

Interview Methodologies for Addressing Autobiographical Ruptures and (Re)Constructing Life Narratives

A Longitudinal Study Among Prostate Cancer
Patients and Their Spouses

Riikka Talsi



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Aalto University
School of Science
Department of Industrial Engineering and Management

Supervising professor

Assistant Professor Natalia Vuori

Thesis advisors

Professor Emeritus Esa Saarinen, Aalto University, Finland
Senior Lecturer Aarno Laitila, University of Jyväskylä, Finland
Professor Timo Joensuu, Docrates Cancer Center, Finland

Preliminary examiners

Professor Jaakko Seikkula, University of Agder, Norway
Professor Miguel Gonçalves, University of Minho, Portugal

Opponents

Professor Jaakko Seikkula, University of Agder, Norway

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Abstract

Major life changes may cause an autobiographical rupture and the need to work on one's narrative identity. In this dissertation, I developed new interview methodologies to work through an autobiographical rupture experience and to support the (re)construction of life narratives. Ten newly diagnosed prostate cancer patients, five with their spouses, participated in the study. Each patient/couple participated in five narrative in-depth interviews during cancer treatment and later in a follow-up interview. The interview series offered the participants several ways to talk about their cancer experience and life, and to re-evaluate and re-construct what they had previously said.

In the Momentary Key Metaphor methodology, the interviewee is asked to describe the illness experience using metaphors and to reflect on their personal meaning. In the follow-up interview, the metaphors are returned to the interviewee for retrospective review. The metaphors provided the participants with a tool to explore, summarize, and reflect on a complex, often contradictory experience at different stages of its development. One key finding was the polyphonic nature of the metaphors. The construction of polyphonic metaphors helped the participants work with emotions, tolerate uncertainty, and deal with different aspects of their experience. The couple context introduced the voice of the spouse and highlighted the mutuality in the couple's dyadic coping process. At the beginning, when uncertainty was high, the spouses used metaphors to create hope. As the patients' agency became stronger, the spouses were able to express their own vulnerability.

In the Clip Approach methodology, the interviewee's narration is reflected back through visual artifacts, "the Clips," that allow the interviewee to re-enter their cancer experience and life, and re-construct their narratives concerning them. The Clips returned the narration in a tangible, re-constructible form in the narrator's own voice. They supported participants in developing self-observation and helped them move from the object position of a serious illness to the subject position of an active agent. The construction of a life story through the use of the Clips supported autobiographical reasoning and helped to explore and re-evaluate meanings, build a bridge between the past and the future and embed the cancer experience as part of the participant's life narrative.

In the dissertation, I propose a series of interviews as a patient-centered guidance and counseling intervention for cancer care. The methodologies can be used to address and explore autobiographical ruptures in a variety of life-changing situations, and they offer encouraging potential for low-threshold psychosocial support interventions in a range of application areas. They may also provide new tools for existing contexts. The Clip Approach suits environments with time for collaborative work, like psychotherapies. The Momentary Key Metaphor can be used as a dialogic opening even in shorter encounters, for example during medical appointments in a longer treatment relationship.

Keywords life narrative; illness experience; narrative identity; prostate cancer; patient-centered; spouse; couple; interview; methodology; visual; artifact; metaphor; meaning; self-reflection; dialogic; polyphonic; low-threshold; qualitative; hermeneutic; longitudinal

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Tekijä

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Väitöskirjan nimi

Haastattelumetodologioita omaelämäkerrallisten murrosten käsittelyyn ja elämäntarinoiden (uudelleen)rakentamiseen

Julkaisija Perustieteiden korkeakoulu**Yksikkö** Tuotantotalouden laitos**Sarja** Aalto University publication series DOCTORAL THESES 37/2024**Tutkimusala** Soveltava filosofia ja organisaatiotutkimus**Käsikirjoituksen pvm** 01.02.2024**Väitöspäivä** 17.02.2024**Väittelyluvan myöntämispäivä** 07.12.2023**Kieli** Englanti **Monografia** **Artikkeliväitöskirja** **Esseeväitöskirja****Tiivistelmä**

Suuret elämänmuutokset voivat aiheuttaa omaelämäkerrallisen murroksen ja tarpeen työstää omaa tarinallista identiteettiä. Kehitin väitöskirjassani uusia haastattelumetodologioita omaelämäkerrallisen murroskokemuksen käsittelyyn ja elämäntarinoiden (uudelleen)rakentamiseen. Tutkimukseen osallistui 10 vastadiagnosoitua eturauhassyöpöpotilasta, viisi puolisonsa kanssa. Kukin potilas/pariskunta osallistui viiteen narratiiviseen syvähaastatteluun syöpähoitojen aikana ja myöhemmin seurantahaastatteluun. Haastattelusarja tarjosi osallistujille useita tapoja sanoittaa syöpäkokemusta ja elämää sekä uudelleenarvioida ja -rakentaa aiemmin sanoittamaansa. Momentary Key Metaphor -metodologiassa haastateltavaa pyydetään kuvaamaan sairauskokemusta metaforilla ja pohtimaan metaforien henkilökohtaista merkitystä. Seurantahaastattelussa metaforat palautetaan haastateltavalle uudelleentarkasteluun. Metaforat tarjosivat osallistujille työkalun tutkia, tiivistää ja reflektoida monimutkaista, usein ristiriitaista kokemusta sen eri vaiheissa. Yksi keskeinen löydös oli metaforien moniäänisyys. Moniäänisten metaforien rakentaminen auttoi osallistujia tunnetyöskentelyssä, epävarmuuden sietämisessä ja kokemuksen eri puolien käsittelyssä. Pariskuntakonteksti toi mukaan puolison äänen ja tuo esiin vastavuoroisuuden pariskunnan selviytymisprosessissa. Alussa, kun epävarmuutta oli paljon, puoliset loivat metaforillaan toivoa. Kun potilaiden toimijuus vahvistui, puoliset pystyivät ilmaisemaan oman haavoittuvuutensa. Clip Approach -metodologiassa haastateltavan kerrontaa heijastetaan takaisin visuaalisilla artefakteilla, "tarinalapuilla", joiden avulla haastateltava voi palata syöpäkokemukseen ja elämäntarinaansa ja rakentaa niitä koskevia kertomuksiaan uudelleen. Tarinalaput palauttavat aiemmin kerrotun konkreettisuutta, uudelleen jäseneltävissä muodossa kertojan omalla äänellä. Ne tukivat osallistujien itsehavainnointia ja auttoivat siirtymään vakavan sairauden aiheuttamasta objekti-positiosta subjekti-positioon aktiiviseksi toimijaksi. Elämäntarinan rakentaminen tarinalapuilla tuki omaelämäkerrallista päättelyä ja auttoi tutkimaan ja uudelleenarvioimaan merkityksiä, rakentamaan siltaa menneen ja tulevan välille ja liittämään syöpäkokemuksen osaksi elämäntarinaa. Ehdotan väitöskirjassa haastattelusarjaa potilaskeskiseksi ohjaus- ja neuvontainterventioksi syöpän hoitoon. Metodologiat soveltuvat omaelämäkerrallisen murroksen käsittelyyn ja tutkimiseen erilaisissa elämänmuutostilanteissa ja tarjoavat rohkaisevia mahdollisuuksia matalan kynnyksen psykososiaalisen tuen interventioiksi useilla sovellusalueilla. Ne voivat antaa uusia työkaluja myös olemassa oleviin konteksteihin. Clip Approach -metodologia sopii ympäristöihin, joissa yhteistyöllä on aikaa, kuten psykoterapioihin. Metaforametodologiaa voidaan käyttää dialogisena avauksena myös lyhyemmässä kohtaamisissa, kuten lääkärin vastaanotolla osana pidempää hoitosuhdetta.

Avainsanat elämäntarina, sairauskokemus, tarinallinen identiteetti, eturauhassyöpä, potilaskeskeinen, puoliso, pariskunta, haastattelu, metodologia, visuaalinen, artefakti, metafora, merkitys, itsehavainnointi, dialoginen, moniäänisyys, matalan kynnyksen tuki, kvalitatiivinen, narratiivinen, hermeneuttinen, pitkittäistutkimus

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To my dearest ones, my family

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I want to thank the Docrates Cancer Center for the opportunity to conduct this study. I would like to express my gratitude to nurses Henna Lundenius and Aili Sihvo for introducing me to the world of patient research and the world of patients. My warmest thanks also go to management assistant Anne Keinänen, for ensuring that the participants and I had a comfortable place to meet and refreshment for the body while we performed mental work that required strength.

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I would like to extend my sincere thanks to Aalto University and especially the Department of Industrial Engineering and Management for their open-mindedness and the opportunity to write a dissertation that is probably quite different in subject and content from the PhD work they are accustomed to, but in line with the innovative future thinking of Aalto, one of the world's leading new

universities. I am grateful for the opportunity to work at the department for six months to finalize my doctoral dissertation. I would also like to express my gratitude to my supervisor, Assistant Professor Natalia Vuori, for her support during the very final stages of my dissertation, to the Doctoral Programme staff, especially Jaakko Autio, for such kind help, and to Matthew Billington for his excellent work proofreading my dissertation.

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Heartened by this work, I encourage each of us, author, supporter, participant, and reader alike, to ask ourselves and each other, “can you tell me your life story?” and to listen with a sensitive, attentive ear. I promise that you will hear something extremely important, unique, and meaningful.

Espoo, January 22, 2024

Riikka Talsi

Table of Contents

Acknowledgements	i
List of Publications	vii
Author's Contribution.....	ix
1. Prologue	1
2. Introduction	5
2.1 Serious Illness as an Autobiographical Rupture.....	5
2.2 Interview as Interaction.....	5
2.3 Visual Artifacts in Qualitative Research	6
2.4 Metaphor as a Tool for Building Meaning	7
2.5 Dialogue as a Context for Emerging Meaning	8
2.6 Serious Illness and Dyadic Coping.....	9
2.7 Prostate Cancer as a Health Crisis	10
2.7.1 Diagnosis—a Psychological Disruption.....	10
2.7.2 Treatment—a Physical Disruption	11
2.7.3 Effects on Body Image, Self-esteem, and Sense of Masculinity.....	12
2.7.4 Long-term Effects of the Diagnosis and Treatments of Prostate Cancer	13
3. Identified Gaps and Research Needs	15
4. Research Task	19
5. Method	21
5.1 Participants	21
5.2 Data Collection.....	21
5.2.1 Life Story Interviews and Thematic Interviews	22
5.2.2 Momentary Key Metaphors.....	22
5.2.3 Dual Lighting.....	23
5.2.4 The Clip Approach.....	23
5.2.5 Retrospective Metaphorical View	24
5.2.6 Follow-up Interviews	24

6.	Summary of the Original Publications	27
6.1	Prostate Cancer Metaphors: A Longitudinal Study of the Lived Experience	27
6.2	The Dialogue of Metaphors: Couples Building Meaning for a Prostate Cancer Experience	28
6.3	The Clip Approach: A Visual Methodology to Support the (Re)Construction of Life Narratives	30
7.	Methodological Results	33
7.1	Participant Feedback	35
8.	Discussion.....	39
8.1	Potential Therapeutic Mechanisms	40
8.1.1	Participants' Own Speech as Therapeutic Documentation .	41
8.1.2	Creating an Observer Position	43
8.1.3	Enabling the Creation of Alternative Stories	45
8.1.4	Metaphors in the Construction of Alternative Stories.....	46
8.1.5	Clips in the Construction of Alternative Stories	47
8.1.6	Storyboards as Alternative Stories.....	48
8.1.7	Enabling the Detection of Change	49
8.1.8	Recruiting a Wider Audience.....	51
8.2	Therapeutic Effects of the Processual Interview Series	52
8.3	Strengths and Limitations	54
8.4	Possible Topics for Further Research.....	56
8.5	Potential Directions for Future Research.....	57
9.	Clinical Implications.....	59
9.1	A Patient-Centered Guidance and Counseling Intervention for Cancer Care	59
9.2	About Time and Timelessness.....	61
9.3	About Listening and Listening Back.....	61
9.4	About the Meaning of the Closest One	63
9.5	For Other Contexts	64
10.	Epilogue.....	67
	References	69
	Appendix 1. Interview Themes.....	80
	Appendix 2. The Interview Process.....	81
	Appendix 3. The Interview Methodologies in a Manual Style	82
	Publications.....	89

List of Publications

This doctoral dissertation consists of a Compilation, two unpublished essays, and one published article, which are referred to in the text by their numerals:

- 1.** Talsi, Riikka; Laitila, Aarno; Joensuu, Timo; Saarinen, Esa. Prostate Cancer Metaphors: A Longitudinal Study of the Lived Experience. 21 pages.
- 2.** Talsi, Riikka; Laitila, Aarno; Joensuu, Timo; Saarinen, Esa. The Dialogue of Metaphors: Couples Building Meaning for a Prostate Cancer Experience. 31 pages.
- 3.** Talsi, Riikka; Laitila, Aarno; Joensuu, Timo; Saarinen, Esa. (2021). The Clip Approach: A Visual Methodology to Support the (Re)Construction of Life Narratives. *Qualitative Health Research*, volume 31, issue 4, pages 789–803. <https://doi.org/10.1177/1049732320982945>.

Author's Contribution

Publication 1: Prostate Cancer Metaphors: A Longitudinal Study of the Lived Experience

Based on her original idea, Riikka Talsi constructed the theoretical basis of the study and designed the interviews. Timo Joensuu supported the preparation of the ethics application, recruitment of participants, and interview arrangements at the Docrates Cancer Center. Riikka Talsi prepared the ethics application. She developed the Momentary Key Metaphor methodology, conducted the interviews (60 interviews, 100 hours in total), and transcribed the interview recordings. Esa Saarinen proposed the metaphor classification by Semino and colleagues (2018) as the basis for the analysis. Riikka Talsi extended the analysis to the sense of agency and empowerment described by the metaphors. Aarno Laitila highlighted the polyphonic nature of the metaphors. Riikka Talsi analyzed the data. She also wrote the entire manuscript. Esa Saarinen and Aarno Laitila provided valuable feedback on the manuscript.

Publication 2: The Dialogue of Metaphors: Couples Building Meaning for a Prostate Cancer Experience

Based on her original idea, Riikka Talsi constructed the theoretical basis of the study and designed the interviews. Timo Joensuu supported the preparation of the ethics application, recruitment of participants, and interview arrangements at the Docrates Cancer Center. Riikka Talsi prepared the ethics application. She developed the Momentary Key Metaphor methodology for the couple context, conducted the interviews (30 interviews, 48 hours in total), and transcribed the interview recordings. Esa Saarinen proposed the metaphor classification by Semino and colleagues (2018) as the basis for the analysis. Riikka Talsi extended the analysis to the sense of agency and empowerment described by the metaphors. Aarno Laitila highlighted the dialogic nature of the metaphors. Riikka Talsi developed the narrative-hermeneutic method of analysis used in the case study. She analyzed the data and wrote the entire manuscript. Esa Saarinen and Aarno Laitila provided valuable feedback on the manuscript.

Publication 3: The Clip Approach: A Visual Methodology to Support the (Re)Construction of Life Narratives

Based on her original idea, Riikka Talsi constructed the theoretical basis of the study and designed the interviews. Timo Joensuu supported the preparation of the ethics application, recruitment of participants, and interview arrangements at the Docrates Cancer Center. Riikka Talsi prepared the ethics application. She

conducted the interviews (60 interviews, 100 hours in total), developed the visual artifacts, “the Clips”, and the Clip Approach methodology, transcribed the interview recordings, and analyzed the data. Aarno Laitila provided insightful suggestions for outlining the key findings. Esa Saarinen made a valuable contribution to the naming of the methodologies. Riikka Talsi wrote the entire manuscript. Esa Saarinen and Aarno Laitila provided valuable feedback on the manuscript.

Life can only be understood backwards; but it must be lived forwards.

S. A. Kierkegaard

How do I know what I think until I see what I say?

