

## Art therapy for women with breast cancer: The therapeutic consequences of boundary strengthening

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### Abstract

Between 2001 and 2004, 42 women with breast cancer (20 women in the study group and 22 women in the control group) participated in an intervention study involving art therapy. This article elaborates on previous quantitative results, taking a discursive approach and drawing on gender theories in analyzing the women's use of interpretative repertoires in interviews and diaries and their answers on single items of the Coping Resources Inventory (CRI). The aim was to inquire into whether and, if so, how and with what consequences women with breast cancer who participated in art therapy improved their access to beneficial cultural interpretative repertoires, compared to a control group. The results showed a connection between participation in art therapy, talking about protecting one's own boundaries, and scoring higher on the CRI compared to the control group. There was also a connection between the control group, repertoire conflicts, and lower scores on the CRI. Our interpretation is that art therapy became a tool the women could use to distinguish cultural understandings about boundaries and, through image making and reflections, to give higher legitimacy to their own interpretations and experience.

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*Keywords:* Art therapy; Breast cancer; Coping; Discourse; Gender; Narrative

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### Introduction

Art therapy has been found to be beneficial in the recuperation process for women after breast cancer surgery (cf. Öster et al., 2006). However, whether art therapy can actually contribute in specific ways to recuperation after breast cancer surgery, and if so, how this happens, is still not known. For example, are there dimensions of art therapy that speak particularly to issues, such as gender issues, that are at stake for women with breast cancer, or is art therapy just another non-specific remedy? This article addresses these questions, through close analysis of patterns in the qualitative and quantitative data in an intervention study involving art therapy. In the study, women with breast cancer who participated in five sessions of art therapy during radiotherapy scored significantly higher on the Coping Resources Inventory (CRI) after the intervention compared to a control group (Öster et al., 2006). More specifically, they assessed their access to personal–social resources more highly than did the women who had not participated in art therapy. Since

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quantitative data cannot give insight into the actual processes underpinning such assessments, we included several kinds of qualitative data in this study. In the present article, we use a gender–theoretical approach to analyze two kinds of qualitative data from the study (interviews and diaries). We combine these analyses with a closer look at the patterns of CRI scores, comparing women in the art therapy group with those in the control group. The purpose is to start pinpointing specific contributions to helpful processes in the recuperation period after breast cancer surgery that may tentatively be ascribed to art therapy, and to discuss how these contributions may be understood within larger gendered societal patterns.

Difficult bodily experiences often do not let themselves be satisfactorily captured in words and verbal forms of therapy. The purpose of art therapy in connection to experiences of trauma, illness, and treatment is to contribute non-verbal ways of enhancing feelings of health and quality of life (Malchiodi, 1999). Within complementary and alternative medicine (CAM), medical art therapy is defined as a mind–body intervention. There is now an increasing body of research on the benefits of art therapy. Below we set out some findings relevant for our study.

Generally, art therapy has been shown to help individuals to explore and develop their imagery and pictorial language (Luzzatto, 1998; Luzzatto & Gabriel, 2000). Research on the effects of art therapy has shown reductions in anxiety and depression, lowered levels of stress, and improved self-assessment of global health (Monti et al., 2006; Reynolds, Nabors, & Quinlan, 2000). It has been shown that art therapy in cancer care can increase communication, stimulate processing of traumatic experiences, reduce negative symptoms, and increase feelings of energy (Luzzatto & Gabriel, 2000; Luzzatto, Sereno, & Capps, 2003; Nainis et al., 2006; Ziesler, 1993). Looking specifically at breast cancer, art therapy has been found to help women with breast cancer confront existential questions and experiences of loss, body changes, and relations affecting their identities (Malchiodi, 1997). In other studies, women with breast cancer who participated in art therapy claimed that it helped them express thoughts and feelings (Borgmann, 2002), and to support meaning-making processes (Collie, Bottorff, & Long, 2006; Malchiodi, 1997; Predeger, 1996).

The above studies, though inspiring, offer few details about what happens in art therapy to specifically help women with breast cancer, and what actual effects on well-being and coping may accrue. Also, the studies almost entirely devoid of any gender perspective (for a single exception, see Predeger, 1996). This is an exclusion which we find somewhat surprising, considering the specific meanings, myths, and “functions” related to breasts, and thus, breast cancer (Thorne & Murray, 2000; Wilkinson & Kitzinger, 1994).

