted and colluded with whatever the patient expressed about her way of viewing hypnosis. The researcher also attempted to answer any questions asked by patients in as pragmatic and simple manner as possible, attempting wherever possible to utilise patient beliefs and expectations. The researcher was aware that whatever answer was given was inevitably contaminated with the researcher's bias. In turn, this would feed back to either maintain or perturb the patient's existing ideas and beliefs. The effect of observer as participant was most notable in this context. No viewpoint held by any patient was contradicted or argued with. When a patient was noted to have had a change of perspective about hypnosis in the interviews inbetween ongoing chemotherapeutic treatment sessions, and subsequent to the initial questionnaire with each patient, the researcher aligned with these shifts in thinking.

The wide and contrasting range of beliefs and attributions of meaning held by the women interviewed attest to the thesis that each individual constructs and creates her own idiosyncratic view pertaining to her particular reality, which in this case is about her illness and all that is relevant to her in this context. Her acceptance or rejection of or indifference to hypnosis fits within this context.

6.7 Conclusion

From an ecosystemic stance, it may be stated that there is no one, correct way of viewing hypnosis. As described above, each person has his/her own personally held viewpoint and attributions of meaning pertaining to the concept of hypnosis. As a result, the way in which hypnosis is or is not utilised for each particular participant in

this research is dependent on that person's idiosyncratic meaning attributed to, or associated with, whatever it is that the word 'hypnosis' conjures up for that person.

Based on the concepts described above and in the preceding chapters, a presentation of the research design and the approach used in the present study, forms the content of the next chapter.

CHAPTER 7

"The trouble with generalisations is
that they don't apply to particulars"
(Lincoln & Guba, 1985, p. 110)

RESEARCH DESIGN

7.1 The Research Approach

7.1.2 The Shift from Quantitative Towards Qualitative Aspects

Scientific research has traditionally required and demanded a quantitative approach involving measurement and proof as prerequisites for validation and acceptance of findings. Inherent in the traditional approach is the adherence to a 17th century paradigm, encompassing a neutral, objective style, based on the mechanistic, analytic reductionism, determinism and dualism of Newton and Descartes (Engel, 1977, 1992; Hoshmand, 1989; Schwartzman, 1984). In conjunction, what is distinctively human has traditionally been excluded from the scientific realm (Engel, 1992). As Tomm (1983) and Keeney and Morris (1985), mentioned in Chapter 1, point out, neutral objectivity has long been shown to be a myth, even though scientists persist in chasing it. Engel (1992, p. 6) elaborates by explaining that scientific thought was developed "as an approach to nature as it surrounds man" and as a result does not offer a way of accommodating human processes. Hoshmand (1989) succintly points out that physical phenomena present problems of access and measurement which are different to psychological phenomena wherein application of the same criteria results in loss of meaning due to oversimplification and to omission of context. In addition, research that clearly defines the aims and means pertaining to a particular paradigm frequently

yields results which corroborate the particular theory giving rise to the research (Andersen, 1995).

Consequently, cause and effect analysis from an objectivist stance, involving the use of data with which to validate, explain and present the findings, plus proof of observation, (as in dealing with bodily processes in scientific medicine), has moved towards incorporating a qualitative and descriptive approach. The qualitative and descriptive approach lends itself to an ecosystemic way of thinking with an emphasis on the construction and co-creation of personalised meaning as opposed to an objective, data-laden, explanatory approach. The two perspectives differ fundamentally in the approach to 'reality', 'objectivity', 'truth' and 'knowledge', and in this difference, they are also irreconcilable.

As an aside and in a limited way, ethnographic research shares some of the qualitative and descriptive approach -- ethnography refers to a research process and also to the product of a research effort (LeCompte & Goetz, 1982). In its analytic, descriptive approach, ethnography "delineates the shared beliefs, practices, artifacts, folk knowledge, and behaviors of a group of people. Its objective is the holistic reconstruction of the culture or phenomena investigated" (LeCompte & Goetz, 1982, p. 54). This approach is supported and validated by Hoshmand's suggestion that: "...new conceptual models are needed to deal with multiple, interrelated, self-constructing, living systems in non-reduced forms" (1989, p. 8).

7.1.3 The Influence of a Second-Order Perspective

The important shift to a second-order cybernetic perspective, describes the researcher/observer being seen as a participant in that which is observed and which is being researched (Fourie, 1996a, 1996b; Stones, 1986). Consequently, any descriptions of the findings cannot be said to be either neutral or objective, nor can they

be assumed to be without bias (Fourie, 1996b). They are coloured by the researcher/observer's idiosyncratic perceptions, attributions of meaning and way of viewing or interpreting the communications (including the beliefs) of each subject i.e. researcher/observer bias. As Engel (1992), extrapolating on ideas of Anderson and Goolishian (1988), clearly states: "Dialogue is in fact the only means whereby the patient can acquaint the physician with those inner experiences which had led him to consider himself ill in the first place." As a result *"...dialogue is truly foundational to scientific work in the clinical realm"* (p. 8; italics in the original). This results in an essential complementarity of both human and scientific data collecting in the clinical realm, where both are relevant and necessary for completeness, particularly in the field of medicine.

7.2 The Focus of this Study

In this study, the personal and individual aspect of each patient in her interaction with the researcher has value and it is the description of this experience which forms the meaningfulness of the thesis. The issue is not about solutions (Mason, 1993). There is no focus on aetiology, cause and effect, end results, proof or generalisations. What assumes importance is not only each patient's idiosyncratic and constructed personal offering of her experience of her illness, together with her associated attributions of meaning to her situation and her experience, but her recursive interaction with all the people involved with her in this experience. This incorporates the co-evolving ideas and beliefs growing out of this interactive process. Such a recursive interaction and co-evolution of ideas will result in what Maturana (1975) has termed a consensual domain involving all the people associated and concerned with the many aspects of experience of cancer for each patient. This describes and becomes the 'meaningfulness' of the experience for each patient.

The emphasis of the research is not to discover an "objective truth", but to co-evolve or co-construct a new map consisting of an ecology of ideas in what may be seen as a holistic approach (Bateson, 1972; Fourie, 1996b; Keeney, 1983). This approach, in its descriptive and qualitative characteristics, not only offers an insight and understanding pertaining more to a holistic experience of the cancer patient (rather than the traditional lineal-causal approach of diagnosis of a disease, treatment, and assessment of outcome), but is also amenable to and facilitative in providing additional meaning to each person's involvement in the process. Inherent in the holistic outlook is the idea of a unity rather than a loose collection of variables. This incorporates the many and diverse interrelations between the parts occurring in the original system as well as the unique qualities, characteristics and patterns that distinguish the particular system from other systems (Reason, 1988).

This emphasis on the unique and distinctive is contradictory to the mandatory generalisation of scientific endeavour. In the same way, psychotherapists are more interested in reading and studying individual case histories and transcripts of therapeutic interactions, meanings and processes in order to obtain results with a flavour and a sense of the therapy and the persons involved, (rather than reading lists of statistical data and measurements relating to samples of people). This approach, described as experiential research by Heron (1988) and LeCompte and Goetz (1982), is more in keeping with the holistic viewpoint. Heron (1988) explains this as "the kind of research on persons in which the subjects of the research contribute not only to the content of the research, i.e. the activity that is being researched, but also to the creative thinking that generates, manages, and draws conclusions from, the research. And the researchers, in the full model, contribute not only to the creative thinking and management, but they also participate, like the subjects, in the activity that is being researched" (Heron, 1988, p. 153). This approach contributes to and highlights the meaningfulness of human experience, an issue which is neither accounted for nor forms part of scientific empirical inquiry and research (Rowan & Reason, 1988). This

meaningfulness applies not only to the human subjects being researched, but to the researcher or interpreter as well who will experience *"the meaning of the phenomenon for his own situation"* (Rowan & Reason, 1988, p. 134; italics in the original).

Reason and Rowan (1988) refer to this research approach as 'new paradigm research' (p. 489) and they describe it as manifesting a much closer relationship than is traditional between the researcher and the subjects. The mutual and reciprocal encounter generates the significant knowledge of the persons involved and this is brought about by the co-ownership and shared power of the language and the process as well as the product of the research (Reason and Rowan , 1988). As Fourie (1966a) states: "It is the ongoing exchange of ideas which is important, not the reductionistic reaching of a conclusion. In the process of the conversation both sides of the autonomy of the people involved, should be continually confirmed, while the ambivalent ideas are simultaneously disconfirmed" (p. 16).

This emphasis on the approach and interpretation of the findings in this work will clearly be affected by researcher bias, as mentioned previously, which incorporates both the structure-determined, inner world (Maturana, 1975), and the personally constructed ideas and beliefs of the researcher. As such, the study cannot be described as an objective piece of work because the researcher actively and idiosyncratically constructs the so-called 'realities' of the particular research work as a result of the above-mentioned issues. No conscious directive pressure and no conscious attempt at change was made by the researcher towards the patients. In other words, no conscious attempt was made which would interfere with or alter patient beliefs, treatment procedure, healing process or outcome. Nevertheless, simply being in the patient's personal space (observer as participant) and introducing certain questions to each patient could induce impingements on each patient's thinking, ideas, beliefs and feelings with regard to that patient's illness and to hypnosis, with a consequent perturbation of the patient's ideas and a consequent shift in the way of thinking about these issues for

the patient (Griffith & Griffith, 1992; Griffith, Griffith & Slovik, 1990; Onnis, 1993). This shift would be determined not by the actual perturbation, but in accordance with the system's idiosyncratic structure (Fourie, 1993; Kenny, 1989).

7.3 The Conservation of Autonomy

In the light of this way of thinking, each individual would manifest a shift in the direction of conserving autonomy (Fourie, 1993), because if the system loses its autonomy, that system is destroyed. Consequently, the person's attribution of meaning, way of thinking and set of beliefs pertaining to her illness and hypnosis, will be idiosyncratically dependent on her maintenance of a semblance of autonomy in dealing with her experience of cancer.

Autonomy, in this particular circumstance, may be seen from two perspectives:
(1) the individual's own particular internal state of homeostasis and autonomy, and
(2) a perspective relating to the maintenance of an external autonomy involving the family system and, in addition, the system encompassing the other important people in the individual's world. Each individual's attributions of meaning and modes of behaviour will be influenced and governed by that individual's internal state, together with the influence from and the need to maintain homeostasis in the individual's family system and close environmental system.

As Patient No. 1 in the Case Presentations (Chapter 8) said, in response to Question 8: (What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?) "I have a wonderful family and also friends. But people are more silent once it happens to you then you can't know what they think. But they also support and encourage you." That she responded this way, with a clear awarenesss of the silence, suggests that in some way she possibly colluded with the silence in order to fit with the people around her and to maintain the familiar

and comfortable balance (homeostatic equilibrium) inherent in the family/friends unit or system. In some idiosyncratic way, this would be likely to affect or influence her attributions of meaning pertaining to her illness i.e. the "silence" could be seen to perturb her way of viewing her illness in the light of what she believed others thought about her illness, in a different way to perturbations through dialogue and communication.

The role of the family and people in the external world are inextricably interwoven in each individual's effort in maintaining personal autonomy.

From this perspective, rather than aiming at symptom modification and/or attenuation (in relation to side effects of treatment), the approach of this research is to focus on attribution of meaning associated with the chosen issues in this research, in an ecosystemic framework. The way each individual has beliefs about or attributes meaning to her experience of cancer, may be seen as that individual's idiosyncratic way of aiding herself to conserve her personal autonomy and her external world autonomy.

7.4 Pilot Study

An initial pilot study was undertaken with a patient suffering from breast cancer, preceeding her first chemotherapy treatment. The main purpose of this was to initially test the researcher's approach and to assess whether the research questionnaire examining patients' attributions was appropriate and feasible.

From this initial administration, it was discovered that explanations of an anticipatory nature, from researcher to patient, were more problematic and anxiety provoking for the patient, than helpful or necessary. Examples of this included an explanation involving the research nature of the project and the signing of a comprehensive consent form involving a statement of permission for the patient to withdraw from the project at

any time should she choose. (The next encounter with a patient, which took place at the Breast Clinic of the Johannesburg General Hospital, omitted these problematic explanations and consent form and was found to be less anxiety provoking and unsettling for the patient, as well as less time consuming for both patient and researcher. This became the standard procedure for the rest of the study).

7.4.1 Case Presentation (Pilot Study)

The patient, aged 47, had recently had surgery (mastectomy) for an aggressive, malignant tumour. She was amenable to the research process and answered the questions willingly and cooperatively. A brief description of the research project, the informed consent form and the questionnaire were presented to her in the oncologist's waiting room. Following this, the patient had her consultation with the oncologist where the type of chemotherapy was decided upon (in this case aggressive treatment for a tumour which had developed rapidly, viz. Adriomycin (red drip) and 5-Fluorouracil cyclophosphamide (clear drip)) and the researcher obtained the patient's consent for future, follow-up telephonic discussions.

Telephonic contact two days after treatment revealed that the patient had reacted severely to the chemotherapy. She could not eat, was experiencing headache, diarrhoea, severe nausea and emesis and was needing excessive sleep. A second telephone call three days after the first, i.e. five days after the chemotherapy, ascertained that the patient was feeling better but very weak and was thinking of discontinuing the treatment. She had her next treatment one month later and coped better, with only one day of nausea (the oncologist had altered the treatment as a result of the previous severe side effects). However, she was distressed at the hair loss which she had anticipated and feared prior to commencement of treatment. According to the prescribing doctor, hair loss is an inevitable side effect of her particular treatment and he had discussed this with her prior to the chemotherapeutic programme. The

suggestive effect of such a discussion and the significance/non-significance of its effect is wide open to speculation regardless of the medically described connection of hair loss with chemotherapeutic treatment. One speculation in particular, revolves around the issue of the infamous side effect of chemotherapy, nausea, and questions whether patients can be conditioned to think that they will experience nausea by such discussions (Fourie, 1992, personal communication,). However, perhaps with regard to her original attribution of meaning associated with chemotherapy, the dimension of 'more-or-less' becomes relevant in terms of the patient's negative or positive beliefs about whether or not hair loss (or nausea) will occur, i.e. how much or how little, and the associated ramifications of meaning to the patient of such a happening. To this patient, the consequence of hair loss was the associated loss of attractive physical appearance. Somehow for her, this seemed to predominate over the mastectomy and the associated loss of physical attractiveness usually expressed by women undergoing this surgery, in that at no stage did she mention this aspect to the researcher. She did not offer further associations or attributions of meaning.