E. M. Forster

It is through our stories that we construct ourselves as part of our world.

J. Brockmeier & R. Harré

1. Prologue

I have graduated from a technical field and pursued a long career in business, but I have always been especially interested in human beings and the psychological side of the humankind. Year after year, my desire to get closer to people, also professionally, has grown. When I was given the opportunity to explore the construction of the life stories of people in difficult life situations through narrative interviews, I immediately jumped at the chance. I am interested in humans as meaning makers and in language as the substance for emerging meanings:

I love stories, language, and writing, the beauty of language—and the human being in a search for purpose, making interpretations. I love how a person builds her story, and the story builds her: fragmented meanings to be collected, turned over in one's hands, wondered at, arranged, and fitted together—finding connections, constructing images—integrity, wholeness, meaningfulness. (Talsi, 2013, p. 25)

In addition to my interest in the people around me, I am also a person who explores herself. Some people write diaries; I have been writing dream books for years. For me, writing is an important channel of self-expression, and dreams are an inexhaustible source for exploring my own mind.

In 2010, I decided to discover whether I could find a meaningful postgraduate path through my former school. Over the years, much had changed. Helsinki University of Technology had become the multidisciplinary Aalto University, and philosopher Esa Saarinen had been appointed Professor of Applied Philosophy at the Occupational Psychology and Leadership Unit of the Department of Industrial Engineering and Management to bring a human-centric approach to the university as a counterweight to technology. Esa supported me in my desire to conduct interdisciplinary research.

At the same time, Timo Joensuu, a co-founder of the Docrates Cancer Center, wanted to take cancer care in a more holistic direction. Esa brought us together. I suggested interviewing patients in a series of interviews, providing them with a context to reflect on their experience and structure their difficult life situation narratively. Timo became excited about the idea.

The study had simple starting points: on the one hand, narrative identity as a social construction and the illness experience as a potential rupture in it and, on the other, the potential of a qualitative research process, in this case, a series of

narrative interviews, as an intervention for narrating and re-constructing one's life narrative. Later, the idea arose of providing the option for the subjects to participate in the research with their spouses.

Involving patients, the research required Ethics Committee approval. I began working on the clinical trial research protocol and studied the course and the content of narrative interviews as presented in the literature. For example, Flick (2002) described them as follows. Narrative interviews are unstructured interviews in which the interviewer asks the participant to tell a story about a given theme and continues with clarifying questions if necessary. During the interview, the interviewer summarizes what has been said and asks if the story *he/she* has constructed describes the narrated events correctly (Flick, 2002). When mapping the analytic methods of narrative research, I noticed that no single standard method of analysis existed. What was typical was that the analysis resulted in a new narrative, written by *the researcher*. Thus, I wrote a conclusion in the research protocol:

As there are no ready-made narrative methods, the interviews and the analysis can be designed to best serve the purpose of the study and the patient or the couple. According to the nature of the qualitative research, data collection and analysis may take place in parallel, and interview and analysis methods can be developed according to what emerges from the data. (Prostate Cancer Interview Study, Protocol of the Clinical Study, 2014, p. 14)

In a postgraduate course essay, I examined the relationship between the voice of the participants and the voice of the researcher:

It is essential that the stories constructed in the interviews are the interviewees' own. At their best, the interviews will help a person find connections between fragmented events, a plot for the whole, a resolution to a complication brought by life, a meaningful life story, a world they own and tell in their own voice. At this point, my voice will fall silent. Listening to my innermost being is to listen to another person, to make their voice heard. (Talsi, 2013, pp. 28–29, shortened)

In the protocol, I considered the importance of iterative, hermeneutic elaboration on various levels of the research:

There is a similarity between the construction of the patient's/couple's story and the construction of the theory of the research. In both of them, the initial understanding and the existing fragments of knowledge are separated by a chasm of wonder, which will be narrowed by iterative, abductive thinking. The work will start from the top and progress spirally deeper until the image is clear and the whole is intact. This will first take place at the level of the story of the patient/couple: When mirrored with contemporary understanding, fragmented experiences, interpretations, and meanings gradually form a meaningful, comprehensible whole. After that, the same will take place on the level of theory formation, for which patients' and couples' narratives are initially fragmented stories, the legitimacy of which will gradually be discovered in the dialogue between them, the current understanding of the researcher, and the theoretical

frameworks. (Prostate Cancer Interview Study, Protocol of the Clinical Study, 2014, p. 15)

In the spring 2014, I took the application to the Helsinki University Central Hospital, summarizing the content of the research for the Ethics Committee as follows:

This study examines the inherent human process of building a new intact inner story after a difficult experience, and whether this process can be supported and accelerated. While being able to focus on the well-described physical therapy, the patient will be offered an opportunity to reflect on his experience and life situation narratively. Half of the interviewees will participate in the interviews with their spouses. This will bring a new dimension to the whole: the story will be built together; it will be shared. The study explores the kind of internal meanings patients and spouses give to their experiences, how their stories change and evolve, and how narration and self-reflection, or mutual reflection, will help them in structuring the whole—in building a new intact narrative. (Prostate Cancer Interview Study, Summary of the Study Plan, 2014, pp. 3–4)

The research was approved by the Ethics Committee for gynecology and obstetrics, pediatrics, and psychiatry of the Hospital District of Helsinki and Uusimaa on November 27, 2014 (161/13/03/03/2014). During the process, we had invited Professor Aarno Laitila from the School of Educational Sciences and Psychology, University of Eastern Finland, to supervise the dissertation in the field of psychology.

2. Introduction

2.1 Serious Illness as an Autobiographical Rupture

Narratives and life stories are created individually and in interaction; they form a narrative identity which develops slowly over time and provides a feeling of wholeness and meaning to life (Sparkes & Smith, 2008; McAdams, 2013; McAdams & McLean, 2013). Becoming seriously ill, and surviving or recovering from a serious illness, is an autobiographical rupture (Bury, 1982; Ricoeur, 1991; Holma, 1999), which a human being seeks to correct by building a link between the past and the future. In conventional life, the life story is nonconscious. One begins to ponder it consciously when it becomes distorted (Hänninen, 2004). Then also telling the story becomes topical (Frank, 1995).

The mere remembering of past episodes is insufficient (Habermas & Köber, 2015); one must interpret and evaluate remembered experiences (Singer & Bluck, 2001) and make connections between distant parts of life, self, and personal development (McLean & Fournier, 2008; Habermas & Köber, 2015). Autobiographical reasoning facilitates coping and contributes to the development of personality, identity (Habermas, 2011), and personal growth (McLean & Fournier, 2008). Life stories showing agency, exploration, and redemptive meanings seem to relate to higher levels of mental health, well-being, and maturity (McAdams & McLean, 2013; Kerr et al., 2020). Even without a positive resolution, negative experiences may contribute to well-being by enhancing meaning through stimulated comprehension of how the event fits into a broader narrative of self, relationships, and the world (Vohs et al., 2019). Narrative identity is at the core of adaptation and development (McAdams & McLean, 2013), and storytelling is at the heart of stability and change in the self (McLean, Pasupathi, & Pals, 2007).

2.2 Interview as Interaction

All counseling and psychotherapy rely on telling stories and, in the end, retelling the client's life story (McLeod, 1996) as a collaborative task (Kohler Riessman & Speedy, 2007). In the oral therapy tradition, the re-authoring of lives is mainly achieved through a questioning process, while in the narrative therapy tradition it is also achieved through the use of written and visual documents (White & Epston, 1990, pp. 16–17; Morgan, 2000, pp. 112–127; Ricks et al., 2014). Narratives allow for the lived experience to be plotted into a story (Ricoeur, 1991).

They enable the recognition of “unique outcomes” and the construction of meaning around them, thus bringing forth alternative stories, the elaboration, scope, and endurance of which can be expanded by recruiting an audience for their performance (White & Epston, 1990, pp. 31, 41, 114, 127). Narrative therapy practice is a form of “live” co-research, described by others as narrative inquiry (Kohler Riessman & Speedy, 2007). It studies the human process of meaning-making and is especially suitable for inquiring into these processes regarding the self (Adler et al., 2017).

In qualitative inquiry, subjects are treated as and called participants, and the research process itself is viewed as a type of intervention (Gale, 1993). Qualitative inquiry may include some, possibly several change processes that have been described as helpful by clients in therapy (Timulak, 2010). As a pluralistic framework of practice, it utilizes the therapeutic possibilities existing in the wider culture in which people live—using what the participant knows, taking it seriously (McLeod, 2013).

Serial interviews allow the participant-researcher relationship to develop and deepen over time, creating trust and enabling participants to voice sensitive issues in their personal accounts (Murray et al., 2009). In qualitative interviews, participants have an engaged audience; they are listened to. Qualitative inquiry appreciates (Adler et al., 2017), even amplifies, participants’ voices (Martin, 1998). Emphasizing the absolute authority of the narrator in how to build the story, Martin (1998) aptly writes, “to speak is one thing, to be heard is another, to be confirmed as being heard is yet another” (p. 9). Telling one’s story may be an empowering act (Martin, 1998), and acceptance shown in an interview carries healing potential (Tomm, 1988).

Serial interviews support self-reflection by allowing earlier findings to be developed and reflected on (Murray et al., 2009). A necessary step towards being able to act upon a phenomenon is that of first becoming an observer, through which both self-awareness and “other awareness,” such as empathy, are enhanced (Tomm, 1987b). In Tomm’s (1987a) concept of “interventive interviewing,” where the entire interview is regarded as a series of continuous interventions, reflexive questions are central (Tomm, 1988). Respecting the autonomy of the participants, they open space for new perceptions, perspectives, and options, creating new connections and fresh solutions, and guiding the participants towards releasing their innate healing capacity in their own manner and time (Tomm, 1988). Serial interviews allow narratives to unfold, forming rich, generative, and contextualized accounts (Murray et al., 2009) with “a nearly endless opportunity for revisiting and for discovery” (Adler et al., 2017, p. 524). It is important that rather than writing the last chapter of the story, research reports allow the stories to continue (Sparkes & Smith, 2008).

2.3 Visual Artifacts in Qualitative Research

The qualitative research approach is phenomenon-based, in contrast to the variable-based nature of quantitative research. To reach the phenomenon under study and enable its investigation, qualitative inquiry may benefit from visual

material used, created, or produced in collaboration with others. There is a growing interest in using visual methodologies and creative artifacts in social research—examples range from photography, documentary filmmaking, paintings, graffiti, and computer-mediated interactions (Reavey & Johnson, 2011) to Lego constructions (Gauntlett & Holzwarth, 2006). In narrative research, visual timelines have been used to locate the main events during a specified timeframe (Black & Warhurst, 2015).

In psychological research, visual methodologies are a salutary way of accessing meaning and expressing and transforming experience (Reavey & Johnson, 2011). They provide new ways of experiencing and creative mediums to generate meanings; instead of only speaking, participants are able to see their world in a tangible dimension, offering a channel for engaging with the experience from the non-discursive side of self production (Reavey & Johnson, 2011). Visual artifacts are symbolic representations through which ideas can be articulated, developed, and exchanged; they provide material entities with which to interact and develop knowledge (Ewenstein & Whyte, 2007). Visual approaches strengthen participant-agency (Reavey & Johnson, 2011) and invite the practice of self-reflection more freely (Mitchell et al., 2005). They may also develop feelings of artistry, creativity, and productivity (Predeger, 1996).

2.4 Metaphor as a Tool for Building Meaning

Metaphors may play a significant and potentially beneficial role when facing a severe illness. Metaphors express, reflect, and strengthen various ways of sense-making (Semino, Demjén, & Demmen, 2018). By reframing complex issues (Penson, 2004), they offer creative means of producing new resources of knowing (Laranjeira, 2013). They structure thinking, provide insight, and create new comprehension (Lakoff & Johnson, 1980), potentially providing new solutions, even new ways for personal growth (Levitt, Korman, & Angus, 2000).

Studies among cancer patients have shown that metaphors may help to express (Gibbs & Franks, 2002) and manage emotions (Appleton & Flynn, 2014) and support coping (Hommerberg, Gustafsson, & Sandgren, 2020). They can help people stabilize themselves when confronted with uncertainty and change by providing distance from frightening chaos (Teucher, 2003). The creation of meaningful metaphors enables the imaginative use of available safe groundings and may even evolve into a core ability through which to express, intensify, and transform anxiety through associations that can contain deep meaning (Skott, 2002).

Metaphors may support patients in managing (Appleton & Flynn, 2014), strengthening, and recreating their identity (Skott, 2002). Metaphors can help them resist disruption, integrate the illness experience into their life, and make plans for the future, whilst highlighting the potential of the experience to foster intellectual and emotional growth (Gibbs & Franks, 2002). Metaphors can also provide tools for patients to present themselves in relation to others (Gibbs & Franks, 2002), produce shared meaning (Harrington, 2012), and link the individual illness experience to a collective one (Skott, 2002).

The meaning of a metaphor is always situated in the discursive practice in which it is born (Kövecses, 2015). Therefore, only by placing metaphors in context and understanding them through the narrators' unique, individual accounts (Appleton & Flynn, 2014) can we fully comprehend the role they play. Furthermore, the order that a metaphor creates is always challenged by the disorder it describes; thus, metaphors and their meanings are always open for re-interpretation and re-negotiation (Teucher, 2003).

Although metaphors can change over time, they are very precise expressions for the narrator when they are told. Just as cancer and the illness experience are often multifaceted and contradictory, so are the metaphors with which they are described. Through multiple, even contradictory metaphors, people facing cancer can make sense of the different aspects of their experience and transform the illness experience into a meaningful one (Gibbs & Franks, 2002; Hommerberg, Gustafsson, & Sandgren, 2020).

2.5 Dialogue as a Context for Emerging Meaning

According to Bakhtin (1986), contextual meaning arises between people—it always includes at least two parties: “*I* in interrelationship with other personalities, that is, *I* and *other*, *I* and *thou*” (p. 167). Each utterance lives by coming into contact with another one; only there “does a light flash, illuminating both the posterior and the anterior” (p. 162), combining the utterance into a dialogue. Everything said is a response to what has been said before (Bakhtin, 1981), and each utterance “includes a question, an address, and the anticipation of a response” (Bakhtin, 1986, pp. 169–170). We often analyze things in a narrow time frame, in the scope of the present day, the recent past, and the imaginable—desired or frightening—future. In reality, the dialogical context has no limits. Any moment, the dialogue encases enormous amounts of forgotten contextual meanings, which may be recalled in a renewed form at certain moments in the later development of the dialogue. The power of meaning is revolutionary. Without changing the actual (existential) composition of an event and reality, it may change the total contextual meaning of it. This is the semantic transformation of existence (Bakhtin, 1986).

Inspired by the dialogical approach of Bakhtin, Seikkula and colleagues (1995) have developed a method called “the Open Dialogue” to support patients and their social networks in severe psychiatric crises. As Seikkula and Trimble (2005) describe, from the Bakhtinian perspective, understanding only arises through active discussion and listening. It is in the momentary details of human interaction that meaning develops. The meaning of an utterance comes as much from the listener as from the speaker: “For words to have meaning, they require response” (p. 465). Meaning is constantly created and changed through the inherently unpredictable process of response. Each new voice included in the “polyphonic” (Bakhtin, 1984) dialogue increases the potential for understanding. When multiple voices join in to share the experience, new possibilities can arise. Making space for the not-yet-said (Anderson & Goolishian, 1988) and accepting

it when it emerges, allows for experiences of healing. Finding language for traumatic experiences and the emotions embedded in them makes them tolerable, and cultivating reflective dialogue helps in accepting uncertainty and discovering “the psychological resources for answering the question of how to go on” (Seikkula & Trimble, 2005, p. 471).