In this article, we apply a discursive approach focusing on patterns of interpretative repertoires in women’s narratives. The analytic term “interpretative repertoires” denotes registers of cultural resources that people have access to when making sense of experiences and communicating with others. It is through the study of how people talk about different phenomena and events that researchers can map how narrators use available interpretative repertoires to construct phenomena, events, and themselves (Edley, 2001; Potter & Wetherell, 2001; Taylor, 2001a, 2001b; Wetherell, 2001a, 2001b; Wilkinson, 2000). A discursive approach seems particularly relevant, since it has been shown that dominant discourses, or repertoires, relating to breast cancer can be disempowering, as they may limit women’s possibilities to construct their own stories (Collie & Long, 2005).

Such repertoires are evident in contemporary education and prevention campaigns for women with breast cancer. Much of the discussion is limited to the individual behaviour, lifestyle, and family history (Petersen, 2004). Research on women’s handling of their life situation after a breast cancer diagnosis has also often located such handling as lying exclusively within the women. It has promoted an individual psychological perspective with a dominating focus on personality types or coping styles, overlooking a contextual or gender–theoretical framework (Moynihan, 2002). Environmental factors, industrial practices, and gendered social arrangements are often left out (Petersen, 2004). Many educational texts are suffused by a strong Western cultural image of a diagnosis of cancer as a challenge which should lead to “fighting spirit,” “positive thinking,” re-evaluation, and growth (Wilkinson & Kitzinger, 1993, 1994, 2000).

Breast cancer is culturally associated with visible “female” aspects of the body (Bassett-Smith, 2001; Broom, 2001; Thorne & Murray, 2000). Historically, women have been advised to “keep” their femininity by concealing the physical signs of cancer treatments (Broom, 2001). Thus, gender issues should not be neglected when studying breast cancer treatment. For instance, gender-insensitive medicalization of women’s bodies in connection with a breast cancer diagnosis can curtail access to helpful understandings (Thomas-MacLean, 2004). As illness experiences are mediated by gendered power regulating social relations and constructing social identity, the analyses in this study are informed by gender theory (Crossley, 2000; Hogan, 2003).

## Aim

The aim of this study was to inquire into whether and, if so, how and with what consequences women with breast cancer who participated in art therapy improved their access to beneficial cultural interpretative repertoires, compared to a control group.

## Methods

### *Participants*

In this article, we report partial results from a study from which one article already has been published (Öster et al., 2006). In the main study, 42 women aged 37–69 years ( $md = 59$  years) with non-metastatic breast cancer living in the northern part of Sweden participated. The women were referred to the Department of Oncology at Umeå University Hospital for 5 weeks of postoperative radiotherapy. The women were distributed fairly widely over socioeconomic and educational backgrounds: 34 were married or cohabiting with a male partner and 8 women were single; 6 had no children and the remaining 36 had between one and six ( $md = 2$ ) children of various ages; 26 were employed, 3 were unemployed, and 13 were early retired or pensioners.

### *Study design*

The data collection took place between September 2001 and December 2004 when, in all, 55 women were consecutively randomized to either a study group with five individual art therapy sessions or to a control group. The randomization was computer generated by the Regional Centre of Oncology at Umeå University Hospital. Stratification was done according to whether the woman had received postoperative chemotherapy or not. All of the women who agreed to join the study met one of the two art therapists to receive detailed individual information about the study. At this meeting, each woman finally decided whether or not to participate. Each participating woman signed a written consent form in which she was assured that ending her participation at any time would not affect her care or medical treatment in any way. After the meeting, each woman was randomized into the study. The envelope with the results from the randomization was not opened until after the first interview to avoid possible effects of knowing the results from the randomization. A total of 42 women out of 55 completed the main study, each during 6 months. Causes of dropping out were too much strain ( $n = 7$ ), disease complication ( $n = 2$ ), and dissatisfaction with the randomization outcome ( $n = 4$ ). All 42 women who participated in the study completed questionnaires in connection with three interviews over 6 months; the first at baseline (start of radiotherapy) and the others 2 and 6 months after baseline. The questionnaires assessed coping resources, quality of life, symptoms, and self-image. In addition, all of the women were asked to write a weekly diary entry about their experiences, thoughts, and feelings concerning their life situation of breast cancer during their 6 months of participation and at the first interview each woman was given a lined notebook together with brief written instructions.

After finishing their participation in the study, the women who wanted them got their diaries back and a copy was kept for the study analyses. The women who asked for it also got a copy of each taped interview she had participated in (cf. Baylis, Downie, & Sherwin, 1998; Taylor, 2001a). The study protocol was approved by the Umeå University Ethical Committee at the Medical Faculty (archive number 99-386).