The third treatment, three weeks later, caused severe nausea, as well as precipitating haemorrhoids (the apparent result of diarrhoea followed by constipation due to the treatment). Before her next treatment three weeks later , the patient chose to terminate the chemotherapy treatment and elected instead to take Nolvadex -D tablets, one per day for the next five years as an alternative to the more aggressive chemotherapy infusion originally prescribed. The side effects of sore mouth, constricting oesophagus (making it difficult to eat or to drink hot tea), very sensitive stomach and ongoing nausea and pain, resulted in the patient's decision regarding her treatment. With a clear attribution of meaning, she stated: "The chemotherapy is holding me back." Her belief was that she could "heal and become more healthy without the poisonous effect of the chemotherapy drip in my body." In a sense, she preferred to personally take control and to take care of herself.

Further contact with the patient was thwarted by the fact that she had moved residence and had no telephone. Phone calls to her work revealed that she was on leave and later, that she was ill in hospital. A subsequent telephone call to the patient's place of work ascertained that she had died (approximately one year after her decision to stop the chemotherapy infusion), her positive attribution of meaning notwithstanding.

7.5 The Research Environment and the Research Approach

The research work for this thesis was carried out at the Johannesburg General Hospital. The mandatory permission was obtained from the professorial head of the Oncology and Haematology Department, the hospital superintendent and the University of the Witwatersrand Ethics Committee (affiliated to the Johannesburg General Hospital) before commencement of the study.

The research was undertaken at the Breast Clinic of the Oncology and Haematology Department, which is held once a week. At this clinic, breast cancer patients are examined, assessed and then prescribed chemotherapy, radiation or alternate treatment. They return at regular intervals for further examinations and treatments (the actual treatments for chemotherapy being carried out in a different section of the Oncology and Haematology Department).

To fulfill the purpose of this investigation, a personal interview was arranged with each newly diagnosed cancer patient who met the short list of criteria set out for this research. The required criteria were: Caucasian female aged between 21 and 75 years who was about to undergo chemotherapy for the treatment of breast cancer. Owing to time constraints between medical consultations in the hospital setting for each patient, the interview was restricted to a fixed number of questions designed to extract individual patient beliefs without being over-extensive in time requirements. (See Appendix for the Questionnaire sheet). The questions initially opened up broader areas

of each patient's attributions of meaning around cancer in relationship to herself, with a narrowing down of questions to beliefs about treatment side effects and about hypnosis.

A brief description of the research work and the requirements regarding suitable patients was given to the two nursing sisters in charge of the Breast Clinic in order to obtain their assistance, cooperation and understanding in the screening and selection of first-time chemotherapy patients. As soon as a patient was prescribed chemotherapy, she was referred to the researcher by one of the sisters so that the research questionnaire could be worked through.

7.5.1 The Personal Approach

The researcher approached each prospective subject with the following introduction: "Good morning -- my name is Phyllis Levy. I'm the psychologist in the Breast Clinic and we're doing some research on the effects of chemotherapy. Could I ask you some questions for the research?" The researcher had decided that ethically, this minimal introduction was necessary, but was aware that even in its minimalist context was likely to evoke at least an assortment of attributions of meaning if not perturbations of ideas for many, if not all the patients.

7.5.2 Personal Responses

All of the patients readily agreed to this with the exception of a Russian man accompanying his wife. As her interpreter, he initially agreed on her behalf to cooperate, but when the researcher started asking the questions, he said that he did "not want her to hear all this -- it would not be good for her" and he terminated the interview. In its negativity, this was a clear-cut example of attribution of meaning on the husband's part. One other husband, sitting with his wife and listening to the questionnaire, responded similarly when the questions about hypnosis were reached.

He took over from her and emphatically stated : "My wife would not be interested in this." In response to this intervention his wife remained passive, giving the impression of acceptance of his control and authority over her and over issues pertaining to her.

None of the women themselves refused to participate and all were cooperative. Some were brief in their answers and others more verbose. Most were friendly and responsive.

7.5.3 Additional Aspects

In the light of the two negative responses mentioned above, it was decided to administer the Consent Form for signing only if the patient subsequently asked for hypnosis and chose to be involved with the research at that level. This decision was made in order to avoid possible feelings of anxiety and intimidation which the wording of the Consent Form might incur in patients, most of whom were already feeling fragile and anxious as a result of their diagnosis and pending chemotherapy treatments. Consent for questionnaire administration was agreed upon at a verbal level as described above.

Because of the lack of privacy and the inconsistent availability of an unoccupied consulting room for interview purposes, it was not possible to tape record patient's answers to the questionnaires (and video taping equipment was not available). The interviews consequently took place in the large waiting area of the Breast Clinic wherever a quieter corner could be found and the written notes of all answers were recorded verbatim, in writing. Relevant asides from the patients were also included in writing.

7.5.4 Technical Problems in the Research Context

An unforseen problem was the relative paucity of patients receiving chemotherapy for the first time in the generally large population of cancer sufferers at this Breast Clinic. The final sample of 42 participating patients was obtained over a period of two years of regular, weekly clinic visits by the researcher.

Over and above the sample of 42 women, a number of patients were excluded from the final sample. One refused chemotherapy outright because of her belief that it was more detrimental than beneficial , and so she did not answer any questions. A second patient was the Russian woman whose husband believed that "she should not know about these things" and therefore was not prepared to cooperate. Several of the patients interviewed changed addresses and telephone numbers without notifying the hospital and so could not be contacted for follow up discussions by the researcher. Three did not return after the initial interview and could not be contacted at home. Certain patients had their treatment changed from chemotherapy to tablets or to radiation or to a single, high dose chemotherapy treatment with no further imminent chemotherapy treatments. Four of the patients died while the research was in progress.

The availability of two new anti-emetic drugs, Zofran and Kytril, coincidental to the commencement of the research project, may to some degree have affected the prevalence of post-treatment nausea and vomiting in many of the patients for whom these drugs were prescribed. This in turn may have affected the relative infrequency of ANV in this study, which is contrary to the reported prevalence of ANV in the literature and which appears to be strongly related to severity of post-treatment nausea and vomiting. Those patients receiving either of these drugs varied in their personal experience as to the efficacy of the drug or lack thereof.

7.6 Demographic Information

Forty-two Caucasian women aged between 21 and 75 years of age, recently diagnosed with breast cancer and prescribed with imminent chemotherapy treatment, were interviewed at the Breast Clinic of the Johannesburg General Hospital. (The one exception to this was the first patient, reported in the pilot study, who met the criteria, but was a private patient and was interviewed at the rooms of her private oncologist). In order to attempt to minimise the complications and ramifications of misunderstandings and misinterpretations due to widely variant language and cultural influences, only Caucasian women with breast cancer, about to receive chemotherapy, were accepted into the study. However, the subjects varied widely in sophistication with regard to knowledge and information about their illness, treatment, side effects of the treatment and hypnosis. There was also a wide variation in the way some subjects simply accepted and others questioned more deeply, the contents of the questionnaire, particularly the issue of hypnosis.

On the occasions when hypnosis was requested by a patient, the hypnosis usually took place in the time just prior to the patient's next chemotherapy treatment. An available, vacant office (usually used by a consulting doctor) in the Breast Clinic, was utilised, and this fulfillled the purpose of privacy and quietness for both patient and researcher. The offices all had chairs and an examination couch so that the patient could either sit comfortably or lie down according to her preference.

7.7 Conclusion

Although the aim of the study is not to offer a statistical analysis with resultant verification, validation and proof constituting the outcome, in order to set appropriate limits to the scope of the study, it was necessary to select a sample of women fitting

certain criteria for interview purpose. This selection, together with the standard questions administered to each woman, formed a foundation or baseline from which each individual's idiosyncratic attributions of meaning to her particular experience could manifest. The aim was not to inform or direct the participants in any specific way, but to create a context in which their attributions of meaning and ideas relating to their own experience of cancer, treatment side effects and hypnosis could be idiosyncratically expressed by each patient.

The following chapter describes the responses, observations and ideas which emerged in the contextual unit encompassing researcher, subjects and relevant others in the subjects' world space.

CHAPTER 8

FINDINGS

8.1 Introduction

8.1.1 Approaches to Research

Personal and idiosyncratic human experience cannot be objectified and consequently it cannot be described objectively. Following on this, there can be no "truth" about such an experience except in the way it is "real" for the individual. The particular experience will be different for each individual involved, with the qualitative and contextual aspects of that experience being imbued with a personal and idiosyncratic meaning. Consequently, the conclusions reached in qualitative research based on small samples need not necessarily represent a typical range of individuals in the population and may thus not be empirically reproducible. Qualitative research may thus lead to highly idiosyncratic conclusions with the researcher often constituting the primary research instrument. The generalizability of findings arising from qualitative research may be described along the lines of hypotheses that could be checked out by quantitative techniques (Huysamen, 1997).

To aggregate such meaning into a quantitative framework by making use of statistical techniques in order to construct a "common reality", at least dilutes, if not erases, the essence of the meaning of the experience for a particular individual. As Fourie (1996b, p.16) states: "The whole idea of replicability in human systems is therefore a realist one. Constructivistically seen, replicated research results are no more of a reflection of "truth" than the "truth" co-created in a therapeutic context and would often fit the therapeutic context less well; that is, would make less sense to the participants, than the

understandings co-created by themselves." "All realities are *not* equally valid or equally useful. Their usefulness or validity is determined, however, not by any "objective" norm, but by the way they fit in with the wishes, attributions, ideas, and conceptions of the people partaking in their co-construction" (Fourie, 1996b, p.17; italics in original), added together with the ideas from a wide assortment of external sources. To attempt to generalise a subjective, idiosyncratic and constructed experience, with its specific meaning and ideas into a statistically valid, reproducible, objective reality/truth may in itself be indicative of the traditional scientist's particular attribution of meaning to research work.

As Schwartz and Breunlin (1983) suggest, a traditional, standard research report usually makes very little sense or meaning of the essence of what occurred in the clinical setting or the treatment. As a result, Liddle (1991) cogently suggests that alternative approaches to research need to be generated, based on a critical examination of efforts at research and the ensuing results, rather than involving attempts at extremist debates. Schwartz and Breunlin (1983) and Liddle (1991) make a stand for new attitudes to prevail in the relationship between clinical practice and research, particularly in the field of family therapy, together with a different approach to training in both research and therapy curricula. Fourie (1996b) similarly suggests that what is probably needed is a "*shift in focus*" (p. 19; italics in original) where the research process includes contextual and social factors as well as attributional aspects in order to make use and sense of the entirety of the particular circumstance. In such an approach, the traditional search for "uncontaminated" truth is not the focus of the research (Fourie, 1996b).

What becomes important is thus the making of sense of the person's experience in a particular situation or circumstance, "rather than discovering context-independent and universal "truths" " (Fourie, 1996b, p. 19). From an ecosystemic perspective, this "*making of sense is a consensual process*" (Fourie, 1996b, p. 19; italics in original),

or, as Aron (1996, p. xii) suggests: "Meaning is generated relationally and dialogically, which is to say that meaning is negotiated and coconstructed. Meaning is arrived at through "a meeting of minds" ."

8.1.2 Application to the Present Study

To attempt to quantify the personal experiences and attributions of meaning of a sample of patients with breast cancer, and to exclude the qualitative and descriptive aspects of personal meaning for each individual, is to minimise and dilute the essence of the experience of each individual. Reducing such personal experience to statistics is to negate the core or flavour of uniqueness of each individual's experience and results in loss of holistic meaning in the research profile.

Does the value of the findings in a research project lie in the possibility/probability of exact replication being able to occur in a future, similar research project or does the value lie in the ecosystemic concept of the interaction of the people involved in the project so that a deeper, qualitative and personal meaning for each patient becomes the focus?

For the reader of the results of any particular piece of research work, the meaning and personal experience attributed to that research work will be different, depending on whether the findings are presented purely statistically, purely qualitatively, or as a combination of both approaches, and depending on his/her own, idiosyncratic attribution of meaning to the findings. Historically in experimental work, the statistical approach fits with the traditional scientific dictates, whereas, clinically, a descriptive and qualitative approach directs an emphasis towards the personal uniqueness of each individual involved in the particular research sample.

In this research project, the qualitative, descriptive approach is seen as coherent with ecosystemic thinking and as vital to the ascertaining of attributions of meaning for each individual -- a minimal, quantitative aspect is added as an extra dimension of the findings.

8.2 A General Impression of the Patients in the Sample

The general picture (with exceptions) which manifested from the interviewing of the selected sample of patients with breast cancer, suggested self-protective behaviours which often occurred as defensive verbalisations. (This interpretation and understanding of the data may be viewed as the researcher's personal attribution of meaning to these findings). These self-protective defenses presented as denial, ambivalence and the suppression of feelings. This aspect will be elaborated on later.

Apparent lack of knowledge and/or very limited knowledge about cancer and cancer treatment, on the part of the patients, permeated all aspects relating to the cancer -- the disease, the treatment, the side effects of treatment and, in particular, hypnosis. An individual's religious affiliation often influenced that person's views, particularly in relation to outcome and to hypnosis.

A general air of lethargy and resignation seemed integrated with the depression which was evident in so many of the patients. This seemed to negate or take away the fighting spirit of these women and often seemed to parallel a childlike quality in some of the patients, as if they were dependent on the authority figures in a hopeless, helpless, impotent way, for the final outcome. In this connection, the literature suggests that such an outlook and a way of being may not bode well for cancer patients -- surveys and findings suggest that individuals with a strongly positive outlook are more likely to extend their medically allotted time prognosis (Simonton, Matthews-Simonton & Creighton, 1978; Simonton & Simonton, 1975; Wortman & Brehm, 1975).

A more in depth examination of the questionnaire and the answers is described in the following section. A list of the questions posed to each patient is presented in the Appendix.

8.2.1 General Attributions of Meaning

Question 1: When you were given the diagnosis of cancer did you think in terms of chemotherapy?

Eleven patients responded in the affirmative -- the remaining 31 reported that they did not think in terms of chemotherapy. This finding may be suggestive of denial and suppression of fears. In the light of an explanation involving attributions of meaning, the belief that if something "bad" or negative is denied or thinking about it is avoided, then it will "go away" or not happen, or not have to be dealt with. If such attributions of meaning formed part of the belief system for some patients, then such thinking may have served as self-protection against fears, anxiety and the dread often associated with cancer and its treatment, for the patients concerned.

Question 2: How anxious do you feel about the treatment? Scale 0-5.
Of the 42 patients, 24 graded themselves at a score of 3 or higher, compatible with high levels of anxiety -- this response may be viewed as appropriate under the circumstances. (Table 1).