Miller and Stiver (1998) write about the dialogical quality of human interaction from the perspective of mutual empathy. According to them, our feelings and thoughts are not clear until we gain the chance to engage with another person who can resonate with them. Through sharing our feelings and thoughts and those that arise in response, we can recognize them more fully. Mutual empathy allows both participants to continue adding something more to their dialogue (Miller & Stiver, 1998). In a relationship that fosters growth, each is open to being touched, moved, and changed by the other (Jordan, 2017). It is on these kinds of relationships that our meaning-making capacity, healthy individual development, and psychological health are dependent (Miller & Stiver, 1998).

2.6 Serious Illness and Dyadic Coping

In her work among couples affected by breast cancer and other life-threatening illnesses, Skerrett (2003, 1998) found that non-resilient couples lacked a co-constructed meaning for the experience, while resilient couples actively redefined self and couple identity in the changing demands of the illness. Optimal couple functioning depended on the ability of the couple to define the illness experience as a shared problem (1998) and to jointly construct a compatible structure of meaning to guide their mutual coping efforts (2003).

Skerrett (2003) defined healing dialogue “as one in which both partners felt empowered to speak from (and listen to) their authentic selves,” “felt heard and responded to,” and “in which there was respect for difference” (p. 72). She, too, reminds us of the significance of empathy. Referring to Frank (1998), she writes that talking about illness is reaching out to another human, the story as a basis for mutual understanding. When we are connected to the speaker and genuinely interested in what they say, we are moved, because when we listen to the other we are listening to ourselves, and the moment of listening crystallizes around the reciprocity of needs—we allow the vulnerability of the other to touch our own. Through being able to empathize with each other, rather than withdrawing into their separate worlds of suffering, the couples in her study began to understand the healing that can occur by seeking connection around a shared experience.

In their study among breast cancer patients and their partners, Kayser and colleagues (2007, 2016) identified three relationship characteristics that facilitated dyadic coping: relationship awareness, authenticity, and mutuality. They define relationship awareness as “thinking about the impact of the disease on the partner and the relationship and how to sustain one’s relationship given the extra demands of the illness,” authenticity as “disclosing of genuine feelings to your partner, not hiding feelings from partner,” and mutuality as “empathic responding; a way of relating in which each of the partners is participating as fully

as possible in a shared experience” (Kayser, Watson, & Andrade, 2007, p. 410). Dyadic coping is a process that involves (a) appraising the illness-related stress as a dyad, (b) communicating about it, (c) coordinating coping efforts and making meaning of the illness experience, leading to (d) adaptation to the stressor, and individual and relational growth (Kayser, Watson, & Andrade, 2007; Kayser & Acquati, 2019).

The concept of mutuality is based on Relational-Cultural Theory, developed by Jean Baker Miller and colleagues, who suggested that mutual empathy—the ability to experience another person’s feelings while remaining in touch with one’s own feelings—is a major component of a healthy relationship (Miller, 1986). Mutual empathy leads to mutual empowerment, characterized by (a) zest (“the energizing effect of the emotional joining”), (b) action (“each acts and has an important impact on the other—each creates change”), (c) knowledge (“an enlarged and more accurate picture of themselves and of each other”), (d) sense of worth (“worthy of another person’s recognition and attention in the experiencing of . . . feelings and thoughts”), and (e) greater sense of connection and desire for more connections (“desire for fuller connection . . . and a concern for that person’s well-being”) (Miller & Stiver, 1998, pp. 24–41). Sharing feelings with another person is important for the growth in mutuality (Miller & Stiver, 1998)—both people grow and contribute to the growth of one another and their relationship (Jordan, 2017, p. 235).

2.7 Prostate Cancer as a Health Crisis

2.7.1 Diagnosis—a Psychological Disruption

A prostate cancer diagnosis is a traumatic experience for patients and their families. Lehto and colleagues (2015, 2017b) investigated patients’ psychological reactions at the time of diagnosis and their psychological well-being five years later in a Finnish national sample of prostate cancer patients ($n = 1239$). More than half (53%) of the participants reported that the diagnosis had caused various emotional changes (feeling blue, 30%; fluctuating mood, 21%; repetitive thoughts, 10%; grief, 10%; feelings of bitterness, 9%; wandering thoughts, 8%; angry feelings, 3%). Every second (51%) patient had worried about whether the cancer was treatable; every third (34%) had felt uncertainty about the future; and almost as many (29%) had been in shock. While 17% of the respondents had felt relief that the cause of the symptoms had been found, almost as many (16%) had been concerned about the future of their family, had felt unreal (15%), and had asked “Why me?” questions (15%) in their minds. Moreover, nearly every 10th had been afraid of death (9%) and disability (8%). According to a meta-analysis by Watts and colleagues (2014), the prevalence of pre-treatment depression and anxiety in prostate cancer patients is 17% and 27% respectively.

In another survey study ($n = 104$), sharing many of the questions of the patient survey, Lehto and colleagues (2017a) explored spouses’ experiences and psychological distress at the time of the diagnosis and during primary treatment. Three out of four spouses reported emotional changes after their partner’s prostate

cancer diagnosis. The most common findings were depressed mood (40%) and grief (34%), followed by wandering thoughts (21%), repetitive thoughts (17%), feelings of bitterness (14%), fluctuating mood (11%), and feelings of anger (7%). Sixty-one percent of spouses had felt uncertainty about the future, 57% had worried about whether the cancer was treatable, 44% had been in shock, and 27% had felt fear about the death of their spouse. While every fifth spouse had been relieved that the cause of the symptoms had been found, almost the same proportion (19%) had asked “Why us?” questions and felt unreal.

While the psychological reactions of patients and spouses to the diagnosis were similar, spouses reported more emotional changes (especially grief), uncertainty about the future, reactions of shock, and fear of death. This is in line with the existing literature, which suggests that spouses of prostate cancer patients are even more distressed than the patients themselves (Couper et al., 2006; Tanner, Galbraith & Hays, 2011; Sánchez et al., 2020), with fear of the unknown and what the future holds playing a significant role (Resendes & McCorkle, 2006; Roberts, Toohey & Paterson, 2022).

2.7.2 Treatment—a Physical Disruption

Prostatectomy and external radiotherapy are curative treatments for localized prostate cancer (Litwin & Tan, 2017). Surgery is often complemented by post-operative radiotherapy, and external beam radiotherapy by long-term androgen deprivation therapy or brachytherapy (Moris et al., 2020). Disseminated disease cannot be treated curatively, thus treatments aim to slow down the progression of the disease and improve the patient's quality of life (Syöpäjärjestöt, 2022b). As an initial treatment for metastatic prostate cancer, chemotherapy prolongs survival compared to androgen deprivation therapy alone (Litwin & Tan, 2017). Combined cytotoxic and low-dose cortisone treatment can reduce pain and other symptoms when hormonal treatments have lost their effectiveness (Syöpäjärjestöt, 2022b).

Both local and systemic treatments have significant side effects, affecting patients' quality of life (Moris, 2020). Prostatectomy causes erectile dysfunction and urinary incontinence (Neal, 2019; Moris et al., 2020; Hoffman, 2020; Wennerberg et al., 2021). The side effects of brachytherapy include urinary irritation, urinary leakage, and bowel dysfunction (Lehto et al., 2017b; Hoffman, 2020; Martell, 2021), and those of external radiotherapy also sexual dysfunction (Lehto et al., 2017b; Neal, 2019). Chemotherapy causes nausea, general fatigue, hair loss, and an increased risk of inflammation (Syöpäjärjestöt, 2022b).

Androgen deprivation therapy is associated with several physical and psychological side effects and an increased risk of osteoporosis, type II diabetes, and cardiovascular disease (Wibowo, 2019; Magee, 2020). Physical side effects include weight gain, fatigue, loss of muscle mass and body hair, genital shrinkage, changes in sexual function (e.g., reduced sexual desire and erectile dysfunction), and feminizing changes (e.g., hot flashes, gynecomastia, and pain in the breasts) (Downing et al., 2019; Wibowo, 2019; Magee 2020). Psychological side effects of hormone therapy include emotional changes, depression, and potential memory impairment (Wibowo, 2019; Yiannopoulou et al., 2020).

Three out of four men with prostate cancer experience fatigue during the course of their illness (Langston, Armes, & Ream, 2013). The combination of radiotherapy and androgen deprivation therapy has been found to significantly increase fatigue scores (Bandara et al., 2019) and lead to the highest prevalence of chronic fatigue (39%) in prostate cancer patients (Langston, Armes & Ream, 2013).

2.7.3 Effects on Body Image, Self-esteem, and Sense of Masculinity

In their thematic meta-synthesis of 68 qualitative studies related to body image, self-esteem, and sense of masculinity whilst living with prostate cancer, Bowie and colleagues (2022) identified the way these dimensions are interrelatedly—and often through shame—impacted by the diagnosis and treatment of prostate cancer, exerting a profound effect on quality of life. The body image of these men was affected both through changes in their bodily functions and through changes in how others treated their bodies. They felt that their bodies were less than whole after prostatectomy, no longer their own due to the side effects of hormonal therapy, and old because of premature aging caused by the treatments. Fatigue, urinary incontinence, and changes in appearance made these men perceive their bodies as deficient and a source of shame. They “could no longer trust their bodies” because of loss of function, physical discomfort, and pain (p. 104). Allowing others to touch and handle their bodies caused “a sense of loss of ownership over their bodies”, vulnerability, and shame (p. 104). In particular, rectal examinations, which some men considered to be related to homosexuality, were experienced as embarrassing. Men felt ashamed of their diagnosis and symptoms, especially erectile dysfunction, incontinence, and inability to perform sexually in the same way as before. They felt worthless because they could not work; they were unable to talk about their experiences with others; and some withdrew from all social life. They experienced a new kind of vulnerability due to physical changes, loss of social lives, and uncertainty about the future. Shame and lack of self-confidence, which were strongly associated with depression, affected their self-esteem. All this, but especially changes in sexual function and libido, and the feminizing changes resulting from androgen deprivation therapy, posed threats to their masculinity. These findings are in line with another recent study (Tsang et al., 2019), which found that prostate cancer patients experience loss of masculinity more for biological reasons (e.g., reduced erectile function, libido, and physical strength) than for social reasons. On the other hand, social support has recently been found to be a potential protective factor against the effects of body image distress on health (Scandurra et al., 2022).

Although most men experiencing prostate cancer are socially resilient, roughly every 10th reports significant social distress. This was found in a British national cross-sectional survey (n = 29351), according to which social stress was most strongly associated with unemployment, followed by the presence of three or more comorbid long-term diseases alongside cancer (Wright et al., 2019). In addition, the following were clearly associated with social anxiety in prostate cancer patients: androgen deprivation therapy, external beam radiotherapy

combined with some other treatment, young age (under 60 years), previous problems with mental health, and living in a socioeconomically deprived area.

2.7.4 Long-term Effects of the Diagnosis and Treatments of Prostate Cancer

Active treatment of prostate cancer has a number of persistent negative effects that predict patient satisfaction and psychological well-being in the long term (Watson et al., 2015; Lehto et al. 2017b). Prostatectomy causes permanent urinary incontinence and a decrease in sexual function (Hoffman et al., 2020). Although patients recover in six months to one year from the urinary irritation caused by brachytherapy and urinary incontinence caused by external beam radiotherapy and brachytherapy, both treatments impair patients' sexual function, even more so if used in combination with hormone therapy (Hoffman et al., 2020). In the study by Lehto and colleagues (2017b), depending on the treatment type, 81–93% of the patients reported that the treatment had a negative impact on their sex life. Furthermore, 70–92% of patients suffered from sexual dysfunction, and 20–58% reported that their intimate life with their spouse had ended. Urinary symptoms were strongly associated with poorer psychological outcomes. The perception of the level of symptoms and discomfort affected patient satisfaction and well-being more than the symptoms themselves (Lehto et al. 2017b).

In a study among spouses of prostate cancer patients (Lehto et al., 2017a), the most commonly reported side effects of prostate cancer treatment were sexual problems (83%), urinary incontinence (75%), the patient feeling depressed or low (58%), and the patient's fluctuating mood or difficulty concentrating (57%). The more side effects the patients experienced, the more their spouses felt that the illness and treatment had affected their intimate life, with 71% experiencing an impact on their sex life. This is in line with the results of another study, according to which more than three out of four spouses experienced a decline in the quality of their sex life after their partner's treatment for prostate cancer (Movsas et al., 2016). Instead of urinary symptoms and erectile dysfunction, the spouses felt that this was mainly due to the patient's pain and mood disturbances, such as mood fluctuations, feelings of depression or melancholy, irritability, hostility, and/or anger (Lehto et al., 2017a).

According to the meta-analysis by Watts and colleagues (2014), nearly every fifth prostate cancer patient suffers from clinical anxiety after treatment and as many experience clinical depression. Recent studies have reported increasing psychological morbidity in prostate cancer patients (Yiannopoulou et al., 2020). Fear of cancer recurrence and PSA (prostate-specific antigen, measured in diagnostics and treatment monitoring) anxiety are prominent symptoms associated with mental health problems and poorer quality of life (James et al., 2022). Suicidal thoughts are not uncommon, and they are not always associated with other depressive symptoms (Fervaha, 2019).

The study by Lehto and colleagues (2017b) showed that stress reactions at the time of diagnosis were strongly associated with greater psychological symptoms five years later, with three out of four respondents reporting psychological

symptoms at a five-year follow-up. The most commonly reported symptoms were worry (57%), irritability (46%), nervousness (40%), and difficulty concentrating (39%). Five percent of respondents reported suicidal thoughts (Lehto et al., 2015). Regardless of treatment type, more than 40% of patients were dissatisfied with their sex life, and there was a strong correlation between intimate life satisfaction and well-being scores (Lehto & et al., 2015). Many respondents felt that their need for information and support were not met, and negative experiences, such as receiving the diagnosis in an impersonal way and dissatisfaction with the information and care received, predicted poorer well-being (Lehto & et al., 2015). The studies showed that unmet needs in cancer care had long-lasting impacts on the psychological well-being of patients.

According to the study by Lehto and colleagues (2017a) among spouses of prostate cancer patients, only one in three respondents were satisfied with the care the patient or the spouse had received. The level of the spouses' psychological distress at the time of the survey (2–7 months after diagnosis) was high. All spouses experienced at least one psychological symptom, the most common being worry (93%), tension (77%), and despair about the future (72%). Younger spouses and those who still had children at home were more anxious. Shock and fear of death at the time of diagnosis and the perceived impact on intimate life correlated with higher anxiety.

3. Identified Gaps and Research Needs

Although psychosocial treatment has been shown to support positive reappraisal of the illness, reduce stress, and promote restoration of sexual intimacy, it is largely unavailable in conventional care for prostate cancer (Wittmann, 2015).

In a recent systematic review of 105 qualitative studies on the supportive care needs of men with prostate cancer, Prashar and colleagues (2022) identified 12 descriptive themes, which they classified into the “three lines of work” defined by Corbin and Strauss (1988) that are required when a person faces a chronic illness. Descriptive themes related to illness management work were information and decision support needs and experiences of healthcare professionals. Everyday life work, in turn, included partner and family support, exercise and diet, peer and group support, work and employment, and disclosure and stigma. Biographical work covered men’s experiences of accepting their diagnosis, developing coping skills, and framing the illness within the wider course of their lives. Descriptive themes related to biographical work were uncertainty, masculine identity, reframing and accepting bodily changes, aging and mortality, and the trade-off between survival and quality of life.

Furthermore, three overarching themes that cut across all descriptive themes were identified: “whole person-sensitive care,” “comprehensive psychosocial and psychosexual support,” and “managing the wider impact on lifestyle” (Prashar, Schartau, Murray, 2022, p. 4). In all the studies included, men felt that healthcare professionals did not take their needs as individuals into account. Almost all studies contained examples of significant psychological needs, many of which were not met. Psychosocial support was poorly implemented and fragmented, especially after primary cancer treatment. Men faced significant needs in their daily lives, with the greatest responsibility for providing support falling on their spouses, who themselves received little or no support. The treatment had challenging psychological and biographical effects, which profoundly impacted men’s relationships and family life.