In the present article, results from the interviews 6 months after baseline and diaries are in combination with results from the CRI used to answer the questions proposed in the study.

### *Art therapy design*

The art therapy intervention was led by either one of the two trained art therapists (the authors IÖ and KET). The overall goal of the art therapy intervention was to (1) give each woman time and space to reflect on and express her experiences, thoughts, and feelings about her situation; (2) give her support in the process of restoring her body image; and (3) reduce stress and strengthen her ability to cope with the breast cancer experience. Every session contained direct experience with art material (pre-art play), the process of art work, visual display, distancing, looking to see, description and sharing, and study of structure, interrelated components and whole-quality, connecting, and integration

(cf. Betensky, 1995). The women returned to their images at the end of the second and third interviews as the art therapist brought the images with her. The design and content of each art therapy session are described in Table 1 and in an earlier published article (Öster et al., 2006).

## Empirical material

### *Interviews*

The three interviews with each woman during her 6 months of participation were carried out by the two art therapists (the authors IÖ and KET), with a total of 126 interviews. The interviews lasted from about 45 min to 2 h and were tape-recorded with the permission of each woman. The interviews took place in a room in an outpatient lodging in Umeå close to the University Hospital. Of the second and third interviews, 29 were conducted by telephone due to long travel distances. The third set of interviews ( $n = 39$ ) was analyzed for this article, with 18 interviews from the study group (art therapy) and 21 interviews from the control group because we only had summaries from 3 interviews due to technical hitches. The interviews were thematic (Polit & Beck, 2006), guided by specific questions. The questions were developed by the project group consisting of an associate professor in nursing, a gender researcher who is also an associate professor in psychology, two physicians who are also oncology specialists, one art therapist who is also a doctoral student in nursing and gender studies, and one art therapist who is also a doctoral student in psychotherapy. The themes were the discovery of the breast cancer; earlier experiences of cancer; the woman's own reactions and reactions from others in connection to the disease; whether the woman had somebody to talk to; her thoughts and feelings about the disease, treatments, and care; ways in which the diagnosis had changed her life; how relations to others had been affected; how the women managed everyday life after the diagnosis; and thoughts and feelings about being dependent on others and about the future. At the first interview, an opening question was asked as an invitation to narrate freely. This question was something like: "Please tell me about your experiences of having being diagnosed with breast cancer." At the second and third interviews, the initial question was something like: "Please tell me about how you have been getting on since we met at the last interview." The interviews were designed as conversations and the thematic questions were used only if the women did not spontaneously touch upon the themes above (cf. Seibold, 2000). Women who had participated in art therapy were encouraged to talk about their experiences in those sessions. The two art therapists took turns leading the art therapy sessions and conducting the interviews, so that the women would feel free to express both positive and negative experiences. Finally, each woman was asked about how she had experienced being interviewed.

### *Diaries*

In all, 38 women wrote diary entries, 19 women from the study group and 19 women from the control group. Four women did not write any diary entries; three of these did not want to do so, and one woman had not received a diary due to a misunderstanding. The women who kept the diaries wrote in many different ways: short daily notes, summaries, weekly notes, and long, daily stories. Two women had chosen to write using a computer. Two women had written two parallel diaries because they wanted to keep some of their experiences, feelings, and thoughts private (cf. Seibold, 2000).

### *Questionnaire*

Coping resources are defined as "those resources inherent in individuals that enable them to handle stressors more effectively, to experience fewer symptoms upon exposure to a stressor, or to recover faster from exposure" (Hammer & Marting, 1988, p. 2). The CRI has been developed to measure individuals' currently available resources and competencies for handling stress in different trying situations. The instrument consists of 60 statements which can be answered through a four-grade scale: never or rarely (1), sometimes (2), often (3), and always or almost always (4). CRI is divided into five domains: cognitive, social, emotional, spiritual/philosophical, and physical. The sum of the scores for the five domains constitutes the total score. Higher scores indicate greater coping resources (Ekekrantz & Norman, 1991; Hammer & Marting, 1988).