Table 1: Patients' Anxiety Ratings (N = 42)

Scale of Anxiety: (0=low; 5=high)	**0**	**1**	**2**	**3**	**4**	**5**
No of Patients: (Total=42)	7	3	8	4	4	16

Speculation around the spread of the level of anxiety in the above 42 patients offers a variety of viewpoints. How each patient constructs her view of what is happening to her, her interaction with the researcher at that moment, her ideas, feelings and beliefs, and the way she then selects to make herself known in the situation with the researcher, will impact on and create her response to any particular question.

The researcher's belief pertaining to chemotherapy is that chemotherapy and the reason for it (diagnosis of cancer), as well as the initially negative impact it has on the treated patient, are well-known and widely known by even the lay community. When patients are directly and personally involved in such a situation, then, in the light of the belief as stated above, it could be expected that all patients would experience some level of anxiety, and probably more rather than less. Even if ignorance manifested, fear of the unknown would be a difficult parameter to exclude. That seven patients reported no anxiety offers the possibility of several explanations: denial in order for the patient to protect herself from all the connotations as discussed above in Question 1; reluctance to engage at a vulnerable level with the researcher (also a form of self-protection resulting in the patient keeping herself emotionally "safe"); automatically conforming to the societally pressurised norm of non-expression of feelings in order to appear "strong" and "good" as opposed to showing "weakness." The power of socially constructed beliefs and ideas together with the ecosystemically interactive milieu and dialogue of patient and researcher, inclusive of whatever it is that the researcher stands for in the patient's idiosyncratic attribution of meanings pertaining to the situation, are suggested as being dominantly responsible for idiosyncratically organising the responses of each patient to each question.

Question 3: What are your thoughts and feelings about the chemotherapy?

A mixture of thoughts and feelings about the chemotherapy were expressed. These included: "no idea"; the belief that it "was a cure"; the belief that it "made you very sick" and a description of side effects of hair loss and nausea as being part of the

expectations. The answers suggest a combination of ignorance, denial and, for some, hope. These constructions of beliefs and expectations were largely based on hearsay from others and/or on the patients' experiences of others in similar circumstances who had had chemotherapy. Such attributions of meaning may be considered to be the result of the combination of each individual patient's idiosyncratic experience of external information sources together with that individual's unique internal structure (Maturana, 1975) into a personal construction which determines individual behavioural outcome and associated cognitions.

Question 4: Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?

Answers were mixed -- some knew of others, some did not. Two knew of good results after chemotherapeutic treatment, but the greatest influence was from information pertaining to negative experiences. The widespread knowledge by the patients of other peoples' negative chemotherapeutic experiences seemed to result in each patient's construction of attributions of meanings around this knowledge and relating and associating this with their own situation. As a result, this seems to have given rise to expectations and anticipations of similar negative occurrences relating to their pending treatment. The opposite set of expectations and anticipations seems valid for those patients having information relating to other peoples' positive experiences of chemotherapy. This suggests that in this field, as in other fields, a purely subjective view on the part of each patient is not possible and that contamination from external sources of whatever sort, influences each individual's internal, structure-determined makeup (Maturana, 1975), resulting in an idiosyncratically constructed set of expectations, anticipations, beliefs and attributions of meaning.

Question 5: What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V, ask: Where do you

think this expectation comes from - i.e. has anyone in your circle of family/friends/ acquaintances told you to expect N & V?]

Of the 42 patients, 18 stated that they "had no idea" or "did not know." General beliefs and expectations, usually gleaned from other people's experiences or from hearsay and books, were around nausea and hair loss, with one patient offering a more explicit description of these expectations. No-one mentioned ANV. This seemed to be due to either lack of knowledge or denial. One refused the treatment on the grounds that "it makes you worse and there's no point", which was her experience of others' treatments and her resultant attribution of meaning to treatment by chemotherapy. (Table 2).

Table 2: Patients' Responses Regarding Effects of the Treatment (N = 42)

No ideas; don't know	Description of possible side effects	Good expectations	Refusal
18	19	4	1

Question 6: Did you ever think this could happen to you?

Answers were mixed with both negative and positive beliefs and expectations manifesting i.e. "Yes, it could happen to me" or "No, I did not believe it could." Several factors could have accounted for these attributions of meaning and will be elaborated upon later.

Question 7: Do you feel angry? If so how angry? Scale 0-5.

Of the 42 respondents, 26 stated that they were not angry at having cancer -- seven used the words "not really" which perhaps suggest difficulty in facing the felt anger. The words "sad", "disappointed", "depressed" were offered by 7 patients. Confirmed anger was directed at the medical profession for inadequate or incorrect diagnosis (initially) and poor handling of the problem by three patients. Only six of the 42 patients gave a clear-cut "yes" response to feeling anger. (Table 3).

Table 3: Patients' Responses to Scale of Anger (N = 42)

Scale of anger scores (0=low;5=high)	**0**	**1**	**2**	**3**	**4**	**5**
No anger	26					
Anger		1		1	2	2
Anger at doctors					3	
Sad, depressed, disappointed	7					

Question 8: What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?

All the women reported that they have support in the form of family and/or friends. However, none were able to state what these people thought the effects of the treatment would be. This is suggestive of lack of open communication, poor communication, denial, withholding and/or protectiveness on the part of the support system members towards the patient. It could also be suggestive of a lack of openness of patients with the researcher possibly because the patient may have found the question difficult to answer, or too revealing and/or threatening if answered fully, once again being self-protective in the presence of the researcher. Equally, she may have possibly been protecting herself from personally facing up to difficult and fearsome thoughts and feelings which could be triggered by any full answer to this question.

Question 9: Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?

All but four of the patients said they knew nothing about hypnosis. Three others then added that they had seen stage hypnosis shows and one of the informed four patients was presently reading a book on hypnosis and self-help. The responses were suggestive of ignorance, denial and/or fear, with fear possibly being the result of the

individual's construction of a specific, negative view of hypnosis and what she believed was associated with that view -- her personal attribution of meaning to the idea of hypnosis.

Question 10: What are your thoughts and feelings about hypnosis?
All but four patients said "I don't know" or else responded with negativity. Denial, lack of curiosity, general apathy, underlying fear and/or hostility seemed to manifest in the answers to this question together with negative religious influences in five cases.

Question 11: Would you ever consider using hypnosis to help yourself?
Despite the ignorance and negativity revealed in answers to questions 9 and 10, the answers here were mixed. Many said "Yes, if it helps"; many said "Definitely no." A sense of ambivalence, unsureness and even a glimmer of hope for help pervaded the answers. Three of the five religiously influenced patients spoke of religious beliefs playing a role in the non-acceptance of hypnosis, with two being prepared to try "if it helps" or "if it can be proved."

Question 12: Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?
Mixed answers: "Yes" and "No." Many of the patients seemed to be confused at this stage and unsure of what they thought or believed in this regard. Their original lack of thought and ideas about hypnosis or their negative ideas regarding hypnosis seemed to have been realigned or perturbed by the introduction of the questions around hypnosis and seemed to have resulted in confusion for them.

8.2.2 A Further Dissection of the General Findings: Interpretations and Specific Illustrative Examples

This discussion enlarges the last section by including a) the researcher's interpretations or attributions of meaning with regard to patients' responses to the questions, and b) specific and idiosyncratic illustrative examples of patients' responses in order to highlight the attributions of meaning wherever relevant. This section emphasises the focus of the qualitative nature of the findings. It also presents a quantitative aspect with regard to relevant aspects of the findings.

Question 1: When you were given the diagnosis of cancer did you think in terms of chemotherapy?

That some women assumed, anticipated or believed that chemotherapy might be prescribed as the treatment following a diagnosis of cancer could suggest : (1) A greater awareness of the treatment of cancer; (2) They had thought further than the present moment and were looking for a cure/solution/remediation for their illness. (3) In their awareness, they were dreading the probability/ possibility of chemotherapy, and this dread may have been based on an awareness or knowledge of other peoples' experiences of chemotherapy which would influence their own resultant constructions and beliefs pertaining to chemotherapy.

In a specific example, one patient said: "Definitely not going to have chemotherapy -- I'm anti-chemo. I saw a lot at Tygerberg Hospital and I don't think the results justify the treatment -- the indignities." This patient seemed to be taking control of and responsibility for her illness into her own hands, rather than allow medical staff to treat her.

For other patients in the sample, that they had no further thought in terms of treatment on hearing the diagnosis of cancer, may be suggestive of several issues. A prominent issue may be the lack of knowledge or lack of awareness of cancer treatments by these patients. Other explanations may revolve around aspects of the patients' defensive, shut-down, or a protective withdrawal in order to maintain a sense of personal and emotional safety in the light of the diagnosis. The apparent lack of thought embodied in this response may also suggest a shift into helplessness and a childlike dependency on the authority figure of the doctor, with a belief and expectation that he/she will take charge and direct all future proceedings. This could be equated with a sense of resignation, an inability to harness a fighting spirit, an inability to harness a sense of taking charge and opposing what is happening i.e. the sense of being a victim with no power to oppose, but to simply accept whatever occurs. The power of such attributions of meaning would dictate the style of personal coping for each patient. For two, their personal, constructed viewpoint resulted in the belief that: "It is God's will" and "It is up to Him" to decide whatever happens. This could also be interpreted as an abdication of personal responsibility in the light of feeling helpless and/or overwhelmed. These different possibilities are all indicative of the personally constructed attributions of meaning, the idiosyncratic, constructive style of each individual -- the way she perceives or constructs meaning and beliefs around the diagnosis of cancer and the associated possibility of treatment/cure/suffering and/or inevitable death as a result of such a diagnosis. These different ways of viewing the responses are also derived from the personal attributions of meaning of the researcher.

Question 2: How anxious do you feel about the treatment? Scale 0-5.

The most clear-cut and easily understood response seems to be the appropriately high levels of anxiety expressed by most of the patients in answer to this question. The anxiety appears related to what each person anticipates or attributes meaning to with regard to what she will experience and have to deal with, following the cancer

diagnosis and the treatment. The issues of the unknown, usually anticipated with fearsome beliefs around the fatality of cancer and the associated suffering, were not openly expressed but were probably underlying the high levels of anxiety. The manifestation of the levels of anxiety exposed by this question, lends credence to the suggestion (the researcher's attribution of meaning) that denial and defenses involving cognitive and emotional shut-down, play an important role in many patients' manner of coping with cancer and its treatment.

Of the 42 patients, 19 scaled their anxiety level at 4-5 on the Anxiety Scale where 5 was high anxiety, and nine rated 2-3 as indicating their level of anxiety. The remaining 14 responded with a mix of answers which, under the circumstances, could be interpreted as denial and/or avoidance, for example: "Not anxious at all -- 0 -- very scared of the unknown"; "No, I won't have that treatment -- I can contain the anxiety"; "No feelings at all -- take it as it comes"; "Don't really care"; and three patients answered: "I don't know." Two of the patients side-stepped the issue of anxiety by responding that they felt very positive about the treatment and saw it as a cure.

A quantitatively inclined summary of patients' expression of anxiety (Question 2) in relationship to the diagnosis of cancer yields the following:
Nineteen patients rated their level of anxiety in the upper end of the 0-5 rating scale.
Nine patients rated their level of anxiety in the mid-low end of the scale, and 14 patients either denied any level of anxiety or else stated that they did not know how they felt.
Linking these numerical findings of Question 2 to the answers to Question 11 which pertains to the idea of hypnosis, the following figures, presented in Table 4, emerge:

Table 4: Patients' Anxiety Levels Correlated to Possible Use of Hypnosis (N=42)

Possible use of hypnosis	Yes	No	Ambivalent (about hypnosis)	Total
High anxiety	10	7	2	19
Medium-low anxiety	7	2	1	10
Denial	6	6	1	13
Total	23	15	4	42

Despite the fact that a professed lack of knowledge about hypnosis predominated patients' responses, the majority nevertheless indicated that they would be prepared to consider using hypnosis in order to assist themselves. Only four patients, however, actually requested hypnosis during their treatment regimen.

Question 3: What are your thoughts and feelings about the chemotherapy?

The answers to this question show strong evidence of the influence of attributions of meaning. Heavily based on an awareness or acquaintance of others' experiences of and verbalisations about chemotherapy, each patient in the present study verbalised anticipations and beliefs relating to her view of chemotherapy and the possible effect the chemotherapy would have on her. A common response was: "It makes you very, very sick."

In a specific response, a patient who later wanted hypnosis, was convinced she would experience severe emesis throughout the chemotherapy, based on her experience of severe and unrelenting vomiting attacks throughout her pregnancy with her triplets. During her chemotherapy treatment, her powerful belief was borne out and her emesis was both extreme and extensive. (This patient is presented and discussed more comprehensively later in this chapter).

Another patient said she felt "very, very positive" about the chemotherapy and attributed the meaning of "cure" to it. However, she too, experienced severe emesis with the treatment and this is likely to be due to the medically recognised side effects of certain anti-cancer medication i.e. drugs such as Methotrexate, Mitoxantrone HCl and Novantrone, Adriomycin, 5-FU-Cyclaphosphin or 5-FU-Cyclophosphamide which usually cause nausea and often precipitate vomiting and/or alopoecia. These drugs were the most predominantly used in the hospital setting and were referred to by their specific colour: yellow, blue, red, colourless or white. In this patient's case, she was treated with the red drug, Adriomycin which has as a side effect, nausea.

One patient said: "I feel very frightened -- everybody who's had it told me you feel very sick and it's the beginning of the end. I have faith in God -- I thought the Lord would heal me." Her post-treatment statement was: "Not so bad as I expected." Her personal construction and belief that "the Lord would heal me" may have helped to mediate her more positive outcome.

Another patient said: "Let me alone to die in peace -- I'm not afraid of that. What I am petrified of is doctors pushing me and pulling me around. I have no trust." This patient procrastinated in her decision making (in a way, she made a decision not to make a decision) about her treatment for four months. She started chemotherapy in the fifth month, having become emaciated and skeletal and died during that month. She seemed to have constructed and lived out a self-fulfilling prophesy.

A clear-cut avoidance of the usual fears associated with chemotherapy and an idiosyncratic attribution of meaning showed in one patient's response: "The chemo doesn't worry me as long as I don't put on weight."

One patient said: "I don't want chemo -- heard too much talk about it. It takes your hair out, lets you feel sick -- I'm afraid for that." Her attribution of meaning to

chemotherapeutic treatment was clearly based on hearsay. Nevertheless, she had chemotherapy and coped well with it despite nausea, tiredness and dizziness. Six months after starting treatment, she had two severe heart attacks, the second one being fatal.

A patient who said she was worried about the nausea and that her hair might fall out, said after her first treatment: "I was very nauseous -- I expected it. If I think about it I can feel nauseous -- I try not to." This was a clear attribution of meaning to personal beliefs and had she been more psychologically sophisticated, she may have identified this as anticipatory nausea.