Roberts and colleagues (2022) conducted a systematic review of the experiences and unmet supportive care needs of the partners of men diagnosed with prostate cancer. In this research, which included 21 qualitative studies, seven domains of unmet needs were identified: interpersonal/intimacy, healthcare service, physical/daily living, psychological/emotional, family-related, social, and spiritual needs. Some partners had narrowed their social networks to protect their husbands at the expense of their own well-being. An earlier study by

Bruun and colleagues (2011) highlighted the loneliness of spouses of men with prostate cancer. Couples chose not to talk because they did not want to burden each other, even though silence often turned out to be a burden itself, and talking would have helped them cope with the difficult situation (Bruun et al., 2011). Although spouses believe that sharing experiences is important for well-being, they often report that the opposite occurs—diagnosis and treatment can cut off contact and intimacy; spouses feel betrayed by the patient’s failure to share their experiences; and spouses avoid sharing for fear of increasing the patient’s suffering (Tanner, Galbraith & Hays, 2011).

Systematic reviews and meta-analyses of intervention studies aimed at improving psychological well-being and quality of life and/or reducing distress, anxiety, and depression in men with prostate cancer (Parahoo et al., 2015; Qiu & Linghui, 2017; Qan'ir & Song, 2019; Mundle, Afenya, & Agarwal, 2021; Nnate et al., 2021) show that the majority of existing interventions are cognitive-behavioral or disease/health/psychoeducational. Interventions do not address the meaning of the illness, its impact on identity, and the participants’ life story more broadly, or how to re-construct them. Furthermore, although increasingly recognized as necessary steps to a “new normal” after prostate cancer treatment, support for grief and mourning—typical reactions to loss—have not been integrated into psychosocial interventions (Wittmann, 2015).

Healthcare professionals also possess a poor understanding of grief and loss (Galbraith, Hays, & Tanner, 2011). When patients indicate a need for support for their entire life, their existential needs are interpreted as needs for (technical) information (Jakobsson & Holmberg, 2011). Moreover, hospital routines and atmosphere are not optimal for existential discussion, and even first-level requirements are not met (Jakobsson & Holmberg, 2011). However, cancer causes disruption to people’s lives both during and after the treatment (Cayless et al., 2009). The experience is complex and places corresponding demands on supportive care, which should aim to help patients and their families make sense of the illness in the context of their lives (Cayless et al., 2009).

Wootten and colleagues (2014) conducted a systematic review of psychosocial intervention studies aimed at supporting partners of prostate cancer patients. The studies focused mainly on two areas: sexual intimacy and emotional distress. They used a variety of theoretical frameworks: psychoeducational, cognitive behavioral, cognitive existential, problem-solving, counseling, symptom management, marital communication, psychosexual function, and supportive-expressive approach. The most promising results were obtained from interventions aimed at helping partners express and reduce their emotional distress, improve communication and sexual intimacy, learn new strategies, and make behavioral changes. The review highlighted the significant unmet psychosocial needs of the partners of prostate cancer survivors and called for the development and evaluation of appropriate and effective psychosocial support interventions for them.

In their study, Lehto and colleagues (2017a) found a strong association between social support received and given, suggesting that couples respond as an

emotional system. However, the support given and received was not evenly distributed. While almost all spouses reported providing emotional support to the patient—half of them reporting that they had given “much” support—only 30% reported receiving much support from the patient, while 14% claimed to have received no support at all. At the time of diagnosis, the spouses’ main source of support was the people close to them, but only 54% had received support from the patient, and 12% had received no support whatsoever from any source. In turn, 11% of spouses had received support from a physician, which predicted less anxiety and more support for the patient. Less support for the patient was associated with the spouse’s own experience of depression, the patient’s irritability, and the perception that the illness or treatment had no impact on the relationship.

Based on their findings, Lehto and colleagues (2017b) call for caring for the psychological well-being of spouses of prostate cancer patients and involving them in the treatment process and care. Gibbons and colleagues (2019) highlight the cancer experience as “a unique opportunity” to build on the relationship’s positive tendencies through developing mutuality in the midst of uncertainty (p. 7). They call for appropriate ways to support couples to work more effectively together to manage shared stress and traumatic experiences. In turn, Kayser and Acquati (2019) recommend support for partners’ relational skills, particularly their capacity for mutuality during cancer-related stress. They suggest that promoting mutuality in the relationship should be central to couple-based interventions for couples coping with cancer-related stress. Badr and Acitelli (2017) emphasize that psychosocial interventions should be offered to couples living with a chronic illness soon after diagnosis or early in the treatment process to maximize their impact.

Nelson and colleagues (2015) call for interventions based on innovative theoretical approaches to support the relational and sexual intimacy of couples living with prostate cancer. Galbraith and colleagues (2011) and Wittman (2015) highlight the need for interventions addressing grief and mourning as a way towards a “new normal” after prostate cancer treatment. Healing the whole person should be the goal of the care (Carlick & Biley, 2004; Galbraith et al., 2011; Tanner et al., 2011; Evans et al. 2012), and clinical interventions should move towards a more integrated approach (Galbraith et al., 2011).

4. Research Task

The research task was to create a psychosocial support intervention for prostate cancer patients and their spouses to support the implementation of patient-centered holistic cancer care. Narrative identity as a social construction (Sparkes & Smith, 2008; McAdams, 2013; McAdams & McLean, 2013), a serious illness experience as a potential rupture to it (Bury, 1982; Ricoeur, 1991; Holma, 1999), and the potential of a qualitative research process—in this case, a series of narrative interviews (Murray et al., 2009; Adler et al., 2017)—as an intervention (Gale, 1993) were the starting points of the study.

5. Method

5.1 Participants

Ten newly diagnosed prostate cancer patients were recruited to participate in the study, five of them individually, and five of them with their spouses. The ages of the patients ranged from 48 to 74 years (mean 61.9) and the ages of the spouses from 48 to 70 years (mean 61.4). The duration of the marriages of the couples involved ranged from 2 to 50 years. One of the patients was divorced, and two patients went through the divorce process during the period of data collection. Both patients and spouses had different professional backgrounds, with a minority possessing an academic degree. Four patients and two spouses were retired.

All patients were treated with external radiotherapy, two of them also twice with internal high dose rate (HDR) brachytherapy. The external radiotherapy lasted for eight weeks with treatment being given every weekday; during brachytherapy, external radiation was suspended. One patient was treated with docetaxel chemotherapy before external radiotherapy. All patients except one were also treated with hormonal therapy. The time from the diagnosis to the start of participation in the interview intervention ranged from 1 week to 2 months.

5.2 Data Collection

The interviews were designed and conducted by the author (Riikka Talsi) with the design being confirmed by Aarno Laitila.

Each patient/couple participated in five narrative in-depth interviews during the cancer treatment period and a follow-up interview a year after the first interview. The five narrative in-depth interviews were scheduled either in quicker succession over two months' radiotherapy or less frequently during a half-year period (for one participant, four months) including both radiotherapy and partly hormone therapy (for one participant, also chemotherapy). These two main options enabled assessment of whether frequent interviews or a schedule allowing more time for reflection between the meetings served the participants better. The shorter interview schedule during radiotherapy minimized the need to travel for participants living further away; however, some of them still opted for a longer interview period. In all, the interview periods were divided evenly

between the two alternatives. Interview intervals within an agreed interview period were suited to the participants' needs. The interviews were conducted in Finnish.

5.2.1 Life Story Interviews and Thematic Interviews

In the interviews, I asked the participants to reflect freely on their lives, the cancer experience, its effects, and the needs arising from it according to and emphasizing what they felt to be of significance. The interview could start with a simple life story prompt (used once with all the participants): "Could you tell me your life story?" or be initiated using the following main themes: cancer treatment; physical, mental, and social well-being; patient and spouse, family; work and leisure; the future; and the cancer experience and life story from different viewpoints. I raised the themes according to the participants' present concerns at the time of each interview while nonetheless ensuring that all the main themes were addressed during the interview period. When necessary, I continued by asking clarifying questions or presented subthemes as narrative topics (see Appendix 1).

Unconditional respect for the participants, their lives, experiences, and what they brought out, as well as careful, responsive listening were important principles for me throughout the interviews. I listened, personally transcribed, and summarized each interview before the next one took place so that I could recall important excerpts and thoughts from the previous interview and thus support the participant(s) in building a broader picture. I conducted the interviews in a reflective mode and, when possible, summarized the content of the ongoing interview to the participant(s). I allowed the participants as much time as they felt they needed, the duration of the interviews ranging from 42 to 160 minutes (mean 95 min). I wrote research journal entries immediately after each interview, which provided me with important moments to pause, reflect, and process how I had felt during the interviews and what kinds of thoughts and emotions had arisen in me.

All the way from the pilot interview phase, the interview methodologies began to develop in interaction with the participants. Eventually, they included several context-situated ideas not reported in earlier studies.

5.2.2 Momentary Key Metaphors

Metaphors became part of the interview process based on an observation that I made in the first pilot interview. When I asked the spouse by which metaphor she would describe the cancer experience at that moment within the whole of her life, the metaphor she gave, and the following dialogue, was so inspiring to both of us that I decided to include a section on "Momentary Key Metaphors" in all the interviews.

Towards the end of the first five interviews of the interview series, I asked the participants to describe the cancer experience at that moment in their lives through a metaphor by continuing the following sentence: "Being ill with cancer in my life is like . . ." (patient) / "My spouse being ill with cancer, in my life, is

like . . .” (spouse). When the sharing of a metaphor opened up a dialogue, I allowed the conversation to continue under its own momentum. However, sometimes asking the participant to reflect on the metaphor’s personal meaning helped to open it further.

Momentary Key Metaphors also gave rise to a series of further innovations.

5.2.3 Dual Lighting

It soon turned out that many of the metaphors presented two different, even contrasting angles, to what was being described, for example, “*A challenge, an opportunity,*” or could be understood as such, for example, “*Trying to wake up from a bad dream*” (being in the midst of a nightmare vs. being awake). The metaphors seemed to contain the current and the desired. This perception led me to develop “Dual Lighting,” a variation of theme-based narrative interviewing.

In this method, I asked the participants to explore the cancer experience and their lives by presenting the above interview themes through the contrasting perspectives that had emerged in their previously formulated metaphor(s). I could, for example, ask, “in which areas of life and this experience, do you still feel like facing challenges, and in which have they possibly already turned out to be opportunities?” and then we would go through the interview themes. Dual Lighting was used as an invitation to help the participants talk about the cancer experience and life using their own words, aiming to support them in seeing their progress in the process.

5.2.4 The Clip Approach

When preparing for the first time for the fifth interview (which concluded the actual interview period), I went through all the preceding interview transcriptions of that specific couple, immersing myself in the data in the same empathizing way I had listened to them in the interviews. All the phases, events, and occurrences in their lives, and their way of telling them in their own personal voices. The challenge was how to reflect it all back, how to help and support them in taking these fundamental building blocks and re-constructing their own story.

Then I developed the next idea. Just as I had orally recalled important excerpts and thoughts from the previous interviews and brought them to the next interview, I would select salient words, metaphors, and sentences from all their previous interviews and write them down on slips of paper. I would set the “Clips” on the table in a random order and ask them to build their life story including the cancer experience, as they perceived it at that specific moment, using the excerpts they felt meaningful for the story, leaving others unused. I would also make a pile of empty slips so that they could add new words and sentences to their story, telling them that the form of the story was completely free and that they could construct a common story or two individual ones, just as they wished.

Selecting the Clips took me to the responsive listening mode on a higher level. At that point, I had already met the participants four times, become acquainted with them as people, and familiarized myself with their individual ways of being,

behaving, speaking, and responding. Their life stories and the cancer experience had emerged and been discussed in a variety of ways. In preparing the Clips, I went through the interview transcriptions—keeping the broader context in mind, based on hermeneutics—and underlined potential Clip candidates: participants’ personal ways of expressing life and its events; self and others; the past and the future; feelings and thoughts; options and choices; evaluations and perceptions; questions and answers; values, goals, and wishes; meanings and metaphors.

The first round resulted in more pieces of text than I thought would be a manageable number of Clips. Therefore, I went through the underlined texts iteratively several times, removing any that overlapped, as well as less central texts, with the objective of identifying the most salient quotations presenting the accounts as the result. I had to make choices, but I made them with my best understanding with the aim of doing justice to who the participants were as people, what they had experienced, and how they had told what they had told. The Clips were my choices, which I brought for the participants’ evaluation, whether sufficient and striking the right chord, remained to be assessed by the participants themselves.

I was encouraged by the simple, impressive stories that the previously mentioned couple created using the Clips. The man quickly produced his story, which to my surprise followed the structure of a story defined by Labov (2006), although he was probably unaware of this. His spouse took a little longer to get started, but she, too, was able to create an impressive personal narrative. When both were ready, I asked them to tell their stories using the Clips they had chosen and then to share what they had added or omitted and why. The unique stories expressed causal connections, re-used personal narratives to recognize and strengthen the participants’ agency, evaluated experience, and interpreted meaning. Heartened by the way both could re-utilize their rich telling beyond the pieces of narratives as independent parts, I decided to use the method with all the participants.

5.2.5 Retrospective Metaphorical View

At the time of the fifth interview, when the main cancer treatment had finished and the participants came to the meeting excited about the reassuring news on the effectiveness of the treatment, I intuitively felt that I should add a retrospective view on the experience as a whole to the elaboration with metaphors. Before asking the participant(s) for a metaphor to describe the cancer experience *at that moment* in their lives, as in the preceding interviews, I asked them to describe the experience *as a whole* from a retrospective view: “Being ill with cancer in my life *was* like . . . (patient) / “My spouse being ill with cancer, in my life, *was* like . . .” (spouse).

5.2.6 Follow-up Interviews

When designing the content of the follow-up interviews, it was obvious that I would return the personal Momentary Key Metaphors to the participants as an additional tool for reflection that they themselves had produced along their way.

As obvious was, on the same grounds, that I would return the story they had constructed in the fifth interview, and ask them to review the story, change it if necessary, and continue it if they wished.

First, we discussed the progress of the participants' well-being and quality of life during the follow-up period. Then I asked the participant(s) for a Momentary Key Metaphor from a retrospective view as in the fifth interview. After that, I handed the participant(s) a sheet of paper with their personal Momentary Key Metaphors in chronological order and asked them to reflect on the metaphors and ponder whether they created a storyline.

Thereafter, we returned to the story constructed with the Clips in the fifth interview (hereafter, "the Storyboard"), that I had rebuilt on the table according to a photograph taken at the time, and I asked the participant(s) to review the story, change it if necessary, and potentially continue it. We then discussed the meaning of the interviews in processing the cancer experience and life and the potential posttraumatic growth created by the cancer experience.

Finally, I checked whether there was something the participant(s) would still like to add.

The interview process is summarized in Appendix 2..

6. Summary of the Original Publications

6.1 Prostate Cancer Metaphors: A Longitudinal Study of the Lived Experience

The first sub-study introduces the Momentary Key Metaphor methodology and presents the results of the analysis of the patients' metaphors. This research is the first study in which cancer metaphors have been collected in a longitudinal setting in a homogenous way. Thus, it provides new information about changes in patients' metaphors over time.

Metaphors were categorized based on a classification presented in the recent cancer metaphor literature (Semino et al., 2018), and the framing they created was analyzed. Agency and empowerment, as defined and explored by Semino and colleagues (2018, pp. 6–7, 281), increased over time. In line with the existing literature, *Journey* metaphors formed a prevalent domain in the data, while *Violence* or *War* metaphors did not, in contrast to previous findings (see, for example, Semino et al., 2018; Gustafsson, Hommerberg, & Sandgren, 2020; Hommerberg, Gustafsson, & Sandgren, 2020). Two new domains were defined: *Natural Phenomenon* and *Creating Something New*. These domains were the next largest domains after the *Journey* domain in the study data.