Table 1  
Art therapy intervention program: content, intermediate aims, and artistic media

Art therapy sessions	Intermediate aims	Art material
<p><i>Session 1:</i> The woman was given information about art therapy and the available art materials. A method of drawing analogues was used (Edwards, 1987; Grätz, 1978). The woman was invited to explore one or several analogues in images using colours.</p>	Through direct experience of art materials, the aim was to encourage the woman to express, in pictorial form, her own experiences and to reduce pressures of performance in order to facilitate expression, agency, and meaning through in a playful, reflective, and creative process within a safe environment.	Sheets of paper, 40 cm × 50 cm, a roll of paper, oil pastels in 48 colours and oil, tempera/fluid paint: green, yellow, blue, red, black, white, and sienna, lead pencils, charcoal, tape, paintbrushes and a scissor.
<p><i>Session 2:</i> A life-size body outline was created (cf. Luzzatto et al., 2003). The woman was asked to choose one colour for the contour line of her body. The art therapist drew the contour while the woman leaned against paper taped on the wall. Within the body contour the woman expressed different feelings in her body using various shapes and colours.</p>	The aim was to give the woman an opportunity to explore and reflect on sensory experiences and emotions in her whole body.	Art materials as described above.
<p><i>Session 3:</i> The woman was invited to express herself through free painting.</p>	The aim was to encourage agency.	Art materials as described above.
<p><i>Session 4:</i> The woman was invited to express herself through free painting.</p>	The aim was to encourage agency.	Art materials as described above.
<p><i>Session 5:</i> All drawings/paintings were pasted on the wall. The woman was invited to look at them silently and, in reflective talk, review the art therapy process. Finally, she created a concluding image.</p>	The aim was to tie together the art therapy process (which was timed to coincide with the radiation period).	Art materials as described above.

## Analysis

### *Analytical approach*

A diagnosis of breast cancer confronts women with social and cultural images of femininities that can affect their identity in many complex ways (Bassett-Smith, 2001; Thorne & Murray, 2000). Within critical discursive psychology, identities are studied as changeable constructions adapted to different social contexts. Identities are seen as result of social, historical, cultural, and situational negotiations and are connected to political, economic, and symbolic power and status. For our analysis, we found critical discursive psychology and the concept of interpretative repertoires useful as they put emphasis upon human agency within the creative and flexible use of language (Edley, 2001; Potter & Wetherell, 2001; Taylor, 2001a, 2001b; Wetherell, 2001a, 2001b). Some repertoires are culturally dominant/hegemonic and therefore more accessible as taken for granted “truths.” A discursive approach is well suited for studying how people as actors use language to construct versions of their experienced social world and themselves (Edley, 2001; Potter & Wetherell, 2001). The discursive approach used in this study is open-ended and iterative and thus time-consuming. We focused on variations and searched for patterns of repertoires and their functions and consequences. We did this from a starting point of not knowing what they would be about or look like, and so we returned to the data repeatedly over a long period. When patterns of repertoires are found, one should write them down but continue looking for new ones. The research questions then limit the areas which are selected for analysis (cf. Taylor, 2001a).

### *Performing the analysis, step by step*

The process of analysis started with the verbatim transcription of the interviews and diaries. Then the first author (IÖ) read through the 38 diaries several times as the women’s entries dealt with the process from inclusion in the study at the start of radiotherapy until the third interview 6 months later. For each diary, an individually oriented thematic description of one to three pages was written. The descriptions contained information about the women’s experiences that stood out as central for us. In order to deepen the understanding, the summaries were read through repeatedly as new patterns were discovered (cf. Magnusson, 1998; Potter & Wetherell, 2001; Taylor, 2001a; Wetherell, 2001a, 2001b).

In the next step, all 39 interviews from the third occasion were read through many times by the first author (IÖ). From each interview, page references were written down identifying where talk concerned a certain theme. The authors EM and SÅ continuously, together with the first author, evaluated and validated the ongoing analysis.

The purpose of reading the diaries and the interview transcripts was to get an overview of how interpretative repertoires were used by the women in the study group compared to the women in the control group (cf. Potter & Wetherell, 2001; Taylor, 2001a; Wetherell, 2001a, 2001b). The several readings resulted in patterns of interpretative repertoires which different women used. The use of the repertoire related to gendered boundaries was also validated through reading these women’s first interview transcripts at baseline. One woman from the study group was excluded from the analysis, as we only had a summary of her third interview and she had not written any diary. The analyses therefore comprise 41 women: 19 women from the study group and 22 women from the control group.

After completing the qualitative analytic work with diaries and interviews, we retrospectively returned to the results from the quantitative measurement (CRI) in order to identify whether and how the self-assessments diverged from baseline until 6 months for each woman and for the women using the different interpretative repertoires.

The last part of the analysis compared how women in the two groups responded to the 13 statements within the social domain in the CRI.