Another patient said: "I've heard horrific things -- I need to hear success stories", implying that success stories would allow her to construct positive beliefs and attributions of meaning. Several patients simply said: "I've heard about it" or "You hear things." Hearsay and externally retrieved information clearly played an important role in contributing to the idiosyncratic construction of each patient's attribution of meaning to the effects of chemotherapy. This finding corroborates Fourie's suggestion that in ecosystemic thinking, the ideas in human systems are not only interwoven, but also "continually influence one another in mutual and reciprocal ways" (1991a, p. 468). The ideas and ways of thinking and linking, as well as personal attributions of meaning and personal constructs for each patient in the present sample, are descriptive and representative of ecosystemic concepts and thinking.

There seems to be a generalised and strongly held set of beliefs or attributions of meaning based on commonality -- what has happened to others will happen to me and this can be either good or bad. This relates to the idea that attributions of meaning contribute to the formation of a consensual domain in this particular arena.

Question 4: Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?

The answers to these questions generally reflected a continuation of the answers to Question 3. Patients either knew or were aware of good or bad results for others (or had no prior experience of others' treatments) and were influenced by these experiences. They used the knowledge to construct a personal set of beliefs and anticipatory expectations with a resultant attribution of meaning to their own forthcoming experience.

Question 5: What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V, ask: Where do you think this expectation comes from - i.e. has anyone in your circle of family/friends/ acquaintances told you to expect N & V?]

Answers here were also generally a reflection and extension of answers to Question 3. Patients' expectations were based on and influenced by what they had seen in others or had heard from others -- mainly people who themselves had been treated with chemotherapy, which, as stated in the discussion of responses to Question 4, is in keeping with ecosystemic principles.

Patients verbalised a common and predominant expectation of nausea and hair loss as the side effects of chemotherapy. As referred to earlier, this attribution of meaning may be postulated to play an important role in the frequent occurrence of these side effects. It challenges the concept of straight forward conditioning of patients, which, to date, has dominated the way of thinking in the research and literature in this field. Mouth ulcers, vomiting and "being sick" were also commonly expected. In no instance was ANV mentioned nor apparently expected by any patient interviewed, except perhaps in an indirect way by the patient who stated: "I was very nauseous -- I expected it. If I

think about it I can feel nauseous -- I try not to." It is possible that the concept of ANV may be too sophisticated a concept to be well known, or to be dissected out from the general experiences of nausea and emesis, particularly in the generally less sophisticated population using the hospital facilities. Patients may simply refer to the phenomenon as 'nausea or vomiting related to chemotherapy'.

Question 6: Did you ever think this could happen to you?

The mixed battery of answers to this question, both "Yes" and "No", seemed to be the result of individual beliefs often based on historic experiences i.e. if a parent had had cancer, the patient often constructed an attribution of meaning around this occurrence, i.e. that this same illness could affect her and therefore she expected this. Such a belief could also be attributed to the patient's knowledge of a medically postulated genetic link and her resultant associated expectation. Stated slightly differently: that a patient's parent had had cancer, often meant to that patient that she would probably have cancer too. This attribution of meaning based on and relating to the parent's diagnosis is suggestive of a strong identification by the patient with the parent and/or a sense of helplessness, being trapped or being a victim within this identification, together with a personally constructed set of beliefs by that patient. "What has happened to my parent will happen to me." Such an attribution of meaning seems to create a sense of disempowerment in the patient and with the associated helplessness, could possibly affect the outcome of the patient's treatment and disease experience i.e. her handling of it and the end result.

In this respect, the following possibility of a relational interplay was examined. Did those patients who answered Question 6 with an affirmative belief to the possibility of contracting cancer, a) admit to feelings of anger (Question 7); b) manifest any attempt to either take responsibility and help themselves e.g. through hypnosis (Question 11) or did they tend on the whole to give up? The following numerical findings based on the answers to Questions 6, 7 and 11, emerged -- the discussion follows later:

Question 6:

Thirty five out of the total 42 did not believe they would get cancer.

Seven of the total 42 believed they would get cancer.

Question 7: Do you feel angry? If so how angry? Scale 0-5.

Of the 35 who did not believe they would contract cancer, 28 expressed no anger at having contracted cancer.

Of those 35, five expressed anger at the doctors for inadequate treatment, and two expressed anger at having cancer.

Question 11: Would you ever consider using hypnosis to help yourself?

Twenty three out of the total 42 stated that they would consider using hypnosis to help themselves, although some were very tentative in this respect. (Only four later requested hypnosis).

Fifteen out of the 42 categorically refused to entertain the idea.

Four out of 42 were ambivalent and unsure.

Twenty-one of the 35 patients who did not believe they would contract cancer were also among the majority of patients who said they would consider using hypnosis to help themselves. This outlook could be interpreted from two differing viewpoints: it could either be seen as a positive stance taken by the patient i.e. I will not succumb to such a diagnosis, or it could be viewed from the perspective of denial and/or omnipotence: "This can't happen to me and I can control/alter/cure whatever is going on." An awareness of hypnosis together with resultant attributions of meaning to hypnosis may have influenced the "Yes" answers.

Of the seven patients who believed that they would get cancer, 3/7 expressed no anger at having contracted cancer, 3/7 were ambivalent and unclear in their feelings of anger; and 1/7 expressed her anger clearly. With regard to helping themselves with hypnosis,

4/7 were ambivalent about the concept and the use of hypnosis; and 3/7 categorically rejected any possibility of considering hypnosis. There were no clear-cut positive responses.

Apart from the preceding discussions in this chapter pertaining to Questions 7-12, no idiosyncratically specific or distinctive answers emerged, and thus no further interpretation is undertaken.
(Questions 7-12 are as follows:

Question 7: Do you feel angry? If so how angry? Scale 0-5.

Question 8: What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?

Question 9: Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?

Question 10: What are your thoughts and feelings about hypnosis?

Question 11: Would you ever consider using hypnosis to help yourself?

Question 12: Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?)

8.2.3 A General Summary of Patients' Answers

The clearest picture that emerged seemed to be one of denial together with a seeming lack of awareness and lack of knowledge (which may have been part of tpatients' self-protective denial). The majority of the patients (36/42) were from a lower socio-economic environment and may have experienced a level of resistance to the questioning for various reasons, including a sense of discomfort and/or feeling threatened. These feelings may have been associated with the experience of being interviewed by a stranger together with each patient's attributed meaning to the stranger being a psychologist. For some patients, this could have resulted in experiencing of a sense of stigma and/or fear relating to the perceived psychological sophistication associated with a psychologist. The sense of stigma, which is often attributed by the lay person to the perceived mental illness aspect or beliefs associated with psychology, may have added to feelings of imperfection and inadequacy which were possibly already aroused by the diagnosis of cancer.

In addition, patients in a hospital setting often appear compliant on the surface, but hostile, angry and resistant at a deeper, masked level, as in the psychological labelling of passive-aggressive behaviour. This may have been responsible for the often cursory answers given by some of the patients. Others seemed to find a release in the answering of questions and elaborated spontaneously. This latter type of response occurred more noticeably in the minority group of higher socio-economic status patients.

Religious beliefs often manifested as unquestioned constructions and attributions of meaning for some of the patients: "God causes sickness"; "God will take care"; God will decide." With regard to hypnosis, "The person who does it must be a child of God cause you're completely in his hands." All of these beliefs suggest feelings of helplessness, dependency, being a victim, no personal responsibility or control and also

a sense of helpless trust in a higher power. Religious beliefs and constructions also accounted for such answers as: "No, it's the devil's work"; "It belongs to Satan"; "It's against religion" when the topic of hypnosis was broached.

It seemed that the mention of hypnosis to patients (apart from two patients who were already using self-hypnosis), many of whom had not thought about hypnosis in terms of their illness and treatment, perturbed their thought processes. This resulted in a shift away from an initial lack of awareness of, or lack of thought about hypnosis,or even refusal of hypnosis. The shift manifested as an apparently internalised reconsideration or reassessment of thinking about hypnosis, (i.e. a reassessment of thoughts and beliefs about hypnosis) and a possibility of acceptance of hypnosis albeit with ambivalence and unsureness. This alteration did not give the appearance of mere compliance -- the apparent perturbation of thought processes of those patients experiencing the shift, seemed to manifest as a meaningful experience for each person.

Initially, on the first question mentioning hypnosis, many patients stated categorically that they had no knowledge of hypnosis. They then spontaneously added that they had seen stage shows or that they didn't believe in hypnosis, or that they wanted control for themselves, not from someone else.

As previously mentioned, an important attribution of meaning for several patients revolved around the belief that they had cancer because parents/relatives had cancer. One patient believed her cancer had come from stress -- "I never believed I would get cancer, but we had a fire and the house burnt down. I believe the cancer started then, from the stress." This is a clear example of an idiosyncratic construction and a consequent attribution of meaning.

In general, where responses to the questionnaire seemed dutiful, often mechanical, rather than allowing any ecology of ideas to evolve between patient and researcher, it

could be postulated that patients may not have 'permitted' themselves to acknowledge the extent and depth of the impact of the diagnosis. In addition, they may not have expected others around them to acknowledge this impact either, and so would not openly admit or acknowledge or discuss their ideas, attributions of meaning and/or feelings with others. The quote from Patient No 1 (which follows this section) seems to highlight this point: "People seem to become more silent." The patient's perception of, and attribution of meaning towards the people in her particular environment (including medical staff), i.e. the people she perceives as the "observers" in her world, and the impact they have on her, through their information, ideas and personal attributions of meaning, may affect and perturb her ideas and belief systems. An expectation of health or sickness as life progresses, is usually based on present experiences and on family history. This would form the basis of construction of reality and future reality for each individual, as well as personal attributions of meaning. For some, the diagnosis of cancer is unexpected and for others, a self-fulfilling prophesy (usually resulting from family history experiences).

In contrast to the more generalised presentation of findings above, individual and specific transcripts and the associated discussions of three selected cases follows.

8.3 Three Selected Cases

8.3.1 Transcripts and Discussion of Three Individual Patients

8.3.2 Introduction

Each patient's answers to the questionnaire varied with regard to the length, detail, richness and openness of the content, as well as idiosyncratic belief systems and attributions of meaning to the different aspects covered by the questions. Equally, there were many aspects of similarity with regard to the above indices. Three patients were chosen from the sample of 42 in an attempt to highlight some of these indices with particular emphasis on the aspect of attributions of meaning held by each of the three individuals presented.

The first patient presented is an example of an individual with an initially ambivalent set of attributions of meaning or belief system in her outlook towards hypnosis. As her treatment progressed and as she was influenced by both her own experience of the treatment and by additional external information (from visiting friends), so her belief system shifted.

The second patient presented is an example of an individual who held strong, unwavering, positive attributions of meaning around hypnosis and was familiar with, and already using what she believed were some helpful aspects of hypnosis and relaxation.

The third patient offers an example of clear-cut, negative attributions of meaning towards hypnosis. The transcripts and discussions of the three selected cases follow.

8.4 Individual Case Presentation: Patient No. 1

8.4.1 Introductory Note

In contrast to the generalised presentation of findings under the heading: General Attributions of Meaning, detailed findings emerging from one specific case is presented. This example has been selected in order to illustrate a patient who experienced anticipatory nausea and vomiting and subsequently requested hypnosis to help her cope. This was the only patient of the total 42 who developed clear-cut ANV. She was also the only one out of four patients (of the total 42) who requested hypnosis in order to aid in coping with the treatment. This is the patient, mentioned above, who was initially ambivalent in her set of beliefs pertaining to hypnosis.

8.4.2 Patient Details

The patient was a 47 year old, married, Caucasian female of Catholic faith, recently diagnosed with breast cancer. Her address suggested a middle class environment and her immediate family consisted of her husband and five children. The presentation of this patient involves a transcript of her answers to the questionnaire and an associated discussion of relevant issues.

8.4.3 Transcript of Patient No. 1

A transcript of the patient's answers to the questionnaire and a discussion of the relevant issues follows:

1. When you were given the diagnosis of cancer did you think in terms of chemotherapy?

"It was given to me all at once, so they told me about the chemo."

2. How anxious do you feel about the treatment? Scale 0-5
"I've heard bad reports about chemotherapy so I'm very anxious. I would be about number 4 or 5."

3. What are your thoughts and feelings about the chemotherapy?
"I feel very negative about it -- I have negative thoughts. I'm worrying about my five children and the family. I carried triplets and I vomited throughout the pregnancy. I'ts not pleasant to think of all the vomiting."

The patient's pregnancy with triplets clearly overshadowed her other two pregnancies in that she made no mention of whether those two were problematic for her or not. Her attributions of meaning to the issue of chemotherapy suggested an association of the triplet pregnancy with the chemotherapy and a strong belief that both meant vomiting for her. In this instance, her idea of chemotherapy did not seem to include the possibility of an alternative or different happening to the vomiting of her triplet pregnancy.

4. Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?
"I know a lot of people. It breaks down all the chemicals and you have a lot of tiredness. You can get blisters in your mouth and gullet and your hair falls out in most cases. You get drying out of the skin and vomiting and diarrhoea. Some just have nausea. Others said: "After the first treatment you won't want to go back." Another said that it broke her down in every physical form. You need a strong mind to get you through."

This patient seems to have been exposed to a great deal of negative input not only from her own past experience with pregnancy, but also from a variety of external sources. Her answer to this question suggests that her ideas and her belief system were focused on, impacted upon and perturbed by this input. Chemotherapy for her, carried a highly negative connotation with an associated negative set of attributions of meaning. She had attributed a commonality to pregnancy and chemotherapy in the form of nausea and vomiting (and hair loss as in the next answer) and had constructed this as her belief system and her attribution of meaning for this issue. She also clearly identified with the negative experiences of "others" and in this identification, assumed or expected the side effects of her own treatment and her experiences to be similar to theirs.

5. What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V, ask: Where do you think this expectation comes from - i.e. has anyone in your circle of family/friends/acquaintances told you to expect N & V?]
"I feel my hair will fall out like it did in my pregnancies. I'm sure I will have at least nausea if not vomiting. I get nauseous very easily."

In response to the second part of Question 5, the patient stated that she expected to be nauseous because of her own personal, past experiences and her consequent belief that she is a person who "gets nauseous very easily." She had also heard from friends and from people who had had chemotherapy that "it makes you very nauseous and sick." These expectations and strong set of beliefs could be interpreted or seen as a form of self-fulfilling prophesy by the patient for herself. Whimsically, would she be pleasantly surprised or disappointed if the expected outcomes did not materialise?