Participants created *Natural Phenomenon* metaphors in the first interview (after the diagnosis) and in the last two interviews, especially when describing the cancer experience as a whole in the follow-up interview. In contrast to the *Natural Disaster* metaphors highlighted by Harrington (2012), most of the *Natural Phenomenon* metaphors were polyphonic. In these metaphors, the narrators either juxtaposed two opposing natural phenomena or illustrated the negative and positive aspects of one phenomenon.

The metaphors were polyphonic in nature in several other domains as well. Some participants created polyphonic metaphors from the very beginning, while some others began to develop them later in the interview series. It is noteworthy that all polyphonic metaphors were empowering—even those in the domains that can be interpreted as negative, such as *Violence* and *Restraint*, while other metaphors in these domains were disempowering.

Creating Something New metaphors appeared in the data from the third interviews onwards, in all phases of the interview series. It is possible that reflecting on the experience and the self over a longer period of time in an iterative way enabled the participants to perceive the cancer experience in this new way.

Journey, as the most common domain, can be seen as a meta metaphor for the data. With *Journey* metaphors, participants described their journey to the external and to the internal—the physical world around and their inner world—recognizing existing and new aspects of the self (Laranjeira, 2013) in their journeys of self-discovery (Coreil, Wilke, & Pintado, 2004). Three of the domains proposed by Semino and colleagues (2018) did not appear in the data. Potential reasons for their absence are discussed in the sub-study.

The formulation of Momentary Key Metaphors helped the participants create a reflective stance on the illness. It facilitated the organization of the experience, provided a deeper understanding of it, and opened up new perspectives on the participant's reality (Lakoff & Johnson, 1980; Levitt, Korman, & Angus, 2000; Gibbs & Franks, 2002). The metaphors provided the participants with a tool to deal with fears, anxiety, uncertainty (Gibbs & Franks, 2002; Appleton & Flynn, 2014), and a lack of future prospects, and supported them in processing and accepting different aspects of experience, moment by moment. With the metaphors—particularly the polyphonic ones—the participants could examine and make sense of various, even contradictory, aspects of their experience, verbalize disorder and order (Teucher, 2003), and transform the illness experience into a more meaningful one (Gibbs & Franks, 2002; Hommerberg, Gustafsson, & Sandgren, 2020). Exploring the dissonances increased self-knowledge and enabled evaluation and change (Aita et al., 2003).

The study highlighted the diversity of domains and metaphors used by prostate cancer patients when describing their experience and showed that they deal with the illness experience with richer imagery than has previously been reported in the literature. The study demonstrates the need for sensitivity in communication concerning cancer and encourages placing everyday interaction at the heart of treatment interventions. Metaphors can enrich and deepen therapeutic relationships (Harrington, 2012). The Momentary Key Metaphor methodology allows access to patients' illness imagery, laying the foundation for a shared language to support patient-centered care (Penson, 2004; Harrington, 2012). While bringing patients' subjective views to the forefront of the discussions, they give meaning to the illness experience and may assist in strengthening the therapeutic alliance around a shared vision (Penson, 2004).

6.2 The Dialogue of Metaphors: Couples Building Meaning for a Prostate Cancer Experience

The second sub-study examines the Momentary Key Metaphor methodology in the context of couples and deepens the illustration of the dialogical nature (Bakhtin, 1981, 1984, 1986) of the methodologies developed in this dissertation. The analysis proceeded from a model-based (Semino et al., 2018), higher-level investigation of all the metaphors (similar to that of the first sub-study) to a hermeneutic, data-driven, in-depth examination of one couple's metaphors in the dialogical context in which they were born, as a single-case study (Yin, 2018).

Journey was the most common domain in both patients' and spouses' metaphors, followed by *Restraint* in patients' metaphors, and *Sports and Games* in spouses' metaphors. The new domains defined in the first sub-study, *Natural Phenomenon* and *Creating Something New*, were also found in the spouses' data, which revealed a third new domain: *Support*. There were three *Violence* metaphors in the patients' data and only one in the spouses' data.

The model-based analysis highlighted a reciprocal relationship between patients' and spouses' metaphors in terms of the agency (Semino et al., 2018, p. 7) and empowerment (Semino et al., 2018, pp. 6–7, 281) they express. At the beginning of the interview series, the agency and empowerment expressed by the spouses' metaphors were higher than those expressed by the patients' metaphors. However, the situation was reversed in the middle of the interview series, and in both cases the agency and empowerment expressed by the metaphors was at its highest when the participants described the cancer experience in the fifth interview.

The analysis of the case shows that a prostate cancer diagnosis, even with a good prognosis, is a crisis for both partners and their relationship. The interview context created a space for discussing the cancer experience, and the metaphors a new way to build meaning for it (Semino, Demjén, & Demmen, 2018). At the beginning of the interview series, the patient was more restrained. The spouse spoke more, showed empathy, and maintained hope. Through the spouses' mutual interaction, their metaphors began to develop, their dialogue deepened, and they succeeded in sharing each other's personal experiences of the illness. Their initial roles changed, their tolerance of uncertainty increased, and different shades of need became permissible for both.

While the metaphors were answers to the interviewer's question, they were also speech directed to the speaker themselves and to their spouse. Through the construction of Momentary Key Metaphors, each spouse was able to build an image of their current experience for themselves and the listeners, allowing them to share their experience and feelings related to it, and enabling the listeners to respond. This enhanced relationship awareness and authenticity and paved the way for mutuality (Miller & Stiver, 1998; Kayser, Watson, & Andrade, 2007; Kayser & Revenson, 2016).

The interviewer played an important role in nurturing a dialogical space through unconditional, respectful, and responsive listening, and through questions that helped the interviewees "thicken" (Geertz, 1978) their descriptions. The content of the dialogues ranged from showing acceptance, appreciation, and mutual empathy (Miller, 1986)—leading to different dimensions of mutual empowerment (Miller & Stiver, 1998)—to further exploration and construction of the metaphor—possibly as a co-creation of the couple—and even to a whole new conversation initiated by a lost meaning recalled by a metaphor (Bakhtin, 1986).

The spoken dialogue was only one of the dialogues that occurred in each moment. In fact, each moment contained four dialogues, the one that could be heard, and three internal ones. Each interlocutor responded "to a multiplicity of voices, internally and in relation to others" (Seikkula & Trimble, 2005, p. 465).

Everything said was a response to what had been said before (Bakhtin, 1981), and each utterance included an anticipation of a response (Bakhtin, 1986). This is true for the metaphors as well. They came to life by coming into contact with each other, creating together an infinite, endless dialogue in which there was neither a first nor last word (Bakhtin, 1986).

The longitudinal setting allowed the couple to take advantage of the infinite dialogical context (Bakhtin, 1986). Each spouse's metaphors evolved over time, intertwining in a dialogue to form an enriching, deepening story that enhanced the couple's mutual understanding not only of the illness experience but also of the wider story of life. During the process, the metaphors converged, indicating an increasing mutual understanding.

The specific features of the method (the couple created personal metaphors in a longitudinal setting and shared them in dialogue) highlighted and supported the reciprocal nature of the couple's dyadic coping process (Kayser & Acquati, 2019). In the early phases of the interview series, when uncertainty was high and patients' agency was low, spouses used their metaphors to create hope. Later, when patients' agency became stronger, spouses could express their own burdens and vulnerability. There was a reciprocal relationship between psychological work and cancer treatment as well. The reflection work supported both spouses' commitment to the treatment, and the success of the treatment dispelled uncertainty, giving them strength to continue the challenging reflection work further.

6.3 The Clip Approach: A Visual Methodology to Support the (Re)Construction of Life Narratives

The third sub-study introduces the Clip Approach methodology. The results section focuses on how the participants used the Clips, and how the Clips helped them re-enter and re-evaluate their experience and re-construct their life story.

The number of Clips ranged from 60 to 102 per patient or couple. On average, more than 4/5 (607/803~83.4%) of the Clips were used, with six participants (two couples) using all their Clips. Two participants added new Clips to their stories, and two participants inserted new text onto the original Clips. Five Clips fitting two places in the story of one participant were duplicated. One couple removed two words from one of their Clips.

The participants organized the Clips on the provided surface in several ways, leading to stories in a variety of visual forms: in columns, in rows, in a pillar, in clusters, in an unclassified form, and even in a pile. There could be parallel Clips inside the columns or a pillar and above or under the rows—even perpendicular to other Clips. There could also be open space and vertical paralleling inside a story. The free visual format of the stories allowed room for creativity. The shape of the story seemed to reflect the personal style of the narrator, the content of the story, and perhaps even the relationship between the spouses.

All stories were continued in the follow-up interview, five of them vocally with no changes to the Storyboard. One story was continued by adding a new Clip in the middle of the story and three others by adding new Clips at the end of it.

Other stories were continued using Clips from the original story, all in different ways: by organizing several existing Clips with no textual changes in a new order at the end of the story, by removing text from and adding new text to one Clip and moving it to the end of the story, and by composing a continuation from several new and original Clips with complementary text added to them.

The participants were amazed when they encountered the Clips for the first time in the fifth interview. They recognized the Clips at once as their own and remembered the stories behind them, finding the Clips meaningful and authentic reflections of their own thinking. The Clips transformed the oral accounts into a visually approachable and movable form, inviting fresh reflection and dialogue, and providing the participants with a “feedforward,” helping them make sense of their experience (Ewenstein & Whyte, 2007). Picking out a Clip and beginning to ponder its significance and position with respect to other Clips strengthened the interviewees’ agency (Reavey & Johnson, 2011). The participants recognized that the physical organization and placement of the Clips was intertwined with the mental work through which their narrative and life itself could be organized in new ways. While creating a beneficial observer perspective (Tomm, 1987b), the Clips enabled the participants to re-enter their feelings, bringing forth affection for and appreciation of their journey. Seeing their speech as a text even made some participants think that they should write a book, the story as depicted by the Clips being a good start for it.

The Clip Approach enabled the participants to construe their life history and the formation of a wider frame for their present life. Most Storyboards included autobiographical reasoning on the participants’ life history and also current issues outside of cancer. Besides cancer, the participants could be struggling with other life challenges shaking their identity and calling for scrutiny of fundamental life themes like targets, way of life, inter-dependency, and the self. The Clips supported exploration and consideration of life, relationships, and self, and the formation and expression of conclusions (McLean & Fournier, 2008; Habermas & Köber, 2015).

A recurring phenomenon in the stories was the handling of the disruption caused by the illness to the participants’ life story (Bury, 1982; Holma, 1999; Hänninen, 2004). The Clips allowed the participants to explore and re-evaluate the illness and come to new interpretations of it (Singer & Bluck, 2001). The cancer experience was recurrently given a meaning related to something new—*“Searching for something new,”* finding or building the new, understanding in a new way, even *“Being born again”*—and the Clips offered a chance to connect the experience to this new perspective.

The ability of the participants to bridge the past and the future became manifest in the stories in several ways, through including the future in their Storyboard, through looking back at the illness experience and then forward to considerations of the future, and through continuing the story with Clip(s) picked out from the original story indicating the evolution of meaning over time. The Clip Approach enabled the participants to embed the illness experience into their life story in a variety of ways: by sprinkling it on the chronological continuum as a narrative intertwined with the whole life story, by embedding it into

the life story through thematical parsing or as an entity in the chronological continuum, or by using a combination of these.

The created narratives differ from any other narrative data in the literature—both in how they were constructed and in their final form. Hermeneutic philosophy is interwoven in two ways in these “dense narratives,” in which each Clip, as a detail of the narrative, stands for a larger whole known to the teller and the listener(s) and forms a new whole together with the other details of the story.

The Clips transformed the oral accounts into a visual form, allowing the illness experience and life to be perceived in a new way. They enabled and enhanced the process of accessing meaning and generating new meaning (Reavey & Johnson, 2011). The Clips enabled the participants to give shape and structure to their experience, and thus reach it from the non-discursive side of self-production, strengthening their agency (Reavey & Johnson, 2011) and potentially arousing feelings of artistry, creativity, and productivity (Predeger, 1996). The Clip Approach generated new perspectives and options (Tomm, 1988) and facilitated the formation of connections between distant parts of life and self (McLean & Fournier, 2008), supporting continuity (Habermas & Köber, 2015) and promoting self-development (Habermas, 2011; McAdams, 2013) and personal growth (McLean & Fournier, 2008). Building a story together as a couple enabled the participants to engage in sensemaking as a common activity creating shared understanding, appreciation, and empowerment—the Clips working as tools for interaction and development of knowledge (Ewenstein & Whyte, 2007).

7. Methodological Results

The empirical part of the study began with the creation of a simple narrative space with only themes, free narration, respect, and a leisurely atmosphere as its original structures. In this dialogical space, participants brought their voice, which was carefully and responsively listened to. Through participant-centered interaction, both the participants' narratives and the interview methodologies began to develop.

The first methodological result was the Momentary Key Metaphors. In most previous cancer-metaphor studies, participants were unaware that the researcher was interested in their metaphors. To reveal this interest at the data collection stage had even been considered a potential problem as it could have led to "a self-conscious way of speaking" (Gibbs & Franks, 2002, p. 146). In this dissertation, the metaphor was offered to the participants as a conscious means of exploring, summarizing, and reflecting on a complex, often contradictory experience at different stages of its development and ultimately on the whole in retrospect. The creation of Momentary Key Metaphors offered the participants one way of constructing reality by (re)interpreting their experience moment by moment and giving it meaning in a social context.

Many of the metaphors turned out to be multi-voiced. While describing the present experience, they seemed to contain what was desired "behind," "around," or "beside" it. Potentially, the wording of the metaphor prompt, in which the narrator was asked to describe the illness experience *in their life* ("Being ill with cancer in my life is like . . ." / "My spouse being ill with cancer, in my life, is like . . .") also evoked voices from around and beside the cancer experience (cf. an alternative metaphor prompt: "Being ill with cancer is like . . ." or "Cancer is like . . ."). In some metaphors, the different voices were clearly expressed, in some others, the other voice(s) was/were emerging or incipient, or not-yet-spoken about but referred to. The "polyphonic" (Bakhtin, 1984) nature of the metaphors helped the participants maintain hope and remind themselves that there was more to life than cancer, enabling them to test what of this "more" could be helpful in handling the cancer experience, too.

The above observation led to the next methodological result of developing Dual Lighting, in which the different voices of the metaphors were returned to the narrators to support them in recognizing their progress from the cancer experience to the "more" that was "behind," "around," or "beside" it in their lives during the process. Dual Lighting expanded the narrative interview approaches

from life story interviews and thematic interviews to interviews that directly utilized the participants' own words.

The couple context highlighted the dialogical potential of the participant-dyad setting. One manifestation of this potential was the dialogue that emerged between the Momentary Key Metaphors of the patient and his spouse in sub-study 2. The example shows how the dialogic dimension of the Momentary Key Metaphors expanded from an inner dialogue to an outer dialogue, from one person's account of internal experience to the interactive account of the participant dyad. As multiple voices joined in to share the experience, new possibilities arose (Seikkula & Trimble, 2005). The more voices were included in the "polyphonic" (Bakhtin, 1984) dialogue, the deeper the potential for emergent understanding became (Seikkula & Trimble, 2005).

The next methodological result was born when considering how to reflect central parts of the participants' narration in their own voice back to them. The oral accounts were transformed into a tangible, visually approachable, and movable form, the Clips. With these fragments of thoughts that they could turn over in their hands, wonder at, and arrange, the participants were able to build connections and construct new images in their own words. Through the narration, fragmented experiences were assigned a plot that enhanced the integrity of the participant's reality (Ricoeur, 1991; Cronon, 1992). Without the need to be exhaustive or objective explanations of the participants' lives, the narratives formed descriptions that gave them new perspectives and helped them understand their experience and lives in greater depth (McLeod & Lynch, 2000). In the follow-up interview, these narratives, and the metaphors, were reflected back to the participants for re-evaluation, validation, and re-construction.