## Results

There were systematic patterns in how the women in our study made sense of their experiences after the breast cancer diagnosis. In the narratives about their experiences, three different interpretative repertoires featured prominently. There was navigation between repertoires, but the majority of women clearly favoured one over the others. However, for a few women, repertoire conflict was prominent. In reporting, we have concentrated on the most dominant repertoire for each woman. The repertoires related to (a) gendered boundaries, (b) breast cancer as a challenge and a learning opportunity, and (c) stoicism in the face of adversity. Finally, (d) confusion and uncertainty about adequate repertoires for some women was important enough to warrant its own category in our analysis.

*A repertoire of gendered boundaries*

The repertoire of *gendered boundaries* concerns the possibilities (or lack of possibilities) to protect one's own needs and give priority to one's own interests in life. Such possibilities have historically been gendered in very distinct patterns. We make use of the concept "boundaries," as developed by the American psychologist Ellyn Kaschak's (1992) in order to analyze connections between gendered power in society and individual identity formation. Boundaries define the protection of personal needs in relation to the needs of other people. Women's boundaries have historically been weaker and more permeable than men's. Women's boundaries have also often been defined, questioned, and violated by others. Like all culturally defined positions, boundaries are relationally created, maintained, and negotiated (Kaschak, 1992).

Women in the study group were the ones who mainly made use of arguments related to gendered boundaries (11 women in the study group, 5 women in the control group). Thus, the art therapy sessions may have contributed to making such arguments more actively available to some participants. These women described gaining greater insight into how much they were prepared to permit people around them to expect from them. These women also told of experiences of taking part in dialogues on equal terms with others, getting factual information, not having others' feelings and ideas about cancer attributed to them, and having their choices respected. Some told of feeling forced to stand up for themselves in order to have their opinions respected or to gain space for their own needs—and of succeeding in doing so. Thus, these women certainly had encountered resistance from people around them, but reported finding new ways of handling such resistance. In the following, we illustrate different ways in which these women made use of a boundary repertoire in their narratives. The first quotation (from a diary) illustrates what we might call the discovery stage—beginning to realize the need to demarcate one's own boundaries: "When I was at my second session with the art therapist, I got to paint how it felt in my body. There are so many things that leave traces in the body; I noticed that when I painted/. . ./Afterwards, when I thought of how I painted, I realized how much I abstain from saying so that other people won't get worried/. . ./When I get back home, I think everybody wants everything to be normal again. But I will never be the way I used to be/. . ./I have already noticed that people don't like it when they don't recognize me. There are so many things I'd like to clean out from my life/. . ./I will learn to live, not just be there for others but mostly for me." (study group).

Later, in the diary, this woman recounted having become more explicit about her need for boundaries against people around her: "/. . ./I have let myself be used sometimes to a certain extent; when it reaches a certain limit I put my foot down and then that's that: I'm willing to go this far, but no further!" (study group).

The women who used a boundary repertoire emphasized the need to break old habits in order to change their situation, as the following quotation illustrates: "Before, I used to think that you had to be first and last everywhere, but you don't, and I am learning that, so when I have done my four hours, I leave for home/. . ./" (study group).

It was common among these women to point out that insights had been facilitated through the spoken, written, and painted narratives in the study. But they also emphasized that there was work involved: beginning to explicitly uphold one's own boundaries demanded both time and conscious effort. They saw this as a long process of careful weighing of one's whole life situation as well as courage to both realize and be prepared to deal with the consequences. One woman in her diary reflected over these processes in relation to her work situation: "Today I am going to my work, and I have mixed feelings about it. Most of all I have been thinking a lot about how I will be able to set boundaries now. New, different boundaries. I have felt anger over how much I have done before, without getting back what I think I deserve, in form of expressed appreciation, salary, advantages such as good work schedules, trips, courses, and influence." (study group).

Many women in the study group said, or wrote, that taking part in art therapy made them feel proud to manage something new. They also told of feeling supported by their own images, and recounted situations where their images had functioned as instruments helping them handle situations in real life. One woman described how her image had helped her to put up boundaries against demands from others: "/. . ./the anger and this 'leave me alone' (title of image)/. . ./I have had difficulty saying no and I would be everywhere and I would help everyone but now: no, I don't want to!" (study group).

In sum, in our study, the women who recruited repertoires of gendered boundaries in their narratives generally told about new and more constructive ways of rationing their time and energy, and about being able to protect their own needs even when this demanded standing up against opposition in everyday negotiations.