6. Did you ever think this could happen to you?
"No -- I did think of cancer but never of breast cancer."

7. Do you feel angry? If so how angry? Scale 0-5.
"No -- there are worse things. God gave me a second chance because it's nowhere else in the body."

This answer carries a degree of positive thinking, reasoning and/or rationalising not expressed in the negative expectations in the answers to Questions 4 and 5. The patient expresses a positive attribution of meaning in this way of seeing her diagnosis rather than any expression of anger. If this particular answer is not taken at face value, but is seen as an instance of denial or rationalisation, then Janis' (1958) observation is relevant. He states (1958, p.82): "Under conditions where a person is strongly motivated to deny an impending danger, he will tend to rationalize his self-perceptions of emotional tension by mislabeling his affective state and attributing it to other, less fear-arousing, circumstances." Viewed from another aspect, the denial or suppression of anger may be a habitual style or learnt pattern in this particular family constellation. This style is likely to be used within the family to maintain cohesion and to minimise anxiety levels.

8. What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?
"I have a wonderful family and also friends. But people are more silent once it happens to you then you can't know what they think. But they also support and encourage you."

This answer is in contrast to the answer to Question 4 which suggests that the patient was exposed to a not inconsiderable amount of negative input from people she knows.

9. Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?
"No."

Considering the fuller answers given to the preceding questions, this particularly brief answer suggests the possibility of a strongly negative attribution of meaning to hypnosis which is consequently borne out by the next answer.

10. What are your thoughts and feelings about hypnosis?
"I am very religious -- I'm not going for anything like that."

The association between religion and hypnosis seems to have created a negative attribution of meaning around hypnosis for this patient. She holds a belief that hypnosis and religion are incompatible.

11. Would you ever consider using hypnosis to help yourself?
The patient responded by asking: "Do you think it could help?" The researcher's response: "Well, I'm needing to understand what you think about this." The patient responded: "If it's a drastic state of vomiting.....one would resort to hypnosis. Even the nausea."

It appears that simply asking this question of the patient, perturbed her previous, seemingly dogmatic response and ideas regarding religion and hypnosis. This perhaps resulted in an amalgamation of the strongly negative expectations about chemotherapy side effects, expressed in the answer to Question 4, with subsequent, newly formulated expectations for the patient. This is, in essence, almost an about turn, arising out of this particular patient/researcher interaction.

12. Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?
"Yes."

When compared to the "No" response to Question 9, this clear-cut affirmative answer seems incongruent unless it can be postulated that the perturbation of ideas mentioned in Question 11 had a profound enough effect to account for this about-turn answer.

8.4.4 Description and Further Discussion of Subsequent Meetings

This patient was again interviewed when she returned to the Breast Clinic one month later for her appointment with her clinic doctor. She had had two chemotherapy treatments with "the yellow and the colourless drips." The researcher ascertained from the medical staff that the drugs administered were methotrexate, a particularly toxic chemotherapeutic medication with the associated side effects of nausea, emesis and alopecia, together with 5-fluorouracil cyclophosphamide which often causes nausea. The patient had not been given this information by the medical staff. The following information emerged:

The patient stated that she had "only experienced nausea" as a result of her two chemotherapy treatments and that she was able to eat despite the nausea. Also, she had not experienced the expected, dreaded vomiting. This was despite her original, strongly expressed attributions of meaning to the chemotherapy treatment, which she equated in similarity to her pregnancy with her triplets where the emesis was excessive. She had nevertheless requested the newest anti-nausea medication, Zofran, which was going to be prescribed shortly.

Viewed from a different angle, the process or act of "mental rehearsal" (Goldstein, 1962) may have been a colluding factor in this outcome. The individual's anticipatory fear of the impending catastrophe or disaster becomes the motivating force which is responsible for a "mental rehearsal" or imagining of the anticipated, feared experience. In this internalised, cognitive enactment-in-advance, which may be described as a personal familiarising with the anticipated event, the individual prepares him/herself

psychologically for the dreaded event. As a consequence of this, the potency or impact of the experience becomes reduced for that individual. This concept may have played a functional role at this particular stage of this patient's treatment.

The patient did not appear at the Breast Clinic during the following weeks and as a result of this, the researcher telephoned her at home one month later. Although on Zofran, the patient said that after her treatments, she felt "sick" in her head and stomach with a gnawing feeling in her stomach, and was experiencing both nausea and vomiting after each treatment. She felt nauseous for five days after each treatment. In her experience, she believed that eating helped contain her nausea.

The initial lack of severity of side effect symptoms was contradictory to this patient's expectations and attributions of meaning as expressed in the questionnaire. That the side effect symptoms became more severe and in line with her expectations as the treatment progressed, may have been due to the chemotherapy regimen prescribed to her i.e. the effects of the combination of the medical and physiological aspects, together with the psychological effects. The former may have been more powerful in influencing outcome than the latter. However, bearing in mind this patient's unusually high level of anxiety in her everyday living, as each treatment occurred, she may have become more and more anxious and this may have contributed as a psychological component (which in turn affected her physiological components) and exacerbated the severity of her treatment side effects.

It could also be hypothesised that the "reality" of a "less bad" experience which occurred for this patient at the early stage of treatment did not necessarily mean that her personal, meaningful and idiosyncratic experience was not frightening, dreaded and stressful for her during the anticipatory phase of her prescribed course of treatment -- in other words, although her actual experience of the first two treatments was not as severe as she had expected, the *meaning* which she created for herself around the

treatments was internalised as a traumatic anticipation/expectation. Consequently, her attribution of meaning to the chemotherapy may have given the experience a strongly negative quality for her. This internalised negative quality may or may not have impacted negatively on further treatments where she was not only nauseous for five days after the treatment, but also experienced associated emesis.

Two weeks later, at the time of the next treatment, the patient reported that while she was waiting to go in, "I got the feeling over me. I felt nauseous before going in and I had that sick feeling all over my whole body -- it comes from my stomach. My husband got orange juice for me -- it helps." This report (describing her first experience of ANV), could be seen to be in line with the hypothesis that the internalised feeling and meaning of the chemotherapy for this patient was negative and traumatic in anticipation, although in reality it had not been severe. As a result, her internally constructed set of beliefs may have been effective in triggering an ANV response as reported by her.

After a similar experience with her next treatment, she told the researcher that she was considering hypnosis to help her deal with the nausea and vomiting and with the sick feelings that she experienced before her treatments. She stated: "Any connection with my treatments, I get nauseous. I cried through my last treatment. I was so sick after my last treatment, that day, and it hit me again three days later. The Zofran blocks the vomiting only but not the nausea and I feel sick and giddy and weak."

After the seventh treatment, with still another five to go, the patient spontaneously told the researcher that: "I didn't think I would need hypnosis at that time when you first asked me those questions, but I have heard that hypnosis helps -- they were talking about it the other day when some friends were visiting me. I really want to try it." This patient's susceptibility to external information sources with subsequent influence by these sources manifested once again. Hearing positive messages about hypnosis

seemed to perturb her existing ambivalent and/or negative ideas about hypnosis with a subsequent shift in her beliefs and attributions of meaning connected to hypnosis. The original importance of religion with its negative connotation for hypnosis appeared to have diminished along with a reconstruction of and a shift in the patient's belief and meaning systems.

8.4.5 An Explanatory Interjection

This form of shift in thinking and meaning is widely corroborated by and elucidated in the literature pertaining to social constructionist views. Anderson and Goolishian (1995, p. 29) summarise this concisely by stating: "Meaning and understanding are socially constructed by persons in conversation, in language with one another." Because people talk 'with' and not 'to' one another, there is participation of the people concerned in the "co-development of new meanings, new realities, and new narratives" (p. 29). Dialogue evolves and as an inherent consequence of this, there is change in the story and self-narrative with associated alteration to attributions of meaning. Although Anderson and Goolishian (1995) focus on the client-therapist system, their way of thinking is equally applicable to relationships outside the therapeutic framework, as in the present study and is supportive of the shift in thinking as described in the patient presented above. Meaning becomes a function of the relationship, with the participating individuals mutually affecting each other's meaning, and co-creating new understanding -- this leads to meaning becoming a byproduct of mutuality.

8.4.6 Back to the Patient

The above mentioned telephonic conversation was followed by a meeting with the patient at the Breast Clinic two days later when the patient was due to see her hospital doctor. She had also started attending the "I can cope" course which was being offered

by the Breast Clinic to cancer patients attending the Clinic, and which she believed would be useful to her.

8.4.7 A Description of the Co-construction of Hypnosis

At this meeting, the researcher, the patient and her husband made use of a vacant office (normally used by an attending doctor) in the Breast Clinic. This was a room which measured approximately 4 x 6 metres, contained a desk, three chairs and a couch, the latter positioned under a window and opposite the door. The patient's husband gave the impression of being very supportive of her and of the idea of hypnosis for the severe nausea, and verbally expressed this on two occasions. In addition, he spontaneously volunteered the information that he would be interested to come into the room with her for the hypnosis session and would do anything he could do to be of assistance. The researcher thanked him and told him that his participation, in which ever way he chose, would be welcome.

The researcher asked the patient about her view of hypnosis and what her needs in this respect might be and invited the husband to participate should he so wish. The patient said that she believed she could have better control over the chemotherapy treatments and the side effects if she could use hypnosis. She thought hypnosis could help her to relax (although she did not offer any ideas or concepts of what "hypnosis" meant to her or how she perceived it), and to keep control of the nausea which was so debilitating for her (she felt that the vomiting was being controlled by the Zofran). Her husband did not verbally add anything to this but while she was talking, he nodded his head and agreed and by this action could be said to be positively indicating a message of support of her beliefs.

8.4.8 Theoretical Interpretation and Discussion

In the above (hypnotic) situation, if the interactional factors are viewed holistically, it can be stated that there is a confluence of ideas generated by external information, inclusive of the experiences and opinions of the people in the patient's environment, the patient's own past experiences (problematic pregnancy), and the meetings and verbalisations of the researcher, patient, and her husband in the office. This confluence creates an intention of 'doing hypnosis' for a beneficial effect/result. Viewed from an ecosystemic perspective, these contributory factors constitute a set of interweaving facets and interactions which influence the patient's ideas and attributions of meaning around hypnosis (and in a different way, with idiosyncratic factors intervening, also influence her husband's and the researcher's ideas and attributions of meaning in this area). As the interactional factors become modified or added to by additional or by changed information (from external sources) during the passage of time, so the patient is seen to construct different or modified attributions of meaning in this area. This manifests in her altered attributions of meaning towards hypnosis during the ongoing meetings between the researcher, herself and her husband. An illustration of this is offered by the following examples which serve to highlight the point.

During the first meeting, between this patient and the researcher, the patient's answer to Question 10: "What are your thoughts and feelings about hypnosis?" is: "I am very religious -- I am not going for anything like that." On the third meeting, the patient volunteered that she was considering hypnosis to help her deal with her "sick feelings" of nausea and vomiting. On the fourth meeting (which was after the seventh treatment, with still another five to go), the patient spontaneously told the researcher that: "I didn't think I would need hypnosis at that time when you first asked me those questions, but I have heard that hypnosis helps -- they were talking about it the other day when some friends were visiting me. I really want to try it."

The patient's ideas about hypnosis may be said to have been perturbed by the impact or the impingement of the external ideas and messages, with a subsequent (internalised) reconstruction of her attributions of meaning pertaining to hypnosis at that moment in time. This emerged as a different or altered set of attributions of meaning with regard to hypnosis.

In addition and simultaneously, it would appear that there was an alteration to the original *meaning* of hypnosis for this patient. This alteration of the original meaning parallels the ongoing alterations and changes in the patient's thinking. This in turn may be seen as a function of the interactional feedback loops which occur spontaneously and intermittently from the above-mentioned sources. As the patient's original ideas (e.g. about hypnosis) evolve and change, so does the meaning for the patient (about hypnosis) evolve and change. It is likely that the patient's own desperation at feeling so ill and her sense of loss of control related to her treatments, may have precipitated an internal shift. This so-called shift may be seen as a perturbation of her ideas which, in turn, may have made her more amenable to the timing and impact of her friends' visit and their discussion of hypnosis. Following on this visit by friends, the patient seemed to construct a new set of attributions of meaning around hypnosis. These new attributions of meaning allowed the patient to view hypnosis as possessing the powerful virtue of control. With this characteristic, she could attribute to hypnosis the possibility of assisting herself with control over, and thus relief from, chemotherapy side effects. This, she believed, would offer her a potential sense of wellbeing. Her initial objection to hypnosis on religious grounds no longer seemed to dictate or dominate her belief system.

This shift in the patient's attributions of meaning to hypnosis, fits with three premises put forward by Patterson and Garwick (1994). Although their work is explicitly within the family domain, in certain contexts, it nevertheless seems to apply to individuals.

They state: "First, the meaning of an event influences behavioral responses to that event. Second, meanings can be changed by the very act of responding to an event. Third, meaning is a social construction" (p. 300). They direct these premises to clinicians working with families who are living with chronic illness, but an awareness of this is equally important to clinicians working with individuals whether chronically ill or not, as chronicled in the present research work, particularly with Patient No. 1.

8.4.9 The Use of the Patient's Attributions of Meaning to Construct an Hypnotic Ambience

In describing to the researcher what she felt would be useful and right for her for her idiosyncratic, hypnotic experience, the patient included, spontaneously, that if she could imagine herself lying on the beach under an umbrella with the sound of the waves all around her and feeling very, very relaxed when she was actually lying on the bed about to have the chemo drip, it would stop her from being so tense. She also asked if the researcher could "give her a message under hypnosis" for more confidence, more energy (lack of energy being a serious problem for her at the present time), better control and no nausea. The researcher had noticed that as the patient was talking she had developed a glazed look in her eyes as if she was in her own space, not connected to the researcher. The researcher responded with acceptance and with a positive manner to the patient's beliefs and requests and asked the patient if she would like the "hypnosis" and the "messages" to be recorded during the session, onto an audiotape. This would allow the patient to use the tape whenever she chose, until the next meeting, which was in one week's time when she came for the next "I can cope" talk. This was acceptable to the patient.

With regard to taping the experience for the patient, the literature offers mixed views of "live versus taped" relaxation and hypnosis sessions. It is not clear-cut as to whether one experience is notably superior to the other or whether each experience is equally

efficacious (Borkovec & Sides, 1979; Burish, Carey, Krozely & Greco, 1987; Butler, 1955; Carey & Burish, 1987, 1988; Israel & Beiman, 1977; Margolis, 1983; Milne, 1982; Morrow, 1984, 1986; Morrow & Morrell, 1982; Redd, 1981, 1986; Redd & Hendler, 1984; Redd, Rosenberger & Hendler, 1983).