In sum, the interview process included two distinctive methodologies, one related to the Momentary Key Metaphors (presented in Figure 1), and another related to the Clips (presented in Figure 2).

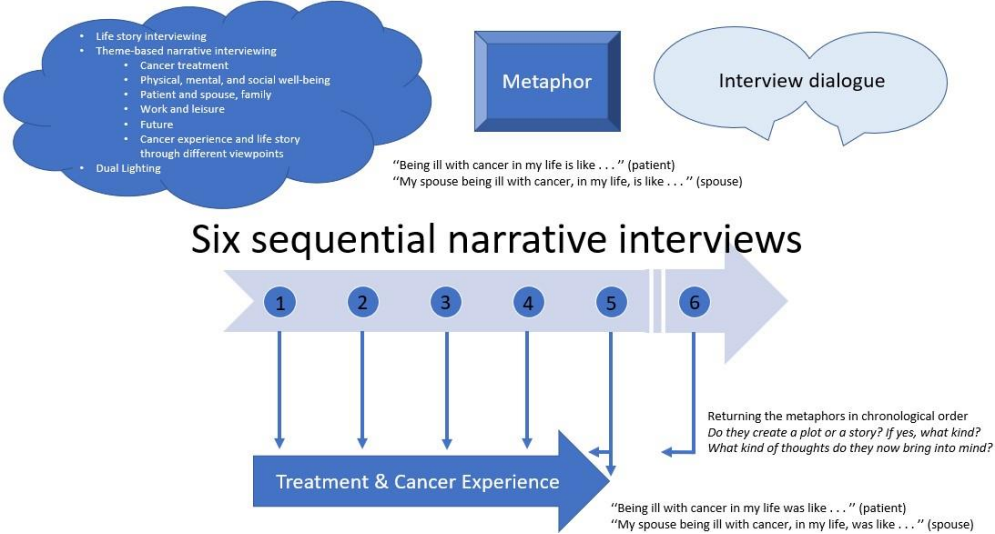


Figure 1. The Momentary Key Metaphor methodology

In the Momentary Key Metaphor methodology, the emphasis is on the processing of the autobiographical rupture experience, while in the Clip Approach methodology, the focus is on the (re)construction of the participants' life narratives, allowing space for both continuity and rupture. In both methodologies, the narrative interview approach and interview dialogue support the reaching of participants' voices to create an understanding of the autobiographical rupture experience and the participant's life as a whole. The methodologies can be used independently or in parallel.

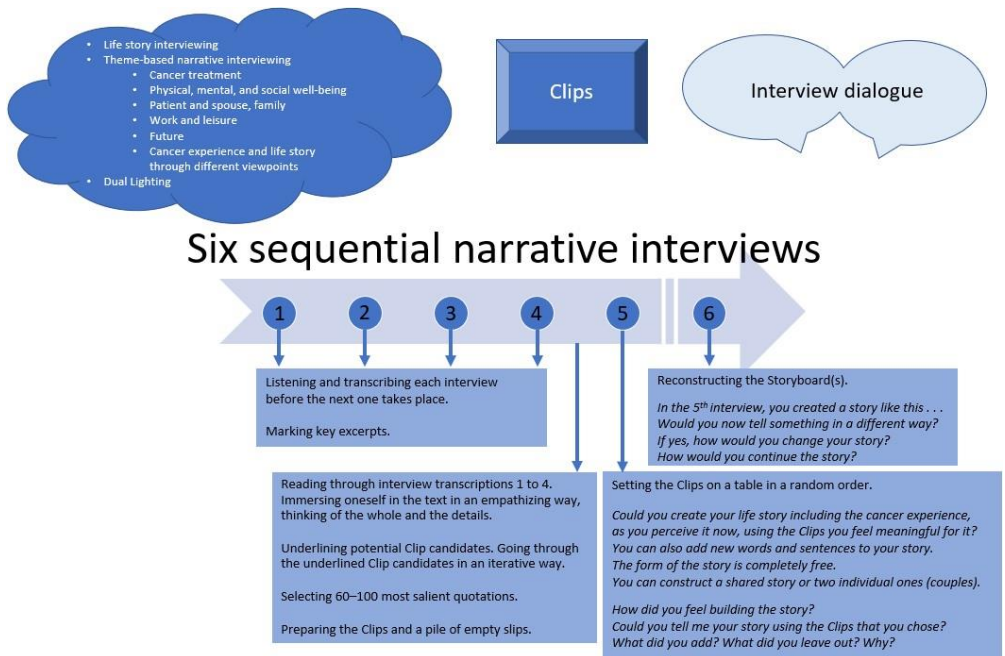


Figure 2. The Clip Approach methodology

7.1 Participant Feedback

The participants found the interviews of this study relieving, constructive, and therapeutic. During the cancer treatment appointments, they gave spontaneous feedback on how meaningful, supportive, and important the interviews were to them, subjectively even as important as the cancer treatment itself. The interviews had “helped,” “supported,” “comforted,” and “strengthened faith”:

Thank God, that I participated in this interview study, this has been extremely important; this has made it a lot easier for me. (patient)

They [the interviews] helped to turn my mind in the direction that life will continue. (patient)

I have been kept together. These [the interviews] have been extremely important to me. (spouse)

The participants felt the interviews were “clarifying,” “liberating,” and “soothing,” giving “inner peace,” “peace of mind,” and “balance”:

I have always left with a lightened mind, even though there has been talk of bad things, difficult things. (patient)

In the interviews, the participants were able to “vent” and “deal with emotions,” “talk out,” “burst out,” and “put thoughts into words” so that issues that would have troubled their minds were “processed immediately,” “not isolated”:

I have been able to ventilate my head . . . to think about why it feels like this. (patient)

To understand this whole cancer and how I have reacted to it . . . that one can talk about it . . . it will be processed . . . I have been able to go through those different feelings. . . . I have been allowed to talk. (patient)

[Things] haven't turned around in my thoughts; I've told [them], and that's it. (patient)

The interviews motivated the participants to “dig and reminisce,” “delve,” and “strongly analyze and process” their lives. They “activated thinking,” and made the participants “put themselves fully into the game” and “think about the consequences, the meanings of life”:

I have been unravelling things that I would otherwise not go through at all. (patient)

I have not been able to analyze it anywhere that way . . . to analyze those feelings this way; I probably never would have analyzed them in this way. (patient)

The participants described the interviews as “constructive” and “empowering”:

*These have been very constructive, these meetings of ours, so I think these kinds of meetings should be accessible to **everyone** (emphasizing) who dares to come and disclose their own life events and how illness or something else changes their life; I think this is **really** (emphasizing) good. (patient)*

. . . going through my history. It has given, at least to me, an awful lot of kind of extra power. (patient)

Here, the whole of life intertwines with the stories now on these clips, so this in a way sheds light on how you have lived and where you are now, and how to get forward . . . I am now much more mature and able to face the life ahead again; I won't worry about this cancer anymore. (patient)

The couples felt that the interviews brought them closer to each other, offered new perspectives to their conversation, and were a window into each other's thoughts, revealing new things even after decades of shared life:

We have approached [each other] mentally, once and for all, and begun to understand [each other] mutually. (patient)

This has been very good. Of course, we wouldn't have discussed these things in such depth, the two of us . . . so yes, this has been, this has been a kind of luxury, that we've been allowed to attend this kind of therapy, in a way. (spouse)

I get to listen to what you [the husband] have been thinking. (spouse)

It is extremely interesting to see what you truly think yourself and bring out of yourself in this kind of situation and what [the name of the husband] brings out; it is extremely interesting and, I think, extremely instructive. (spouse)

The participants found the interviews and the working methods "positive" and could be surprised by their own positive thoughts that emerged through them:

Here, I have been able to bring up things . . . and not just problems, but things that came to my mind, also positive ones. . . . solving the problems is so much easier when sometimes there is talk of something positive as well and the good sides. (patient)

Already structuring of this kind [creating one's life story with the Clips] was a really positive thing, and you can see, when you read these clips . . . many of these points are quite life-affirming, kind of positive (enthusiastically) forward-looking stuff, and strengths, and all sorts of that kind of good stuff. . . . it is very useful, this kind of a processing. (patient)

To me in a way (gives a laugh) it came as a surprise that in my own thinking, there is always faith and hope . . . they truly are there, yes, yeah (laughs), yes, they truly are there, and I want that they are there. (patient)

Several participants used the word "therapeutic" to describe the interviews. They felt that they were "psychotherapy," "therapy," or "mind care" for them:

What does a psychotherapist after all do more? This has functioned very well, and if I think, it is not easy sometimes, in fact, after an interview, I've felt, I've realized that one needs to use one's brain a lot; one feels even a bit tired physically, but absolutely the fact that you have, you have put effort in doing these excerpts, it is, especially now, during the 6th time, I realize it even more clearly, that when we go through these, what I have said, and what I see . . . then all of a sudden it starts to build up. I see a bit what I think or how I change during this process. . . . when one sees that there has been a variety of mental development, and physical and mental hardship, and construction on different levels, and also development as a human, it brings forth stories like this. (patient)

8. Discussion

In this dissertation, a psychosocial support intervention to work through an autobiographical rupture experience and to support the (re)construction of life narratives was developed. Contracting a serious illness, prostate cancer, and the illness experience during the treatments, from the perspective of the patient and the spouse, formed the frameworks of this study. Narrative identity as a social construction (Sparkes & Smith, 2008; McAdams, 2013; McAdams & McLean, 2013), a serious illness experience as a potential rupture to it (Bury, 1982; Ricoeur, 1991; Holma, 1999), and the potential of a qualitative research process, in this case a series of narrative interviews (Murray et al., 2009; Adler et al., 2017), as an intervention (Gale, 1993) were the starting points of this study.

The methods of analysis began to evolve as part of the interviews. While the interviews were oriented by a narrative approach and designed to be open, they were enriched by practical experiments that turned out to be even more important than the researcher could have foreseen at the time of their creation, also for the participants, who were amazed: “We have *truly* been listened to,” “I have said something so meaningful,” “the right words have been chosen, and they set into motion meaningful chains of thoughts that encompass even more than the words on the paper.” Being part of the outer dialogue of the interview interaction, the enrichment of which became clear, these comments suggest an enrichment of the participants’ inner dialogue (Seikkula, 2008; Lidbom et al., 2015; Blomdahl et al., 2018; Viou & Georgaca, 2021) as well.

The interview process provided the participants with a variety of ways to talk about their experiences and lives, to re-enter and re-consider what they had previously said, and to re-construct their narratives about the cancer experience and their lives. Their narration was reflected back to them in several ways. For the participants, this was a validation of their experience, a confirmation of being heard (Martin, 1998), and an opportunity to build something new (Seikkula, 2008). It enabled an exploration of the whole through the details and the details through the whole, reaching meanings and creating new ones—taking the participants a step beyond being confirmed as having been heard, therein allowing them to create and recreate themselves through narrative choices (Martin, 1998; Ricoeur, 1991, p. 27).

Hermeneutic elaboration—reflection and iteration—took place throughout the use of the new methodologies, helping the participants work through the cancer experience and setting it in the context of their unfolding story of life. Both methodologies created a reflective position in relation to the autobiographical rupture experience and life itself, and invited in iterative elaboration, producing dense narratives in the participant's own voice as a result. Hermeneutic philosophy was interwoven in two ways in the resulting narratives. In the Storyboards, each Clip, as a detail of the narrative, stood for a larger whole known by the narrator and the listener(s), and, together with the other details of the story, it formed a new whole. The Clips were like hypertext links, which together, in the Storyboard, parsed earlier meanings and created new ones. Each metaphor, in turn, could be seen as a concluding or balancing part of the corresponding narrative interview (Flick, 2002). The metaphor could summarize something previously said or begin something new, but, in both cases, it crystallized a momentary experience which, together with successive crystallizations, formed a new, larger whole.

While the different approaches to narrative interviewing (life story interviewing, theme-based narrative interviewing, and Dual Lighting) helped the participants expand their narration, the Momentary Key Metaphors and the Clip Approach provided participants with tools to summarize and organize it. Both methodologies facilitated the participants' iterative, abductive thinking, helping them narrow the gap between the initial understanding and the existing fragments of knowledge (Ricoeur, 1991) during the process. The methodologies supported participants in seeing alternative perspectives and options (Tomm, 1988), reaching meanings, and creating new ones, and recognizing change and development in their own narratives and themselves (Gonçalves et al., 2012). Evaluating, interpreting, and making connections between different aspects of life and self (McLean & Fournier, 2008) contributed to the development of personality and identity (Habermas, 2011; McAdams, 2013) and personal growth (McLean & Fournier, 2008), with storytelling being at the heart of stability and change in the self (McLean, Pasupathi, & Pals, 2007).

8.1 Potential Therapeutic Mechanisms

Participants consistently report serial interviews as helpful (Murray et al., 2009), sometimes even more therapeutic than therapy interviews (Gale, 1992). Gale (1992) reported three reasons for this outcome in his study. First, participants were acknowledged as the sole owners of their experience, the holders of knowledge, highlighted by the possibility to revisit and correct the information (video recordings of their therapy sessions) gathered earlier. Second, research interviews involved participants in a self-reflexive and recursive manner, allowing them to re-examine themselves and thus gain flexibility and produce multiple descriptions of their story. Third, the interviewer provided the participants with clarifying procedures (analogies) that helped to understand their situation, and that they could develop further, leading to a collaborative re-telling of their

story. In Gale's study, the use of Interpersonal Process Recall (Kagan & Schauble, 1969) in qualitative research interviews came very close to psychotherapy, as self-reflection, which had not succeeded in therapy, became possible in a non-clinical research context, in which the participants were able to observe themselves in therapy. Moreover, the interviewer was in the role of researcher rather than helper, thus removing from the interaction the "must help" requirement typical of psychotherapy.

All the above dimensions can be found in the methodologies presented in this dissertation. The methodologies acknowledge participants as the sole owners of their experience, invite them to engage in iterative self-reflection, and offer metaphors and Clips as clarifying procedures to re-write participants' stories of illness and life as a collaborative effort. Furthermore, when a person faces a serious illness, the need to talk can be particularly strong, and this need may not necessarily be responded to in the context of somatic treatment. In this sense, the research interviews were genuinely inclusive, whereas treatment situations may be objectifying. Trust built up over a longer series of interviews (Murray et al., 2009), acceptance shown in the interviews (Tomm, 1988), and factors common to all psychotherapies (Wampold, 2015), such as an alliance, empathy, and unconditional respect (Lindfors, 2019), may also have therapeutic significance in this study.

The interviews, Momentary Key Metaphors, and Clips work in several ways analogous to psychotherapeutic work. While usually associated with psychotherapy, in this study—under the influence of the realistic and imagined threats related to cancer—careful listening and intensive responding provide the participants with similar therapeutic tools, allowing them, during the interview series, to widely reach and utilize the narrative resources of both their personal and social stock of stories (Hänninen, 2004; McAdams, 2013). In the methodologies presented, the participants' own speech works as therapeutic documentation supporting the creation of an observer position and enabling the construction of alternative stories and the detection of change (White & Epston, 1990; Morgan, 2000; Fox, 2003). The couple context widens the audience of the performance of the new stories (Fox, 2003), expanding the development, scope, and endurance of the alternative stories in the participants' lives (White & Epston, 1990, pp. 41, 114).

8.1.1 Participants' Own Speech as Therapeutic Documentation

Similar to written documents in narrative psychotherapy, the Clips serve as testimonies—they are more than spoken word (Morgan, 2000; Fox, 2003; Speedy, 2005). They are black-and-white, not transient like speech (Speedy, 2005), thus reaching the "unsurpassed authority" of the written tradition "from the fact that it is not heard but seen" (White & Epston, 1990, pp. 33–34). Through the themes of the small stories picked out and stored on them, the Clips provide a structuring perspective on the participant's own world, triggering thought association chains that cover much more about their own experience and life than the text on those little tags themselves.