### *Breast cancer as a challenge and a learning opportunity*

Gender-informed analyses of media representations of cancer have shown that the idea that a cancer experience can be educational and “teach” a person something is especially connected to women with breast cancer. They are often portrayed as developing qualities such as altruism out of the cancer experience. Men, on the contrary, tend to be described as having a pre-existing character with qualities which are tested by the cancer experience but remain largely unchanged (Seale, 2006).

We were thus not surprised that many of the women in our study at some point talked about their experiences in terms of “an educational challenge.” However, though one-fourth of the women used this repertoire, it was the dominating understanding for five women’s narratives only (two women in the study group, three women in the control group). These women all described the breast cancer diagnosis as a challenge containing a message. “This has given me a second chance” and “One learns from all such experiences” were common expressions in their stories. The imperative of learning and growing as a human being as a result of the cancer diagnosis was central. For a few, this learning concerned paying more attention to one’s body signals and slowing down in life. For others, the message contained an explicit moral dimension. For instance, one woman suggested that both she and people close to her needed to learn to be more humble. A recurrence of the disease, she said, would be a message that she probably had not learned anything: “You need some adversity or—to learn to appreciate, and learn to be grateful—to become a little humbler. And I think that this thing has made me remind myself even more of this, to try to be a better person. So, there’s some meaning to this, it isn’t just some kind of exclusion, I don’t think so at all/. . ./if I was meant to have a recurrence, then I have a recurrence, and then I haven’t learned anything by all this. . .” (study group).

All the women who used this repertoire talked about the breast cancer as a sign that there was something they ought to change about themselves, their lifestyle, or their behaviour. In that sense, this repertoire tallies well with contemporary individualist thinking along similar lines in many parts of societal life (Crossley, 2000; Giddens, 1996).

### *Stoicism in the face of adversity*

Stoicism in relation to being diagnosed with cancer is often portrayed in media as a male characteristic connected to strength and a realistic attitude (Seale, 2006; see also the previous section on gendered expectations). However, in northern Sweden, stoicism is often described as a common and culturally preferred attitude regardless of gender, and it applies in most aspects of life including when dealing with a cancer diagnosis. Thus, in this group, 11 women predominantly used this repertoire (5 women in the study group, 6 women in the control group). They all focused their narratives on acceptance and/or probability, saying, for instance: “It is such a common disease, so why not me?”, or “Every third human being gets cancer,” or “This belongs to the infirmities of old age.”

These women compared themselves to family, friends, or acquaintances and the strains and diseases that they were suffering from. In particular, the older women in our study who had additional diseases and/or dysfunctions portrayed the breast cancer diagnosis as a small strain compared to other strains in their lives. Women who had experienced great stress in connection to a family member’s illnesses and diseases, functional disorder, addiction, or death told similar stories. Three women recounted how the pain and reduced movement caused by other diseases or functional disorders already restricted and made their everyday lives difficult. At the same time, these women emphasized how highly they valued being able to manage everyday life: “/. . ./daily life is important. The days become even more valuable, and one tries to make the most of everything—one has so incredibly much to be grateful for, if one stays healthy and can manage daily chores.” (study group).

In spite of the fact that a cancer diagnosis is life threatening, it seemed that the women using this repertoire found some solace in using comparisons to downplay the severity of their own situation with breast cancer. This repertoire became a way to narrate how they managed everyday life despite all strains.

### *Confusion—repertoires in conflict*

Repertoire conflicts were seen almost exclusively in the control group (one woman in the study group, two women in the control group). The conflicts between repertoires that their narratives evidenced gave the impression that these women were unable to find a lasting way of understanding their life situation. Their stories contained dimensions related to being a good patient, mother, partner, and colleague. They uneasily moved between wishing to be there for



others versus needing access to one's own time; feeling forced to embrace unfamiliar opinions versus claiming one's own opinion; feeling forced to develop and change versus accepting oneself; trusting "experts" versus trusting oneself; having caused the breast cancer by a "faulty" lifestyle versus having little impact on influencing causes of breast cancer; and being versus doing. Some had found that their own experiences and feelings were not in accordance with accounts by health care "experts." These women also described feeling unaccustomed to reflecting on themselves, their bodies, and their situations. They talked about feeling unsure in relation to themselves and their bodies, and said that they ought to listen more to their own bodies, take a break, and try to take hold of their condition. But they also said that they were unaccustomed to doing that and they did not always know how to interpret body signals. Many of them had not noticed any signs before the detection of their breast cancer, and this also made them feel insecure in relation to their bodies. These women also mentioned that in their daily life, it usually had not made any difference whether they were feeling good or bad, they just used to do what "had to be done" as demanded by others. One woman described collisions of different expectations when her physician encouraged her to be aware of signs from her body: "To try and find out how I feel—that's something I actually haven't done before. I have never done that, I have just made up my mind about how to do things—there are certain things that have to be done, and then I have done everything whether I have been tired or not. It has never really been important how I have felt." (control group).