The patient asked if she could lie down on the bed in the office rather than remain seated in the chair "because it will be like lying down on the bed for the chemo drip." The researcher colluded with this request in order to utilise the patient's attributions of meaning, in adherence to ecosystemic thinking. In order to fit with the patient's belief system as much as possible, and to consequently co-construct a meaningful experience for the patient, the researcher asked the patient what she thought was a good way for her to start "being hypnotised." After some thought, the patient said that if she could: ".....just help my body to become more relaxed maybe by breathing slowly and peacefully and thinking of being on the beach, that would be a good way." She added that actually she didn't really know and she hoped that the researcher would be able to "get her to be hypnotised." This seemed to indicate her expectation of the researcher's involvement, experience and ability in the field of hypnosis. By this, she also relegated or attributed some power and control to the researcher. This belief or attribution of meaning was noted by the researcher, and in an attempt to maintain the ecosystemic framework, was capitalised on to create an acceptable experience of 'hypnosis' for the patient. The researcher fed back to the patient, some ideas of "what usually works well in helping people to be hypnotised." The patient was amenable to the idea of focusing on her breathing (an extension of her idea) and of her body becoming heavier and more relaxed as she focused, (also an extension of her idea), and then drifting off into the beach scene. The requested "messages" were introduced before the end of the session and an ending, appropriate to her verbalised expectations and requests, was created. This involved suggesting that when she felt ready, she would be able "to wake up slowly and gently, she would be able to open her eyes and she would continue to feel very relaxed and well and full of energy."

At the close of the session, the patient spontaneously stated that she had enjoyed the experience and was feeling "very relaxed and very good." She and her husband then went to the chemotherapy treatment floor where she was due to have a further treatment. She later reported back to the researcher that she had felt fine for the first 15 minutes but had then vomited and had "felt very sick." (It is not clear whether her psychological or medically induced physiological reactions intruded after the first 15 minutes, to perturb the ideas in her existing internal state and so to replace her "feeling fine" with her "feeling very sick." This may have been an example of the previously mentioned 'conditioning' which could be seen as an anticipated expectation in the situation and consequently, an attribution of meaning to the situation, resulting in the switch from 'fine' to 'sick').

8.4.10 A Description of the Meetings Subsequent to the Patient's Initial Experience of Hypnosis

The patient came to the arranged meeting the following week without having used the tape or having rehearsed what she had experienced with the researcher. She said that the triplets were writing exams and that "it was chaotic at home, but we'll be better for time next week." That her next chemotherapy treatment was only due in two weeks' time may have played a role in her lack of urgency regarding rehearsing the tape and/or she may have been disappointed in feeling so sick after her last chemotherapy treatment. The possibility also existed that she had requested the hypnosis because others had said it had value, without integrating the information into a construct of her own -- i.e. she was "talking about" other peoples' positive beliefs about hypnosis rather than having her own positive attributions of meaning related to hypnosis. As a result, she may still have been ambivalent in her beliefs, at least, or at most, negative in her beliefs pertaining to hypnosis. This may have accounted in part for her non-use of the hypnosis tape during the previous week.

However, when the patient was seen two weeks later, before her next chemotherapy treatment, she said that she had practised the tape twice a day for a week. She also offered the information that "the children are using the hypnosis tape before their exams and to help them sleep." Her husband told the researcher that "she has been feeling much better this past week." He had often mentioned her tense, hectic, busy lifestyle with so many children to look after. The patient asked for "another hypnosis session now, before my next chemo just now." The researcher agreed and asked if it would be helpful for the patient " to "be in hypnosis at the beach" when she went upstairs for her chemo and then to count to three in order to "come out of hypnosis" " once she was back at home and/or whenever she chose. This procedure was carried out.

Telephonic contact with the patient four days later elicited the following information: After the last live hypnosis session, the patient said she had had no ANV, much to her relief, and that the treatment had gone well but that she had vomited just as she got off the bed at the end of the treatment. Nevertheless, she reiterated that "it had been amazing through the treatment, just until the last part." She also stated that she had been able to go out for the whole day on the Sunday after that Friday treatment, which was different to her previous posttreatment experiences. On the whole she had had less fatigue and nausea. She did state, however, that "the thought of the next treatment less than a week away was driving me mad." She planned to continue using the tape (with her husband actively supporting her decision) -- this was her choice, without pressure from or coercion by the researcher.

Just before the next chemotherapy treatment, the patient told the researcher that she was "feeling O.K., but felt so bilious last night and very blown up, and the same this morning. I did the tape twice last night and once this morning before I came." The

patient requested a live hypnosis session at that point,(and this was carried out), before her treatment later on that morning.

A phone call to the patient by the researcher, four days after the last live hypnosis and the chemotherapy treatment, elicited the following information, which is reported verbatim: "I had a terrible time. I lost control completely and I vomited on the treatment bed. On Friday I was so sick and so weak after the treatment and I also vomited at home on Saturday (the next day). My future son-in-law is a doctor and he thought that my blood sugar level had dropped so he gave me Coke and chocolates and glucose. I was sick and weak 'til Sunday. By Monday there was a dramatic change -- I got up and did a full day's work -- no lying down. I did no hypnosis during that time. The tape got me through the Friday treatment, even though the treatment was so terrible -- I wouldn't have coped without it...it has its good effects for me. I'm just so tense about all of this and sitting around waiting for Doctor D. at the hospital doesn't help. I'm battling to get control of myself and maybe the hypnosis will help with the control. I couldn't have coped without it."

The next meeting was at the Breast Clinic before the patient's penultimate treatment session. She stated that she had coped for the two weeks and felt fine except for tiredness, but that "the tiredness had not been as bad as before." She had had some degree of anticipatory nausea the day before when she had taken her one child to the Asthma Clinic at the Johannesburg General Hospital, but it had not been as severe as before. The researcher noted that the patient looked much better than she had on previous occasions. She requested and received 'live hypnosis' before her treatment that day.

Four days after that treatment, the researcher phoned the patient at home and she said: "It wasn't too bad. When they were putting the needle in for the drip, I vomited lightly there on the bed two or three times, but then I calmed down. When I got home, I went

to bed and I had no vomiting. I was only in bed when I got home and the next day I was up and coping O.K. I had no anticipatory nausea before the treatment. I'm dreading next Friday -- it's my last treatment."

On the morning of the last treatment, the patient said that she had been "feeling better, in fact, O.K. this week -- much better with the hypnosis than before having it. It's my last treatment and I've learnt the hypnosis so well, I can do it myself."

Four days after the last treatment, a phone call to the patient's home elicited the following: "Friday was bad -- I was quite sick. I was in bed on Friday, got up a bit on Saturday and rested a lot. I was very weak. Sunday wasn't too bad and Monday and Tuesday O.K. But I can't rush around. I only vomited on Friday -- I couldn't control it during the treatment, three times, and at home. The worst vomiting I've had -- off and on the whole Friday afternoon. I got very tense and worked myself up. I wouldn't have got myself into that treatment room if not for the hypnosis -- it definitely helped the anticipatory nausea. I didn't want to go back with the anticipatory nausea so bad. Friday night I played the tape and stopped the vomiting and then I fell asleep. If you let go and the vomiting starts, you can't control it -- the hypnosis helps. Zofran didn't really help. I would've stopped the chemo without the help of the hypnosis." Despite failure of full control of her emesis, the patient seemed to have consolidated firm, positive attributions of meaning around hypnosis.

Three weeks later, the patient presented at the Breast Clinic for her checkup and reported that she was doing well. (She died three years later).

8.4.11 Discussion of Miscellaneous Issues Related to the Patient's Experiences

Although the patient experienced a degree of lack of success in comparison to her expectations of what hypnosis (and the researcher) could do for her, her description of the last chemotherapy treatment suggests that she still held a positive attribution of meaning in relation to her concept of hypnosis.

The patient's level of anxiety preceeding her treatments was heightened by the fact that her hospital doctor consistently ran late with his appointments. This inevitably made the patient late for her chemotherapy and as a result she only arrived home after 4 p.m. with excessive worries about the caring of her children and their needs for the day. To try and circumvent this, she would arrive at the hospital at 7 a.m. in order to be one of the first in line for the doctor. Any delays precipitated severe agitation and anxiety for her and may have affected her amenability and receptivity to her utilisation of hypnosis, either negatively (in that she was too agitated to respond to hypnosis), or positively (with a heightened receptivity and dependency upon it, to stabilise her anxiety and assist her in coping). It is perhaps less likely that there would be no influence whatsoever from the effects of anxiety.

8.4.12 Conclusion of Discussion

The patient's original belief system pertaining to hypnosis (highlighted in her answers to the questionnaire) was of a negative nature with a degree of ambivalence. The latter aspect suggests that she was not totally closed to a possible shift in her attributions of meaning. It could be postulated that the questions themselves caused perturbations in her pre-established ideas and thinking patterns and when she heard her visitors discussing hypnosis in such a positive light, she began to attribute positive connotations to the idea of hypnosis. It seems that the perturbations were involved in an alteration

or shift around whatever original definition she attributed to or believed constituted hypnosis. After she had experienced "hypnosis" in accordance with her expectations of the content, the style and the outcome, she seemed to create or construct her own idiosyncratic concept of hypnosis. In this, she perceived hypnosis as a control mechanism and a help, even though with repeated use of hypnosis, she was not always successful in her aims. The toxic nature of her treatment drugs, her excessively anxious and tense manner of coping and the lack of benefit from Zofran, militated against an easy treatment regime.

Whether it was (1) her newly adopted, positive attributions of meaning to hypnosis; (2) her personal contact with and the talking to the researcher; (3) her own beliefs regarding taking control of whatever aspects of her treatment that she could by means of hypnosis; or (4) a combination of these factors, she seemed to obtain a measure of support which allowed her to persist with the treatment through to the end despite the serious ordeal she experienced.

The concept of constructivism is useful as a partial explanation in understanding and clarifying the patient's ability to collate information and ideas to create her own idiosyncratic attributions of meaning around her particular circumstance. This process also included her acquired ideas about hypnosis and her consequent ability to utilise her recently constructed beliefs and expectations to her possible benefit. The evolution of such a process from the time of the researcher's first contact with the patient via the administration of the questionnaire, through to the last chemotherapy treatment session, will of necessity be different for each patient involved in the process. Each patient's internal make up, past and present experiences and beliefs, idiosyncratic style and personal way of constructing or creating attributions of meaning, will produce difference. The outcome may be viewed as less important than the *personal meaning* of the experience and outcome for each patient. In this respect, the qualitative

approach takes precedence over the quantitative, empirical research method under these circumstances.

8.5 Individual Case Presentation: Patient No. 2

8.5.1 Introductory Note and Patient Details

This patient was a 46 year old, married, Caucasian female of Jewish faith, recently diagnosed with breast cancer. Her address suggested an upper middle class environment and her immediate family consisted of her husband and his three children from a previous marriage. This patient was already positively aware of hypnosis and associated concepts when the researcher met her. The transcript of her answers to the questionnaire follows, together with a discussion of the relevant issues:

8.5.2 Transcript of Patient No. 2

1. When you were given the diagnosis of cancer did you think in terms of chemotherapy?
"Yes -- it was a shock and I was prepared to go for the best treatment, homeopathy as well and I take special herbal tea and vitamins."

2. How anxious do you feel about the treatment? Scale 0-5.
"Scared -- it's poison for my body. Very anxious, number 5 for me."

3. What are your thoughts and feelings about the chemotherapy?
"I believe it's going to help me, otherwise they wouldn't give it to me."
Despite the patient's belief that the treatment was "poison for my body", she nevertheless seemed able to construct a positive attribution of meaning of benefit.

towards the treatment, so maintaining a positive outlook in relation to her diagnosis and her expected outcome (as reflected in her answer to Question 5 below).

4. Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?
"No."

5. What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V, ask: Where do you think this expectation comes from - i.e. has anyone in your circle of family/friends/acquaintances told you to expect N & V?]
"Cure me up."

6. Did you ever think this could happen to you?
"No. I have a very positive mind -- it has alot to do with my mind. Disease catches you when you're under stress. Now I know how to cope -- I have a special casette to calm me down. I'm involved in the Kabbalah and in the people around."

This patient presents with an attitude of very positive thinking together with an ability to actively construct and create ideas, beliefs and attributions of meaning to her experience around the diagnosis of her cancer, as well as an ability to take charge for herself. An alternative aspect to her attitude may be the view that this is her way of denying the enormity of her burden and all the painful, associated feelings.

7. Do you feel angry? If so how angry? Scale 0-5.
"I'm angry at the doctors for the wrong diagnosis. They missed it and they didn't do a mammogram in the beginning. I'm not angry about the cancer, but I'm at number 5 for the doctors."

For this patient, it may be easier to direct anger at the doctors (however realistic and appropriate the anger is in terms of the misdiagnosis), rather than at the cancer in order to once again deny or mask over the fears and the burden of her diagnosis. She seems to have found comfort in constructing attributions of meaning of positivity within herself, her "positive state of mind", her expectation of "cure" from the "toxic" treatment, and by externalising her anger and any negativity.

8. What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?
"My husband, his three children, a special friend and good friends. They're very positive -- they get it from me. One friend's mother had chemo -- it was successful but she felt weak. I expect to be down but I'll take pills to cheer me up." Her husband added that he expected her to be nauseous and that he'd heard that dagga was useful for that.

9. Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?
"I was reading a book yesterday. It was about relaxation and those things. I'm thinking about hypnosis and I'm reading Jason Winters' book."

10. What are your thoughts and feelings about hypnosis?
"If it's going to do what I think, I'll go for it. I think it works on my subconscious and I want to go deeper."
This patient held an unusually clear and non-ambivalent positive attribution of meaning around hypnosis (in comparison to the ambivalence and/or negativity of the rest of the sample where only one other patient held the same clear, positive view because her husband had successfully used hypnosis to undergo dental work). This patient subsequently used this belief to help herself take control of and deal with her situation.

11. Would you ever consider using hypnosis to help yourself?
"Yes -- I'm prepared to try it. I have to have aggressive chemotherapy and I am prepared to try anything."

12. Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?
"Yes, definitely."

After the interview, while the patient was talking to a member of the medical staff, her husband told the researcher that she had been misdiagnosed originally and that her present diagnosis suggested a severe spread of the cancer, involving her liver, a serious complication. He did not believe that the prognosis was favourable, but although she knew of the cancer spread, she was prepared to take whatever action she could to fight the progress of the disease and to help herself. He believed that her highly positive outlook was helpful to her and he would do whatever he could to support her. In other words, the husband did not have a positive outlook regarding her prognosis, but he did hold a positive attribution of meaning in relation to her very positive outlook and her way of handling her illness. At that level he participated as an important, supportive, interactive person in her environment. From an ecosystemic perspective, although the husband's belief about his wife's prognosis was negative (hidden from her), he 'openly' supported her positive outlook and showed congruency with her way of thinking at this level. In this way, he helped to stabilise and maintain, rather than perturb his wife's already acquired set of ideas and associated attributions of meaning.