The Clips combine several types of written documents typical in narrative psychotherapy. They can be seen as “letters” (Morgan, 2000, pp. 128–139; Fox, 2003) which “due to their visibility to all parties, can be easily amended, contested, or confirmed” (White & Epston, 1990, p. 126). At the same time, they are documents that during the process have been and will be further “authored by the person who is their subject,” thus providing the participant with “a central role in contributing to the specification of her own self” (White & Epston, 1990, p. 191). Through working with the Clips, participants became “conscious of their participation in the constitution of their own lives,” which could “lead to a profound sense of personal responsibility, as well as a sense of possessing the capacity to intervene in the shaping of one’s life and relationships” (White & Epston, 1990, p. 191).

Furthermore, the Clips can be seen as “certificates” that invite “ongoing performances of meaning on behalf of the recipient and the audience” or as “declarations” (White & Epston, 1990, p. 192), or even more—as they are the participants’ own words—as “self-certifications” and “self-declarations” that invite them to develop a new account of their lives and new descriptions of both themselves as persons and their relationships (White & Epston, 1990, p. 213; Morgan, 2000, pp. 116–120; Fox, 2003, p. 32).

The Clips consolidate and thicken participants’ stories, “providing a permanent expression of what might have been key moments” (Speedy, 2005, pp. 285–286) in their lives. They are “documents of knowledge and affirmation” which record “particular knowledges that a person needs to have available to them at times of crisis” (Fox, 2003, p. 26). The Clips share a similarity with Fox’s (2003) practice of printing out patients’ words on laminated cards to enable them to return to their preferred stories and spread the news of their stories to others, but the Clips go further, allowing participants to continue their narratives of what they have previously said. By recording memories from the participant’s entire life, Storyboards made up of Clips resemble “memoirs” (Rick’s et al., 2014, p. 106) as well.

In the follow-up interview, the Momentary Key Metaphors also became a written document, a “letter” (White & Epston, 1990, p. 126; Morgan, 2000, pp. 128–139) written during the process by the participants to themselves (Fox, 2003). Recalling the events of Michael Radford’s *Il Postino*, these letters show how ordinary men—and their wives—gradually found their own voice, a language to express their feelings and make sense of their inner world, their own poetry (Sabbadini, 1998).

In contrast to the card sets used in some experiential techniques (Stein, 2007), both the Clips and the Momentary Key Metaphors directly refer to participants’ own life experiences in their own words, being a confirmation of being heard (Martin, 1998) and strengthening participants’ dignity (Persson et al., 2020). They combine the narrative and the dialogical—the black-and-white is cognitively observable, but at the same time it activates something in the self where the emotional content is at least as important as the cognitive.

8.1.2 Creating an Observer Position

All successful psychotherapy involves some kind of meta-observation and detachment from ongoing psychological processes (Castonguay & Hill, 2007). A necessary step towards being able to act on a phenomenon is that of first becoming an observer, through which both self-awareness and “other awareness,” such as empathy, are enhanced (Tomm, 1987b). This new perspective allows for greater freedom of choice and the opportunity to be free from negative emotions when contemplating issues that trouble the mind (Dimaggio et al., 2003).

In the present study, positioning through a metaphor helped the participants externalize *cancer* (Fergus et al., 2017, 2014) while reaching the complexity and depth of the illness experience (Legowski & Brownlee, 2001). As with client-created metaphors in narrative therapy, Momentary Key Metaphors allowed the participants to reframe their experience, introduce new meaning to it, and spontaneously identify new perspectives and options (White & Epston, 1990, p. 30; Legowski & Brownlee, 2001). The iterative mode of working helped the participants develop and “thicken” (Geertz, 1978) their metaphors during the interview series. This was an empowering process in which the participants could weave their own images of the past and present into the future and give meaning to the cancer experience in the context of their own lives (Legowski & Brownlee, 2001). Externalization helped the participants free themselves from problem-oriented views of cancer, assisted them in identifying and developing a new relationship with the illness and fostered a new sense of personal agency (White & Epston, 1990, p. 65).

The Clips, in turn, helped the participants develop *self*-observation (Tomm, 1987b), providing tools to organize it and thus helping them shift from an object position (as the victim of a life-threatening illness) to a subject position with personal agency (Leiman, 2012) and self-mastery (Kerr et al., 2020). Like the writing used in some psychotherapies, the Clips allowed the participants to keep a larger number of their experiences in their working memory than would have been the case through simply thinking or talking (Dimaggio et al., 2003). While the Clips can be seen as Chafe’s (1985) “idea units,” which express the amount of information (about seven words in English) that a person can hold in their short-term memory at any particular point in time (p. 106), the construction of Storyboards provided “a mechanism by which the informational content of idea units can be significantly increased, and by which these idea units can be reorganized in different relations of dependence” (White & Epston, 1990, p. 36). Thus, the Clips offered a mechanism through which the participants could be “more active in determining the arrangement of information and experience and in producing different accounts of events and experience” (White & Epston, 1990, p. 37), helping them locate themselves as protagonists in their own world (White & Epston, 1990, p. 82; Bruner, 2004).

In a functional sense, the Clips have much in common with the natural objects, such as stones, used in “composition work” in the dialogical reconstruction of self-identity (Konopka, Neimeyer, & Jacobs-Lentz, 2018). Like these tangible elements, the Clips allow exploration of the dynamic relationships between the

elements (e.g., tension and support) and the possibilities for their transformation. Moreover, instead of solely reflecting various aspects of one's identity ("I positions") (Konopka, Neimeyer, & Jacobs-Lentz, 2018), the Clips depict one's experience and life more broadly. They support movements in time and between presence and reflection, providing participants with an "opportunity to see utterances from different perspectives," thus allowing "access to experiences, thoughts, feelings and words not yet said" (Lidbom et al., 2015, p. 7). Such movements and the interaction between them, in the inner dialogue of clients, have been found to be important for the emergence of significant and meaningful moments in therapy (Lidbom et al., 2015).

The serial interviews as such and the reflexive questions presented in them (Tomm, 1988) support participants in self-reflection by allowing earlier findings to be developed and reflected on (Murray et al., 2009). However, in the present study, the potential for self-reflection was taken to a new level through the opportunity for the participants to create their life story using the Clips and through working with the Momentary Key Metaphors, both of which, as White and Epston (1990) describe, are:

invitations for persons to engage in activities that generate an awareness of a process in which they are simultaneously performers in and audience to their own performance, and a consciousness of one's production of one's productions.
(p. 18)

The Clip Approach generates this kind of awareness/consciousness first on the level of the participant's own speech, then through the construction of their own life story, and finally through the possibility to develop and continue the life story. The Momentary Key Metaphor methodology creates the above awareness/consciousness through the participant's creation of and reflection on their own metaphor in each interview, then through the observation and reflection on the metaphors from a longer-term perspective, and finally through the detection and construction of a plot linking the metaphors in the follow-up interview. Together, the interviews and the methodologies used in them create a multi-dimensional, multi-level "context of reflexivity" (White & Epston, 1990, p. 18) that brings forth new options for participants to re-author themselves and their relationship to the cancer experience during the interview process. They support participants in reaching a "metaposition" in relation to the illness and their own lives, helping them put "together orderly series of emotionally laden events in a flow of consciousness" and tell a coherent story of their own (Salvatore et al., 2006, p. 204). By inviting participants to self-reflect on both the details and the whole, the interviews and the methodologies used in them allow the participants to create and recreate themselves through narrative choices (Martin, 1998).

The narrative mode redefines the relationship between the observer and the subject: while allowing both to take their place in the story presented, it gives the observer the role of privileged author (White & Epston, 1990, p. 82). Besides building on exact citations of the participants' speech, the Clip Approach em-

phasizes the authorship of the participants (Martin, 1998) through the possibility to select quotations, add and remove content, write new Clips, edit the story later, and continue it.

The extent to which existing Clips were used, the low level of changes made to them, and the small number of new Clips written suggest that the participants found the existing Clips relevant and adequate for their story. The stories constructed in the fifth interviews were also regarded as valid after the follow-up period. The changes made rather reflect an evolution of meaning: the original building blocks of the Storyboard evolved into building blocks that continued it.

As the Momentary Key Metaphors are created by the participant, expressed in the participant's own words, and presented in the follow-up interview in the same order in which the participant has created them, they, as well, highlight the participant's role as the privileged author.

8.1.3 Enabling the Creation of Alternative Stories

Respecting the autonomy of the participants, the new methodologies opened up space for new perceptions, perspectives, and options, and supported the participants in creating new connections and fresh solutions, releasing their innate healing capacity (Tomm, 1988). Both the Momentary Key Metaphors and the Clips facilitated participants in re-entering and re-considering their experiences and lives and re-constructing their narratives concerning them. Not only did the methodologies provide space for the identification and performance of "alternative knowledges" around which "alternative stories" could be built (White & Epston, 1990, p. 31; Morgan, 2000, pp. 85–97), but they also helped participants richly describe and meaningfully experience their new empowering stories (Rajaei & Jensen, 2020).

Both the Clips and the Momentary Key Metaphors supported participants in recognizing "unique outcomes," or "Innovative Moments," as Gonçalves and colleagues (2009) call them, and building meaning around them (White & Epston, p. 31; Morgan, 2000, pp. 70–85). Thus, they enabled the support of the participants "from behind rather than from ahead," which is a primary mechanism for building a receptive context in therapy (White & Epston, 1990, p. 148). Unique outcomes are narrative details outside the main story (Matos et al., 2009), experiences or events that fall outside the effects of a problem story and oppose it (Morgan, 2000, pp. 70–79). They are exceptions to the rule (Gonçalves, Matos, & Santos, 2009). Supporting the Galilean tradition of the philosophy of science, instead of confirming the rule, they overturn it and call for a reformulation of the rule. Unique outcomes are moments of new insight and action which connect the person favorably with themselves, with other people, and with their own beliefs (Morgan, 2000, pp. 70–79). They are new emergent meanings that enable the construction of a novel, more flexible and adaptive self-narrative in which previous maladaptive assumptions are revised and changed (Gonçalves et al., 2012). Dialogically, they are opportunities for new voices to gain strength alongside and eventually beyond the dominant narrative (Gonçalves, Matos, & Santos, 2009).

Unique outcomes could appear as contradictions to the dominant story (as in many polyphonic Momentary Key Metaphors) or stand as puzzling anomalies (as some of the Clips) (White & Epston, 1990, p. 127). There were “action” type Innovative Moments (especially among Clips) and “reflection” type Innovative Moments (among both Momentary Key Metaphors and Clips) (Gonçalves, Matos, & Santos, 2009) as signs of something new under development (Matos et al., 2009), but also “re-conceptualization” (especially among Clips) and “new experience”-type Innovative Moments (among both Momentary Key Metaphors and Clips), which have been recognized as essential for therapeutic change in narrative therapy (Matos et al., 2009). Through “new experience” Innovative Moments, the participants expanded their stories of self and illness into the future (Gonçalves, Matos, & Santos, 2009; Matos et al., 2009). These included new activities, projects, and experiences (Matos et al., 2009; Gonçalves et al., 2012), which helped the participants imagine and move towards their future selves (Gonçalves, Matos, & Santos, 2009; Matos et al., 2009). During the activities of building new stories around unique outcomes, the participants’ own lives and their relationship to the illness experience were re-described (White & Epston, 1990, p. 127; Morgan, 2000, pp. 85–97; Gonçalves, Matos, & Santos, 2009).

8.1.4 Metaphors in the Construction of Alternative Stories

Momentary Key Metaphors are miniature stories of illness which can, as such, *be* an alternative story or *contain* an alternative story. Many *Journey* metaphors and *Creating Something New* metaphors are examples of the former, whereas many polyphonic metaphors (e.g., in the *Natural Phenomenon* domain) are examples of the latter.

Working with the metaphors helped the participants organize a disordered experience, provided deeper comprehension of it, and opened up new perspectives on their own reality (Lakoff & Johnson, 1980; Levitt, Korman, & Angus, 2000; Gibbs & Franks, 2002). The participants used *Journey* metaphors to describe their journey both to the external and to the internal (Bruner, 2004), recognizing existing and new sides of the self (Laranjeira, 2013) in their journeys of self-discovery (Coreil, Wilke, & Pintado, 2004). The first *Creating Something New* metaphors were created in the third interviews, and they could be found in all subsequent phases of the interview series. It is possible that reflecting on the experience and the self over a longer period of time, in an iterative manner, enabled the participants to perceive the cancer experience in this new way. Using various polyphonic metaphors, such as those describing a natural phenomenon, the participants were able to examine and make sense of the contradictory aspects of their experience, create an evolving dialogue between them, and transform the illness experience into a more meaningful one (Gibbs & Franks, 2002; Hommerberg, Gustafsson, & Sandgren, 2020). When the participants received their metaphors in chronological order in the follow-up interview, the metaphors formed yet another alternative story or a basis for creating one by building a plot around them.

8.1.5 Clips in the Construction of Alternative Stories

The Clips are alternative stories in themselves, as they transform the oral accounts into a tangible, visually approachable, and movable form, encouraging and inviting fresh reflection and dialogue. The Clips enabled and enhanced the process of accessing meaning and generating new meaning (Reavey & Johnson, 2011). They helped the participants explore and re-evaluate the illness and find new interpretations of it. Furthermore, they enabled the participants to express strength, perseverance, and survival in themselves, allowing new interpretations of the illness experience. While helping to make negative emotions related to the experience visible and validated (White & Epston, 1990, p. 159; Salvatore, 2006), the Clips supported participants in identifying and circulating positive aspects of their experience and life (White & Epston, 1990, p. 17). The cancer experience was recurrently given a meaning related to something new, and the Clips provided an opportunity to connect it to this novel perspective. Individual Clips could turn out to be unique outcomes around which the alternative story began to build. Active participation in the restructuring of the experience made it possible to rewrite it (White & Epston, 1990, pp. 17–18) and helped the participants “draw out of these story-fragments a narrative which would be at once more bearable and more intelligible” (Ricoeur, 1991, p. 30).

The participants recognized that the physical organization and placement of the Clips was intertwined with the mental work through which their narrative and life itself could be organized in new ways. Plotting their life stories using the Clips helped the participants synthesize the “heterogeneous elements” of a story in the three aspects discussed by Ricoeur (1991, p. 21). Through “the operation of emplotment,” the participants organized a comprehensible whole out of events that were more than occurrences and thus contributed “to the progress of the narrative as well as to its beginning and to its end” (p. 21). The participants synthesized the “discordant” with “concordant” by literally organizing

together components that are as heterogeneous as unintended circumstances, discoveries, those who perform actions and those who suffer them, chance or planned encounters, interactions between actors ranging from conflict to collaboration, means that are well or poorly adjusted to ends, and finally unintended results. (p. 21)

Finally, through composing their stories, the participants made a synthesis of “two sorts of time . . . a discrete succession that is open and theoretically indefinite” and “another temporal aspect characterized by the integration, culmination and closure,” “a particular configuration”—the resulting Storyboard as “a temporal totality” and the poetic act of constructing it as “the creation of a mediation between time as passage and time as duration,” ending up with “something that endures and remains across that which passes and flows away” (Ricoeur, 1991, p. 22). The process culminated in the moment of the participant reading their own story, which allowed the narrative to reshape the reader’s experience and reconfigure their life (Ricoeur, 1991, p. 26).

By creating a Storyboard and telling their life story with it, the participants were able to question, discuss, and make connections between unique outcomes across landscapes of time (past, present, and future), action (setting, actors, and actions), and consciousness (intentions, desires, values, and beliefs) (Gonçalves, Matos, & Santos, 2009; Matos et al., 2009). The construction of the Storyboards allowed the participants “to feel, think, and act differently from the feelings, thoughts, and actions framed by the problem-saturated story” and literally helped them “construct from heterogeneous UOs [Unique Outcomes] a new gestalt that can be transformed into a new narrative of life” (Matos et al., 2009, p. 69).