Time was central in these women's stories. They talked about undisturbed time as a commodity in short supply, a luxury, and something that they were unaccustomed to having. Undisturbed time would provide rest and reflection, a chance to be by themselves and just do something pleasant in order to regain their strength. However, many said that they did not want to complain and make demands and they talked about the conflict of wishing to be there for others versus needing access to their own time. One woman's account illustrates: "Many of the people I have had around me this summer are ones I no longer have time for. . . /this makes me feel guilty but the equation is impossible: job, kids, parents, etc. I want to try to give priority to exercising and spending time outdoors, but I don't get much of that done either. . ." (control group).

These women posed many questions in their stories, and some gave the impression of feeling that something was wrong with them, so wrong that they were on the verge of labelling themselves lazy or failures. One woman wrote in her diary about how she felt inadequate when she compared herself to others: "There are so many demands on me. Even if I tell myself that I am who I am, and do things the way I want to, I can't get rid of the feelings of stress. I feel somehow that I am not allowed to be as lazy as this, although I am on sick leave. . . /Think about all the others who work at their jobs, and are also able to do so much at home. . . ." (control group).

Being caught in repertoire conflicts seemed akin to having lost one's direction, having no available repertoire that was stable enough to lean on. Among the women evidencing conflict, disparaging comments about themselves were common, as well as expressions of guilt feelings, and feelings of inadequacy about things they ought to do or qualities that they ought to have.

### *Interpretative repertoires in sum*

The use of the *repertoire of gendered boundaries* showed large differences between the study and control groups: more than half of the women who had participated in the art therapy intervention used this repertoire but barely one-fourth of the women in the control group did. Major differences were also seen in the occurrence of *confusion—repertoires in conflict*: only one woman from the study group but one-third of the women in the control group showed such conflict. The other two repertoires, the *breast cancer as a challenge and a learning opportunity* and *stoicism in the face of adversity*, were used by almost equal numbers of women in both groups.

### **The Coping Resources Inventory**

After completing the qualitative analysis, we returned to the results from the Coping Resources Inventory (Hammer & Marting, 1988) to relate repertoire use to patterns in score changes from baseline to 6 months later. We found that 11 out of 19 women in the study group (included in the analysis in this article) had scored higher after 6 months and that 10 of these women mainly used the repertoire of *gendered boundaries*, while 1 used the repertoire of *stoicism in the face of adversity*. Out of the 22 women in the control group, 5 scored higher after 6 months: of these, 4 women mainly used the repertoire of *gendered boundaries* and 1 woman used the repertoire *breast cancer as a challenge and a learning opportunity*. The remaining women in both groups either lowered their scores or had similar scores after 6

months. Of the women who displayed *confusion—repertoires in conflict*, all but one had lowered their scores after 6 months. In sum, these analyses showed a connection between the use of repertoires of *gendered boundaries* and higher scores after 6 months, while no such connection was seen for the other interpretative repertoires.

In the concluding analysis, we studied how the women had answered the 13 different statements within the social domain in the CRI (Hammer & Marting, 1988). Earlier published results had shown significant differences in this domain after 6 months favouring the study group (Öster et al., 2006). The comparisons showed that the result for four statements differed between the study group and the control group. These statements were statement 8: “I am comfortable talking to strangers,” statement 9: “I am part of a group, other than my family, that cares about me,” statement 27: “I initiate contact with people,” and statement 35: “I enjoy being with people.” Women who had participated in art therapy predominantly answered these statements with “Always or almost always” and “Often,” while women in the control group mostly answered “Often” and “Sometimes.”

## Discussion

Interpretative repertoires are powerful cultural resources that help people organize and make sense of their experiences. Different repertoires have different origins, and probably also different consequences for the individual, as the analyses in this article suggest. The purpose of this study was to discern patterns in how art therapy influenced the ways in which women with breast cancer used interpretative repertoires in the recuperation period. We also wanted to start looking at possible connections between different repertoires and improvements in coping strategies. Our analysis showed that women who had participated in the art therapy intervention, considerably more often than the controls, by making use of repertoires of *gendered boundaries*, were able to access ideas and practices that gave legitimacy to an active protection of their own boundaries against others. These women improved their total scores on the CRI.