At this point in the interview, the patient was taken to her appointment for a set of scans in order to ascertain the extent of the spread. No treatment was commenced at this meeting. The patient was given her first treatment one week later, but did not come to the Breast Clinic beforehand and so did not meet with the researcher.

The following week, the patient (who, at this meeting looked pale, weak and fragile), reported that she had had a bad reaction to her first chemotherapy treatment. (The drugs used were Adriomycin (red drip) and 5-Fluorouracil cyclophosphamide (clear drip)). She felt very weak and tired, had severe mouth ulcers and was unable to eat. (The occurrence of mouth ulcers and severe physiological reaction, despite her very positive attitude, suggest drug-related side effects rather than psychological components). She was constipated, took the doctor's prescribed laxatives and when she had wanted to go to the toilet, she had fainted in the bathroom. As a result, she had been taken by ambulance back to the Johannesburg General Hospital. When she returned home she went back to bed. With no preamble, she said: "I want hypnosis for the mouth ulcers and my difficulty with eating."

The same office used for the preceding patient (Patient No. 1), was used, and a discussion around this patient's beliefs, needs, expectations and requirements regarding hypnosis, was undertaken. She had specific ideas about what would be useful, helpful and potent for her and said some of her ideas had come from books she had been reading. She stated that what she would find helpful would be visual images of soldiers, the army, planes and guns all used to fight the cancer. (It is interesting to note that this woman had been born in Israel and her choice of 'weaponry' may have been related to her original environment which was familiar with war weaponry used successfully against the enemy. Her attributions of meaning relating to victory as a result of the use of these weapons may have been influenced by this background and may have promoted this choice in her fight against cancer). She said she helped herself to relax by concentrating on her breathing, getting heavier in her body and then lighter, and then going into the mental images and she felt she would respond well to such a procedure. At her request, the personalised session was taped as it progressed, and it was arranged that she would meet with the researcher the following week at the Breast Clinic.

The following week the patient reported that she "felt fine" and it was noted that she did look healthier, stronger and more robust than the previous week. She said: "I am using the tape four times every day and I feel the benefits. *I believe it will help whether it does or not.*" This last statement shows the powerfully positive attribution of meaning which this patient constructed for herself and which she designated to hypnosis.

One week later, the patient again reported that she was feeling fine after her treatment. She stated that she had slight nausea for three days after her treatment, but that she "brushes it aside and it goes away -- it's not severe." This pattern continued for approximately two months. At that stage it was discovered that there was no change in her tumours and she was sent for further scans. She was told that the situation was serious and that the treatment dosage would be doubled. She told the researcher that she gets depressed at times, sometimes for three to four days at a time, but it lifts and that the tape helps and has a positive effect. Treatment with the increased dosage caused her a "bad time, with nausea and weakness and tiredness and alot of discomfort in my arms."

Throughout the increased chemotherapy regime, to which was added radiotherapy, the patient maintained her "very, very positive thinking and I'm very keen on hypnosis -- I use the tape every day and I believe it helps me. I've had nausea and vomiting for six weeks since they've started the high dose chemo, but I've coped. I have a positive outlook. They're talking about a liver biopsy but I don't want that. I'm doing my tape every day -- it's part of my life and I'm still very, very positive."

This patient was lost to further follow-up because her husband made the abrupt decision to take her overseas for further assessment and treatment with no clear-cut return date.

8.5.3 Discussion

As described in the literature, a patient's positive attitudes and strong beliefs seem to assist the patient in dealing with serious illness and suffering (Friedman, 1963; Goldstein & Shipman, 1961; Jacobsen, et al. 1988; Mathews-Simonton, 1984; Pattison, Lapins & Doerr, 1973; Rosenthal & Frank, 1956; Simonton & Simonton, 1975; Simonton, Simonton & Creighton, 1978). Despite a potent and clearly disabling treatment regime, this patient kept herself coping and buoyant with some sense of being in control and in charge of what was happening to her in her everyday life. Her personal constructs and attributions of meaning around hypnosis created a way of coping with her illness that was meaningful for her although, clearly, her physical condition was deteriorating, not only with the severe treatment side effects, but also as the cancer was advancing and was not responding to the treatment.

8.6 Individual Case Presentation: Patient No. 3:

8.6.1 Introductory Note

The third patient presented is representative of the sample of patients who held negative attributions of meaning with regard to hypnosis. Her outlook concerning hypnosis is in contrast to the first two patients presented above, and her beliefs and attributions of meaning around her illness and pertaining to hypnosis, although idiosyncratic and personal, are more in line (notwithstanding the personal differences) with the attitudes of the majority of patients in the sample.

8.6.2 Patient Details

This patient was a 35 year old, married, Caucasian female of the Methodist faith, recently diagnosed with breast cancer. Her address suggested a middle class environment and background. During the interview, she made no mention of any members of immediate family, only of friends.

8.6.3 Transcript of Patient No. 3

A transcript of the patient's answers to the questionnaire and a discussion of the relevant issues, follows:

1. When you were given the diagnosis of cancer did you think in terms of chemotherapy?
"Yes. I thought I was going to have to have my breast off, but when I didn't, I was happy about that. The shock is still there -- of the cancer."

The patient's initial belief/expectation that the cancer would be treated/removed by the removal of her breast was not fulfilled. Although she reports being "happy" with the non-removal, the consequence of the cancer still being contained within her body may perturb and shift her mental ideation, her attributions of meaning and her beliefs.

2. How anxious do you feel about the treatment? Scale 0-5.
"I've heard so many things that I don't know what to expect. I'm prepared for the worst. I think I would be about two with anxiety."

The patient's answer points to strong influences from external information sources which have impinged upon, and/or perturbed her own ideas to the point of confusion and a lack of clear attribution of meaning on her part. Her way of dealing with this

confusion is to prepare herself for all eventualities and to "expect the worst." Her 'self-protectiveness' also extends to her feelings of anxiety, which she assesses as two, a low level on the scale, despite her reporting, that she "expects the worst."

3. What are your thoughts and feelings about the chemotherapy?
"Hope it'll cure."

4. Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?
"Yes. One lady suffered alot -- in the glands. I know there's vomiting, you feel tired, there's losing your hair and feeling miserable."

5. What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V, ask: Where do you think this expectation comes from - i.e. has anyone in your circle of family/friends/acquaintances told you to expect N & V?]
"Don't know. I think maybe nausea and possibly losing my hair. I hear people say that's what happens -- those are the side effects. It's in the cancer book they distribute at the hospital."

The power of hearsay and external information is in evidence in this answer and again seems to blur the patient's belief system in relation to herself.

6. Did you ever think this could happen to you?
"No."

7. Do you feel angry? If so how angry? Scale 0-5.
"I was upset. Not really angry. I was angry with the doctor for not doing his job properly with the first test. He did a biopsy and afterwards he said there was nothing to

worry about. I saw the report and I then I saw a surgeon with a copy of the report and he said to keep checking, not to just leave it. The first doctor said it was a milk gland. So my anger at the cancer would be 0."

8. What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?
"I have friends. They've been talking. They say that it's not so lekker for the first three days after the treatments -- there's nausea and hair loss."

9. Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?
"No. Just what I've seen on TV. Silly programs."
Based on the potency of external influences on this patient as mentioned in the preceding answers, such an answer is likely to suggest a negative attitude and negative attributions of meaning with regard to hypnosis, for this patient.

10. What are your thoughts and feelings about hypnosis?
"Not interested."

11. Would you ever consider using hypnosis to help yourself?
"No."
Perhaps if this patient had heard positive stories or seen good TV programs, her attributions of meaning towards hypnosis may have been different.

12. Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?
"Probably could. I don't believe in things like that."
This patient is clearly influenced and guided by her belief system in her choices for herself.

This patient was given three chemotherapy treatments in the following five weeks (the drug used was Adriomycin (red drip)) and after each treatment reported that she had been "fine." The researcher noted that apart from stating that she was "feeling fine" on each subsequent interview session, the patient also looked well, her appearance verifying her statements. This pattern continued for the following two months at which stage she told the researcher that she was going to "have one, single high dose chemo tomorrow with six doses in one." In the follow up on this treatment, the patient reported being "sick" only once and that she had experienced hair loss, but was "feeling fine." At subsequent visits to the clinic for her checkups, the patient consistently reported that she felt "fine."

8.6.4 Discussion

It could be hypothesised that in preparing herself "for the worst," with regard to her chemotherapy, whatever the patient's consequent experience of the treatment was for her, she experienced it as 'less than' the worst and so was tolerable for her. Her level of denial may also have been useful to her. This outcome is in contrast to the outcome reported by Patient No. 1 where her level of anxiety, fearful anticipation/expectation and chronic state of worry may have promoted a form of self-fulfilling prophesy with regard to the severe side effects related to her treatment. Her treatment drugs may have been more toxic than those of Patient No. 3, but the high dose treatment given to the latter did not severely alter the pattern of her response to the drug, unless she chose not to report accurately so as to maintain a "fine" facade, or to avoid possible introduction of the issue of hypnosis again.

This discussion reflects the researcher's attribution of meanings to the patient's experience of her chemotherapy treatment. Clearly, the discussion remains hypothetical and unverifiable.

8.7 A General Discussion of the Disclosures and Findings of the Full Sample

Several factors, in addition to the idiosyncratic internal makeup of each patient as conceptualised by Maturana (1975) and discussed previously, appear to be influential in organising the personal and idiosyncratic attributions of meaning for each patient. These factors attempt to serve as additional facets of explanation and understanding in connection with the way each patient expressed herself and attributed meaning to her illness and her experiences related to the illnesss and will be described below:

(1). Socio-economic and patient-sophistication levels:

The majority of hospital patients used in this sample fitted into the lower levels of socio-economic and patient sophistication categories. Patients falling into these categories are less likely to be well informed with regard to the details, ramifications and concepts relating to cancer, its treatment plus treatment side effects and hypnosis. That no patient mentioned ANV prior to treatment offers support for this hypothesis. (Only one patient -- Patient No. 1 -- used the term after she had had several treatments, had experienced and described her ANV and had then asked the researcher about this phenomenon and whether it was a prevalent feature of chemotherapy treatment. As a result, she learnt and accepted the term from the researcher and used it in her subsequent verbalisations to describe her experiences).

(2). Influence of external information on issues relating to cancer, chemotherapy and hypnosis.

The combination of lower levels of education and associated level of intellect together with the likelihood of an unsophisticated and poorly stimulating environment would reduce the possibility of a wide range of awareness and knowledge in this group. These

patients would probably also be more likely to fit with the concept of the compliant group (mentioned below), with a concomitant attitude of helplessness, associated with expectations of knowledge and power attributed to the medical team treating them.

This picture with its intricate and interactive processes is closely interwoven with the idiosyncratic constructions of each person's reality and each person's attributions of meaning related to their personal experience of their illness. From a more general viewpoint, this is likely to contribute to manifesting as a constriction of experience. Consequently, this may be a factor in the paucity of content noted in some responses. An additional explanation could also be related to patient inhibition in talking to the researcher as: (a) a stranger (where the patient may not feel relaxed or free enough to be vulnerable and/or verbally open); (b) a psychologist (where the perception of psychology/psychologist may be intimidating and/or stigmatising, and thus constricting for the patient).

(3). Personal/personality style of each individual with regard to openness and acknowledgement or denial of feelings. This would be in tandem with the common cultural expectations of behaviour under the circumstances of illness and cancer in particular i.e. stoical behaviour and "stiff upper lip" attitudes prevalent in Western societies. This attitude is not only protective of the patient but also of the individual members within the culture who are in contact with the afflicted person and who may often find it difficult to deal with such issues. (As Patient No. 1 stated in her answer to Question 8 regarding her support systems of the people around her: "I have a wonderful family and also friends. But people are more silent once it happens to you -- then you can't know what they think").

(4). Compliance with authority figures, (which, although offered here as a wide generalisation, may be noted as a frequently prevalent characteristic of past generations of children growing up in the South African environment and particularly in the lower

socioeconomic and less sophisticated Caucasian members of those generations. These generations would fall into the now older age group of the sample seen at the Breast Clinic). If compliant behaviour does play a role in this context, it could be expected that many of the patients would probably/may possibly have a limited internal construction of developed ideas, opinions and ways of coping with their diagnosis and treatments. They would probably be limited in their outlook by however much or little external information they had encountered, together with the level of their ability to construct idiosyncratic attributions of meaning for themselves. Responsibility would probably be invested in the authority figures dealing with their treatments.

8.8 Conclusion

The cases presented in detail highlight the idiosyncratic variations in attributions of meaning of three female patients, who are all dealing with a similar life-threatening disease. This finding is in accordance with Dell (1985) who suggests that different individuals interpret the same incoming information differently. The use and application of ecosystemic hypnosis is demonstrated in the first two cases, with the third case offering a contrast, based on the patient's negative view of hypnosis.

The following and final chapter attempts to link the findings of this research with the preceding theory. How this material could beneficially be employed in the arena of medical dealings with patients and more generally in the field of psychotherapy, together with a discussion of directions for further research, is offered.

CHAPTER 9

CONCLUSIONS AND RECOMMENDATIONS

9.1 General Discussion of the Study

The theoretical background and the unique personal experiences of each individual subject in this study have concomitantly been presented as both separate, and with interconnected links throughout this work. A function of this chapter is integration i.e. a holistic view of the aforementioned theories, ways of thinking and the impact of this approach on the findings as they emerge and are evaluated.

The chosen stance in this study highlights or emphasises description, and minimises explanation with reference to the findings presented in Chapter 8. Traditional, quantitative methodology would have given priority to the methodological considerations, with emphasis on measurement rather than meaning, whereas the qualitative approach has focused on the personal and idiosyncratic experiences of each patient in the sample. This has allowed for an understanding of the unique meaning of the experience of being diagnosed with cancer for each particular patient, together with the unique meanings of the associated issues which were explored with each patient. As Stones (1986, p.117) succintly states: ".....any research approach, such as a quantitative one, which gives priority to the methodology as opposed to the phenomenon is based on inappropriate ontological reduction. Consequently, it is argued that psychology should aim more at being a descriptive science rather than an explanatory one." In addition to the preferred qualitative aspects, a quantitative view of the commonalities and differences of certain meanings has been added in order to offer further dimensions to the findings.