The results in this study are unique. To the best of our knowledge, there are no published studies showing an art therapy intervention resulting in women strengthening their boundaries *and* showing that such boundary strengthening can be connected to improved scores on the CRI. We suggest that for these women art therapy became a tool that helped them to recognize, and then distance themselves from, traditionally gendered understandings of legitimate limits and boundaries that give women less space and less boundary protection. We also suggest that the women, through image making and reflections on their images, were able to give legitimacy to their own interpretations and experiences.

Experiences of being diagnosed with cancer are very often like “being thrust suddenly into a self-conscious living which is bathed constantly in the shadowy light of death” (Colyer, 1996, pp. 497–498). Anxieties of family, friends, and colleagues can intrude powerfully into women’s reflections on their choices in the recuperation period (Broom, 2001). Here, art therapy can make a difference: during the art therapy sessions in our study, the participating women often expressed surprise when they discovered strength and energy as well as new abilities to take action (cf. Predeger, 1996). These experiences are in accordance with similar results described by Nainis et al. (2006). In their study, adults with a cancer diagnosis showed significantly reduced levels of fatigue and increased levels of energy after taking part in an art therapy intervention, compared to a control group.

We think there is reason to believe that such experiences are related to the preferential right of interpretation, a cornerstone of art therapy which gives the client the power to define the situation: that is, it gives validity to the client’s choice of repertoires (cf. Hogan, 2003; Malchiodi, 1997). In this light, it is interesting to note that in our study *confusion—repertoires in conflict* was seen practically exclusively in the control group. Repertoire conflicts, as we saw, involve oscillation, which is felt as insecure and unpleasant. Achieving legitimacy for one’s own interpretations and repertoires may be a necessity when making sense of experience, and art therapy may be one way of enhancing such a process.

Being given an opportunity to verbalize and express experiences, feelings, and thoughts was something that the participating women strongly emphasized as a way to make their situation clearer for themselves. Otherwise, dominating sociocultural discourses surrounding breast cancer, and regulating practices, understandings, and talk about the disease, can silence women or force them to stay with un-constructive repertoires that counteract improvement (Broom, 2001; Collie & Long, 2005). To address this, health care professionals and art therapists need to be aware of the complexity of repertoires relating to these issues, and the consequences of them. Such awareness will help professionals both to acknowledge diversity and to encourage and enable disruption of dominant traditionally gendered discourses.

In our study, stories about being aware of and defending one’s own boundaries showed a connection to higher total scores at the CRI at 6 months after baseline. On the 13 single statements within the social domain in the CRI,

the women in the study group answered that they felt more connected to other people and enjoyed social interaction more than those in the control group. Similar results have been found by others after other art therapy interventions in cancer care. Gabriel et al. (2001) described how communication with family and friends was facilitated and improved after participation in art therapy. In another study, the participants described how they had overcome fears to express themselves and had improved their trust, respect for, and empathy with other people after a 10-week art therapy program (Luzzatto & Gabriel, 2000). In a study by Monti et al. (2006), social functioning was significantly improved among people in an art therapy intervention group compared to a control group. These examples can all be seen as related to issues of defining boundaries against other people's demands, establishing limits for one's own space, and understanding and mastering such issues in constructive ways, similar to the women in our study who had taken part in art therapy.

We prefer to interpret our results in terms of *limits* and *boundaries*, concepts that Ellyn Kaschak (1992) has developed in order to analyze connections between gendered power in society and individual identity formation. She describes how identities and relations are often affected in destructive ways by traditionally gendered limits and boundaries. We believe that there is much to learn from closer analysis of these issues. Consequently, in a forthcoming article, we will analyze the women's narratives of consequences of different culturally gendered understandings of limits and boundaries in relation to their experiences of being diagnosed with breast cancer.

## Acknowledgements

Contract grant sponsors of the study were the Swedish Research Council, the County Council of Västerbotten, the Cancer- and Traffic-Injured Rehabilitation Foundation (CTRF), the Elsa and Folke Sahlberg Fund for Medical Research, and the Medical Faculty of Umeå University. We sincerely thank all of the women who participated in the study and shared their stories. We would also like to thank Marie Sjödin, MD, and Ulla Sandgren, RN, of the Department of Oncology, for help with administration in the recruitment of the patients.

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