9.2 An Integration of the Concepts with the Findings

All meanings or attributions of meaning for individuals are idiosyncratically created and are maintained through social interaction -- this is inclusive of images of reality (Berger & Luckmann, 1966; Patterson & Garwick, 1994). It is through language, verbal and non-verbal, that these meanings are expressed, exchanged and thus understood by others in the particular person's environment (Anderson & Goolishian, 1988). This is in accordance with Maturana's (1975) concept of "structural coupling" which suggests that individuals fit in with one another in social space and so form a relationship between their idiosyncratic, structure-determined internal makeup and the medium or environment in which they exist or live (Dell, 1985; Patterson & Garwick, 1994).

For any particular individual, when an integration of these concepts, viz. structure-determined internal makeup and "structural coupling" takes place together with the interactional processes of shared consensual ideas emanating from or originating in that person's world, the importance of constructivist and social constructionist explanations arise, and in turn can be integrated into this holistic way of thinking. The creation and construction of that particular individual's idiosyncratic attributions of meaning and belief system(s) may then be described through the totality of this conceptual chain. These constructions and their associated meanings are not necessarily static and often tend to change over protracted time, as adaptations to, or as a result of new experiences. Changes may also occur more rapidly and spontaneously as a result of more immediate, dramatic and/or potently modified input from external sources, during which the particular individual will undergo internal changes with resultant shifts in the original attributions of meaning. Such an integrated and holistic stance fits within the framework of an ecosystemic view and as Fourie, (1996b) has stated, may be described as a "...process of making sense of a *total* circumstance, including contextual and attributional elements." (p.19, italics in original).

The findings of this study corroborate this description and offer a way of viewing patients in a medical situation which contrasts with the traditional medical model. This way of thinking is supported in a study undertaken by Limacher, Dahler, Bosch and Egli (1991) who emphasise that every physical illness has psychological and social dimensions and the importance of interdisciplinary perspectives should not be ignored in patient care. These authors state that quantitative research and knowledge pertaining to patient's presenting problems (back pain in their research), often preclude the physician's knowledge of his/her patient i.e. how much the patient is actually "known" by the doctor. This described lack of qualitative knowledge is likely to significantly affect the quality of patient care. One perspective on this suggests that what becomes known or conceptualised or "worked out" (Limacher et al., 1991, p. 67), between doctor and patient, is not something which can be quantitatively categorised or marked with crosses on a questionnaire sheet with any particular beneficial or valuable outcome resulting from this process of categorising.

In the present research, if patients would have been administered a questionnaire, the answers to which would have been statistically analysed and presented, the findings discussed in the research would have been notably different to what has been presented. Personal, idiosyncratic atributions of meaning may have arisen but would have been tabulated into categories and given statistical importance i.e. significance or non-significance, rather than being understood and/or utilised from an ecosystemic perspective -- not necessarily "better" or "more true", but different. What seems to be disregarded in the application of the traditional medical model to patients, is the aspect of the patient's individual way of integrating, perceiving and understanding his/her diagnosis, with the resultant attributions of meaning. The patient's view or beliefs may be different to the doctor's view or beliefs, and although the patient's perceptions may be assessed by the doctor to be medically inaccurate and therefore without relevance or value, these beliefs have strong validity, importance and influence for the patient. For the doctor to ignore or to negate these patient beliefs and perceptions, which are likely

to be deeply meaningful to the patient, may result in a breakdown in communication as well as a closing of doors on many of the possible avenues to treatment options. Such a situation might lead to precluding maximum patient cooperation, to the detriment of both patient and doctor.

9.2.1 An Illustration of this Concept Taken from the Present Study

An illustrative example of this concept may be seen in the patient who requested hypnosis, Patient No. 1 presented in Chapter 8. Initially, in response to the questionnaire, the patient's views on hypnosis were more negative than positive. If this first finding had been tabulated and analysed in a statistical approach, she would have been or become one of a statistical number, comprised of patients who had a negative view of hypnosis, for whatever reason, and that may have constituted the finality of the data. However, in the present study, where further meetings occurred with a chance for her to talk more personally with the researcher about her experience of her illness and her treatment, and the people in her life, she began to construct and evolve an altered set of ideas and attributions of meaning, with regard to hypnosis and how it could become a part of her life at that moment in time. Her original negativity relating to hypnosis shifted to a positive outlook probably through perturbation of her ideas by her interaction with "visitors". Their opinions, ideas and discussions which they expressed verbally in front of her, seemed to perturb her originally held, idiosyncratic ideas and beliefs about hypnosis, from something she did not want, to something which came to have value and positive connotations for her. With this shift, the researcher, utilising an ecosystemic frame of reference, was able to co-evolve, through language, an hypnotic experience for the patient, with the patient, in a way which was suitable and fitting for her attributions of meaning about hypnosis. This gave the patient a dimension which she could add to her coping repertoire and which she found highly beneficial in dealing with her disease and the medical treatment. As a statistic in a

quantitative study, this aspect with its personal meaning for the patient may have been overlooked and/or may not have emerged for her or for the research findings.

From her description of her experience with her medical doctor, shared with the researcher in one of the meetings, it seems that the focus of discussion was directed towards her symptoms and medication for these where possible, and her chemotherapy treatments and how many more she would need. Her severe anxiety at being kept waiting long hours by the doctor, the psychological and social content and context of her life, and her personal attributions of meaning in the situation were not explored or taken into account. This approach reflected the influence or role of the medical model and medical training, and probably also the limited time factor in the overpressurised hospital setting, where patient numbers necessitated setting a limit on time. However, in general as well as in this instance, the clear-cut, medical model, cause-and-effect approach excludes the holistic view of the patient, with certain impact and effect on the experience for the patient as well as the outcome of treatment.

The traditional role of the patient as passive receptor of a medical diagnosis and consequent medical dictum with regard to treatment and prognosis, may often leave a patient with a sense of helplessness and immobility, together with a shut down of communication and a wide dimension of unspoken feelings. These factors may not augur well for healing or cure.

If the doctor's trained viewpoint and the patient's personal attributions of meaning relating to his/her illness are in conflict, the way the doctor perceives this conflict and the way he/she deals with it, could have restricting and negative implications for the patient and the treatment. Conversely, this could become a co-constructed, co-evolving set of ideas with a consensual meaning which could then become creative and growth-producing for both parties, with a different outcome to the first postulation.

9.3 Limitations of the Study

Because of the emphasis on the qualitative, personal, idiosyncratic nature of the method used and the influence of this stance on the findings, future replication of this study to verify and prove the findings is neither possible nor valid. This study with its chosen approach stands as a statement in its own right, highlighting each patient's personal set of attributions of meaning in the particular circumstance of illness. From a traditional, quantitative and statistically biased viwpoint, this lack of possibility of replication may be seen negatively as a research limitation with the inherent criticisms. However, from an ecosystemic stance, as described in Chapter 2, such an interpretation holds little validity. In this respect, as previously mentioned, rather than one research approach being seen as better or more true than another, each approach may be more appropriately described in terms of difference.

The questionnaire contained a mix of closed and open-ended questions. Questions 1, 6, 11 and 12 were closed questions; 2, 3, 5, 8 and 10 were open-ended questions and 4, 7 and 9 were initially closed with a move towards opening up depending on the answer given. The intention of the questions was to attempt to glean an understanding of the patient's world and experience, following on the diagnosis of cancer. In devising the questions, the researcher was mindful of the possible intrusive nature of such questioning and perhaps in offering closed questions as part of the questionnaire, the researcher may have limited what could have been extracted. The researcher believed (researcher's attribution of meaning), that the issue of intrusiveness might apply more readily to persons who found themselves in an unfamiliar environment being questioned by an unfamiliar figure, particularly under stressful conditions such as the cancer clinic in the hospital setting. (As previously reported, despite this care taken, two of the husbands of patients objected to the nature of certain questions and refused further participation). In actuality, the closed questions were intended to be sensitive to the patients involved rather than simply closed questions, but may have limited the scope of

the answers. However, although some patients simply answered "Yes" or "No", approximately one third of the sample went on to elaborate their answers as if to fulfill their needs or, perhaps in the belief that an elaboration would please the researcher.

9.4 Indications for Future Research

The implications of this study which offer a direction for future research, highlight the point that even though patients depend and rely on the medical doctor in charge of their case to make decisions regarding treatment and for the general handling of their illness, they simultaneously have their own ideas and beliefs, attributions of meaning and anticipations around their illness and the treatment. These ideas, beliefs and attributions of meaning are not necessarily static and can change at short notice depending on input or perturbations from external sources (e.g. other people, the media). That the medical profession, certainly in this study, and probably generally in medical circles, disregard the patient's often powerful belief systems rather than utilising them in the treatment and handling of disease, suggests not only the manner in which doctors are trained, but also highlights the stereotyped sets of attributions of meaning in the medical profession. The scenario suggests that where attributions of meaning differ markedly (between doctors and patients), and where there seems to be no likelihood of discussion, dialogue or reciprocal interplay in this area, there is a closure of communication concomitant with an unwitting imposition of multifaceted limitations. The outcome of patients' experiences based on this closed process, is likely to be different to an outcome based on reciprocal interaction.

It is suggested that if aspects of medical consultations with patients could include such reciprocal discussions, it is likely that there could be benefits to both patient and doctor in different ways. In being heard, understood and simultaneously offered space to have participatory powers in the treatment and handling of his/her illness, the patient may shift already held ideas and attributions of meaning to a more beneficial way of viewing

his/her illness. For the patient, the sense of being more of a participant and more of an equal partner on some levels, may be a positive contribution to such an approach, with a concommitant sense of increased control for the patient over the difficult and often frightening experience of serious illness. Evaluation by means of further research, to assess whether this approach and these assumptions have benefits for patients (some patients, not necessarily all), over the traditional, authoritarian, reductionistic medical model, may prove fruitful. Such an approach would collude with the move away from Newtonian theorising to the second-order cybernetic stance and the associated ways of thinking as advocated in the present study.

9.4.1 Contributions of this Research Project

Based on these speculations, this research may be seen to add the following contributions to the accumulated "pool of knowledge" in this field. The contributions may be viewed as arising from two aspects:

(a) With regard to the theoretical approach: Application of the concepts of constructivism and ecosystemic thinking has largely been to the fields of family therapy, to hypnosis and to psychotherapy. The findings in this study suggest that these concepts would be equally applicable to the field of cancer treatment in particular, and in general to medicine as a whole. This study has highlighted the issue that in the field of cancer treatment as well as with regard to hypnosis, attributions of meaning are noticeably present and are often potent in their influence of the patient.

From a more specific vantage point, the proposed relationship between anticipatory nausea and vomiting and the concept of conditioning as indicated in the literature (mentioned in Chapter 1), may not be as clear-cut as suggested. The aspect of attribution of meaning i.e. in this particular set of circumstances, the patient's anticipation, expectation and/or belief regarding her physiological feelings of nausea

and possible emesis, which are based on her treatment experience, may have played an important role in determining the development and manifestation of ANV. This may be a separate issue in its own right or may occur in parallel with the concept of conditioning. If attributions of meaning are taken into account in the chemotherapeutic treatment of cancer patients, a new or additional approach utilising ecosystemic thinking to assist in the management of ANV could be offered. Since the standard approaches to date, using cause and effect medication techniques, inclusive of the latest drugs (mentioned in Chapter 1), have not had a satisfactory record of success in alleviating ANV, an approach using attribution of meaning may add benefits.

(b) From the aspect of clinical application: The findings of this research supports the importance of a holistic approach to patients in the field of medicine. The incorporation of a holistic approach into the curricula and training for medical degrees in order to introduce a new and wider dimension, could become a valuable and beneficial aspect of the practice of medicine. A fuller awareness of each patient's experience of illness would add a more humanistic dimension to medicine, in addition to the traditional, technical and mechanical aspects so prevalent at the present time. To neither utilise nor take a patient's attributions of meaning in to account (as the present medical system functions) is to deny and ignore a powerfully influential aspect of human functioning.

In support of this latter view and based on their research, Limacher et al. (1991, p. 67) state: "It is not the quantity of psychosocial knowledge about our patients that counts but, above all, the relationship, the exchange of information, and the way the doctor and patient cope with mutual information. It is not the numbers that are important, but what happens between human beings." They suggest, that: "...the aim is to understand the subjective process of the physician-patient interaction and to use this knowledge for further training" (p. 68). Following a similar train of thought, as with Melidonis's (1989) hypothesis, this approach could utilise the ideas, cognitions, constructions and

attributions of meaning of the clinician to perturb an already existing and possibly negative, idiosyncratic set of beliefs within the patient, to an altered framework with a more beneficial set of beliefs for that patient. At the same time, the doctor could understand the patient more holistically and at a deeper level, and consequently modify the treatment accordingly to fit idiosyncratically with the patient, with the possible outcome of a greater degree of benefit for that patient. Limacher et al. (1991, p. 67) state this differently, but with similar emphasis: "What happens and grows between a physician and a patient is important. Filling in questionnaires, statistical inquiries of our work can only touch surfaces. As in the world of arts, the essential cannot be expressed by numbers."

9.5 Conclusion

In support of Bloch (1987) and Capra (1987), the plea for a shift in emphasis from the patient, the illness and the symptoms with the associated symptomatic treatment, to a more holistic and ecosystemically oriented approach towards the individual person and his/her context, which is inclusive of his/her physical and psychological pain, cognitions, ideas, attributions of meaning and emotions, is proffered.

APPENDIX

QUESTIONNAIRE:

NAME; ADDRESS; PHONE NO (W & H); AGE; RELIGION; TYPE OF CANCER; NAME OF PRESCRIBING DR.; TREATMENT REGIMEN.

1. When you were given the diagnosis of cancer did you think in terms of chemotherapy

2. How anxious do you feel about the treatment? Scale 0-5.

3. What are your thoughts and feelings about the chemotherapy?

4. Do you know anyone else who has had chemotherapy? If so what do you know about their treatment?

5. What effects if any do you think the treatment will have on you? (How do you think the treatment will affect you?) [If they mention N & V* ask: Where do you think this expectation comes from - i.e. has anyone in your circle of family/friends/ acquaintances told you to expect N & V?]

6. Did you ever think this could happen to you?

7. Do you feel angry? If so how angry? Scale 0-5.

8. What support systems do you have in terms of the people around you? What do these people think the effects of the treatment will be?

9. Do you have any knowledge of hypnosis? If so where did you gain the knowledge and experience of it?

10. What are your thoughts and feelings about hypnosis?

11. Would you ever consider using hypnosis to help yourself?

12. Do you think hypnosis could be useful to help you deal with some side effects of chemotherapy?

N & V* : Nausea and vomiting.

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