8.1.6 Storyboards as Alternative Stories

The resulting Storyboard is an alternative story of life, self, and illness, both in terms of content, but also as a visual representation. It is literally “a new history that is attached to a new future” (White & Epston, 1990, p. 159). As “a visual representation of the life journey both outwardly traveled and inwardly lived,” the Storyboard resembles a “life map,” which presents life as a visual collection of images and symbols (Caldwell, 2005, p. 174). Like life maps, Storyboards are simultaneously the end result of a life review, a powerful invitation to new reminiscences, and a place for a new beginning. As with life maps, how participants shaped their story in turn shaped their experience. The story was both their creation and their creator (White & Epston, 1990; Bruner, 2004).

Storyboards share several characteristics with the poetic documents created from therapy session notes by Jane Speedy (2005). Both the Clips and the stories created with them carried “intimate,” “succinct” distillations of meanings that surprised and encouraged the participants, who felt that they hit “the ‘heart and soul’ of their words and phrases” (p. 286). The Clips “brought different dimensions of spaciousness, playfulness and hopefulness” to the processing of the cancer experience and life and, like Speedy’s poetic documents, took the participants “into some unexpected places” (p. 296). Already receiving the Clips, and later (as I did with one of the couples) “hearing poetic versions of their conversations read out to them,” assisted the participants in “stepping into a space that exoticises the domestic, the everyday, the taken for granted and the unquestioned in their lives” (p. 287).

The Clips and the Storyboards not only captured “‘sparkling’ images and metaphors,” but also *literally* enabled examination of “the spaces in between the said, the ‘as yet unsaid’ and the ‘as yet unsayable’” (Speedy, 2005, pp. 286, 296). They allowed this not only within a single fragment of conversation, like the poetic documents created by Speedy, but also between numerous narratives (Clips) from different parts of the conversations (interviews) by bringing them into contact with each other through the construction of the new narrative (Storyboard). Working with the Clips made it possible “to loiter for longer in the open spaces . . . and (perhaps) to ask some of what might have been asked and say some of what might have been said” (p. 286). It positioned participants “as curious co-researchers,” added new dimensions to the stories that shaped their

lives, and provided “fruitful means of describing and navigating the landscapes of [their] identities and actions” with “unexpected ease and delight” (pp. 287, 294–295).

Like me, Speedy (2005) had invented the practice of co-authoring poetic documents “by accident” when she had been immersed in her “work in a research project that involved the transcription and distillation of a substantial number of conversations” (p. 290). In the same way as I, she had captured the words and phrases that caught her attention when “navigating and peopling the landscapes of action and meaning across people’s lives, histories and possible futures” (p. 290). The main difference is that where Speedy had mostly constructed poetic documents from the clients’ quotes after the session by *herself*, I returned direct quotes to the participants so that they could construct their own stories by *themselves*.

8.1.7 Enabling the Detection of Change

The perception of change that arises from the introduction of a linear concept of time is vital for meaning making and experiencing personal agency in one’s life (White & Epston, 1990, p. 35). Both the Clips and the Momentary Key Metaphors facilitate “the mapping of experience onto the temporal dimension” (White & Epston, 1990, p. 36), the metaphors when returned to the participant in chronological order in the follow-up interview, and the Clips by allowing the participants to organize their experiences and life events in chronological order in their Storyboards. However, these are only two of the ways in which the new methodologies enabled the participants to perceive a change in their experience and life.

Polyphonic metaphors allowed the detection of a change in the interpretation of the illness experience even at a single moment. This change in interpretation was exploited in Dual Lighting, which helped the participants observe and self-reflect on their progress—i.e., change—in different areas of their lives during the process. Asking participants for two metaphors in the fifth interview (a retrospective image of the whole and another image of the current experience) allowed for the perception of change, as well. As a longitudinal method, the Momentary Key Metaphors created space for meaning to evolve throughout the process and allowed the change to be seen as a whole, as participants were able to re-visit their previous metaphors in the follow-up interview. This could lead to the identification of significant changes in agency and empowerment and, in the couple context, also in the relationship.

In a therapy setting, a gradual transformation from using “being burdened” metaphors to “unloading the burden” metaphors has been related to therapeutic change (Levitt, Korman, & Angus, 2000). In this dissertation, in the context of the research interviews, a single metaphor could, explicitly or implicitly, include two or more different, often contrasting, aspects of the illness experience, with the focus shifting from a negative aspect to a positive aspect during the interview series, with both acknowledged when the experience was described as a whole at the end. This was particularly evident in the patients’ data, where the sense of agency and empowerment expressed by the metaphors increased during the

interview series. Exploring dissonances through the metaphors—particularly the polyphonic ones—increased the participants’ self-knowledge and enabled evaluation and change in self (Aita et al., 2003).

The Clips enabled the cancer experience and the feelings related to it to be structured, demonstrating the change in both. All Storyboards discussed the illness experience from the moment of hearing the diagnosis, with fears of death (patients) and being left alone (spouses), to seeking treatment through a sometimes difficult consideration of treatment options, to then illustrating the treatment period, together with empowering thoughts, sentiments and images, and, at some point in the story, recognizing agency and confidence in oneself and, finally, entering recovery with feelings of relief, trust, gratitude, and hopefulness. Through their Storyboards, the participants were also able to see how they had changed and developed during the process. The accounts and the stories repeatedly showed that the core questions caused by cancer dealt with narrative identity, and addressing these questions promoted its development. The Clip Approach helped the participants make connections between distant parts of life and self (McLean & Fournier, 2008), supported continuity (Habermas & Köber, 2015) and made visible development in self (Habermas, 2011; McAdams, 2013) and personal growth (McLean & Fournier, 2008).

The modifications and extensions to the Storyboards during the follow-up interview were yet another source for detecting change. The participants expressed change in various ways: by adding new Clips to their story, by rearranging existing Clips, by removing text from and/or adding new text to existing Clips, or simply by continuing their story orally. Continuing the story with Clips from the original story indicates evolution of meaning. The participants could implement such a change in meaning by moving and potentially editing several existing Clips or, as one couple did, by moving and editing just one Clip, resulting in a dramatic change in their story. These changes make the “pre-narrative quality” of human experience (Ricoeur, 1991, p. 29) visible and illustrate the ability of the Clip Approach to create space for the not-yet-said (Anderson & Goolishian, 1988; Speedy, 2005) and to generate “stories that have not yet been told” (Ricoeur, 1991, p. 30).

Both new methodologies create a structure that supports repetition, which is central to the process of change (Gonçalves et al., 2012). They facilitate the elaboration of unique outcomes as a cyclical process (Matos et al., 2009), allowing the participant literally “to step back and see him- or herself changing” (Gonçalves, Matos, & Santos, 2009, p. 14). Several iterations support participants in validating the change and projecting themselves into the future through their new narratives (Gonçalves, Matos, & Santos, 2009; Gonçalves et al., 2012). Through the reauthoring process, a thick, coherent description of the experience of change is developed (Gonçalves, Matos, & Santos, 2009).

Like the poetic documents co-created by Speedy (2005) and her patients, both Storyboards and the Momentary Key Metaphors reminded the participants “about the ways in which their stories change over time and the ways in which they position themselves differently” (p. 286). By making “the self in the past” and “the self in the present” visible, the Storyboard and the telling of one’s life

story with it created “a metaposition over change,” calling on the participant to reflect on and describe the “processes that allowed the transformation from the past to the present” (Matos et al., 2009, p. 69; Gonçalves, Matos, & Santos 2009). Thus, they enabled and supported the emergence of “a particular type of unique outcome—reconceptualization—that facilitates sustained change” (Gonçalves, Matos, & Santos, 2009, p. 1). The participants were not only actors in the change process but also its authors (Gonçalves, Matos, & Santos, 2009) and were thus able to affect the process of change (Matos et al., 2009). Through reconceptualization, the participants could connect unique outcomes with each other, give them narrative meaning and structure, and expand “these elementary novelties to a new, consolidated self-narrative” (Matos et al., 2009, p. 76). By visually showing how they had evolved from a previous position to a new one, the Storyboards helped the participants maintain a sense of continuity (Gonçalves et al., 2012). They provided a structure for assessing change (Matos et al., 2009) and supported the participants in “gradually identifying with a new self-narrative” (Gonçalves et al., 2012) and in imagining a future with new possibilities (Matos et al., 2009). Reflecting on the change not only in the participants’ life stories but especially in the metaphors created a narrative contrast to the process of change (Gonçalves et al., 2012) and allowed the participants “to avoid the eternal dichotomy between the two voices in opposition, by transforming the dichotomy itself” (Gonçalves, Matos, & Santos, 2009, p. 18).

8.1.8 Recruiting a Wider Audience

The development, scope, and endurance of alternative stories can be further expanded by recruiting a wider audience for the performance of new meanings in the participants’ lives (White & Epston, 1990, pp. 41, 114; Fox, 2003). For all the participants, the researcher acted as an “outsider-witness” (Fox, 2003), who observed the new knowledge first by hearing it, then by returning it back to the participants (Seikkula, 2008) through the Clips and the Momentary Key Metaphors, and finally by witnessing the reconstruction, telling and development of the new stories.

Involving the spouse in the interviews directly widened the audience from the researcher to the person nearest in the patient’s life. This was meaningful for both spouses. The interviews were a window into the spouse’s thoughts. They created “other awareness” (Tomm, 1987b), revealing new things even after decades of shared life. Building a story together helped the couples make sense of their situation through collaborative action, creating shared understanding, appreciation, and empowerment (Miller & Stiver, 1998). The Clips worked as tools for interaction and development of knowledge (Ewenstein & Whyte, 2007).

In the acts of witnessing the performance of a new story, the spouse contributed to the writing of new meanings (White & Epston, 1990, pp. 17–18). This comes clearly out in sub-study 2 in the dialogues opened up by the metaphors. Demonstrating acceptance, appreciation, mutual empathy (Miller, 1986) and mutual empowerment (Miller & Stiver, 1998), the dialogues helped both spouses further explore and construct their metaphors. Each cycle was intensified by the validation of the significant other, triggering new cycles of novelty

exploration (Gonçalves, Matos, & Santos, 2009). Through the interaction between the spouses, their personal metaphors began to develop, and their dialogue deepened. The longitudinal setting helped the couple exploit the limitlessness of the dialogical context (Bakhtin, 1986) as they constructed meaning for the cancer experience in their lives. Each spouse's metaphors evolved over time, and intertwining in a dialogue formed an enriching, deepening narrative that enhanced the couple's mutual understanding not only of the illness experience but also of the wider story of life. Thus, the dialogue not only helped the couple create a polyphonic understanding of the shared experience, but also provided a relation to the self and a process of self-formation (Seikkula, 2008). Both spouses contributed to the growth of each other and their relationship (Seikkula & Trimble, 2005; Jordan, 2017), each serving as an "outsider-witness" to the other's new stories (Walther & Fox, 2012; Chow, 2015), which were completed in their living receivers (Ricoeur, 1991, p. 21). The couple context involved both spouses as experts in their own experience of illness, enabling the partners to recognize and be aware of each other's preferred stories, to acknowledge and actively thicken them, and to connect around shared intentions and values (Fox, 2003).

Finally, the fact—and the participants' awareness of this—that the study they were participating in was a dissertation study, widened the participants' audience both objectively and subjectively. For many participants, it was meaningful that by taking part in the study and telling their story, they were helping not only themselves, but also, potentially, other patients and spouses in a similar situation, as well as assisting healthcare professionals in improving care. This transformed the participants from patients and spouses into "consultants," with Storyboards and Momentary Key Metaphors as "documents of rite of passage," that helped them, at the end of this joint work, take recourse in the alternative stories they themselves had generated during it (Fox, 2003, p. 34).

8.2 Therapeutic Effects of the Processual Interview Series

The interviews and the methodologies developed in this study are resource-oriented and dialogical. They follow the words that the participants use and create a genuine interaction event. They take place over a longer period of time and emphasize the meaning of the participant's life story. Like therapy built on a narrative mindset, they (1) emphasize the lived experience of the person, (2) encourage the perception of a changing world by plotting the lived experience through the temporal dimension, (3) invite the creation of implicit meanings and multiple perspectives, (4) encourage polysemy and the use of ordinary, poetic, and picturesque language to describe experience and construct new stories, (5) invite a reflexive stance and an appreciation of one's own participation in interpretive acts, (6) encourage a sense of authorship and re-authorship of one's life and relationships in the telling and retelling of one's story, and (7) acknowledge that stories are co-produced and establish conditions under which the "subject" becomes the privileged author (White & Epston, 1990, p. 83).

The interviews provided the patient with a participatory experience of care, which may, given the stage of the disease, otherwise be objectifying. Whereas a medical file “has a significant, if not central, part in rituals of exclusion” (White & Epston, 1990, p. 190), Momentary Key Metaphors and Storyboards represent what Bryan Turner calls “rituals of inclusion” (Turner & Hepworth, 1982). They are a version of a co-constructed reality shared dialogically rather than as a professional monologue (White & Epston, 1990, p. 126). In contrast to case notes written for the care provider, they “constitute a form of recording for the benefit of those who attend” (Fox, 2003, p. 26). They are “alternative documents” (White & Epston, 1990, p. 191), which as practices supporting the externalization of the problem, provide an alternative to cultural practices that objectify people and their bodies, and open space for people to rewrite themselves and their relationship to their problem according to alternative narratives and knowledge (White & Epston, 1990, p. 75).

Life is merely a biological phenomenon until it is interpreted, and a narrative provides symbolic resources to creatively imitate “the mixture of acting and suffering, the very fabric of life” (Ricoeur, 1991, pp. 27–28). This mimesis is two-fold: “as narrative imitates life,” so does “life imitate narrative” (Bruner, 2004, p. 692). We construct ourselves by continuous interpretation and reinterpretation of our experience (Bruner, 2004), and “the story of a life grows out of stories” we tell about ourselves, constituting our personal identity that we never cease interpreting (Ricoeur, 1991, p. 33). Our life is not “how it was” but how we interpret and reinterpret, tell, and retell it (Bruner, 2004, p. 708).

The interview series allowed for iterative storytelling and ultimately retelling of the participant’s life story (McLeod, 1996) as a collaborative task (Kohler Riessman & Speedy, 2007). The Momentary Key Metaphors and the Clip Approach supported the participants in creating new meanings and helped them organize their stories, compiling “emotions, memories, cultural norms, options granted and paths forbidden, dreams, fantasies and desires” into “*scripts*” that they could use (Dimaggio, 2006, p. 104). The new methods helped to achieve the objectives of a good intervention as defined by Dimaggio (2006): “there needs to be a modification not only of the contents of the stories, but also their form” (p. 106). Of these two, the latter is potentially even more important, at least according to Bruner (2004), who notes that “it is form rather than content that matters” (p. 696) and that the “formal structures” (p. 709) of self-narration may be established early on in the discourse of family life, and:

become so habitual that they finally become recipes for structuring experience itself, for laying down routes into memory, for not only guiding the life narrative up to the present, but for directing it into the future. (p. 708)

The new methodologies supported the emergence and maintenance of the dialogical process characteristic of successful psychotherapy: they created a metaposition from which other positions in relation to the illness and the self could be seen and evaluated (Dimaggio et al., 2003; Hermans, 2003; Matos et al., 2009). This metaposition created distance to other positions, provided an overarching view of them, and facilitated the evaluation of different positions and

their organization (Hermans, 2003). It helped the participants integrate different positions into their personal history, organize positions, and identify how one position had led to another, pointing the way for the future development of the self (Hermans, 2003). Furthermore, the interview series provided the participants with a means to recognize and find their own voice (White & Epston, 1990, p. 159; Ricks et al., 2014), and by enabling the participants to be the audience for their own presentation of the new alternative stories, it enhanced their sense of personal agency and potentially the survival of the new stories as well (White & Epston, 1990, p. 17).

Cancer patients experience a great need to do something themselves (Melman & Newnham, 2011). For many, a cancer diagnosis is like a death sentence, leaving them speechless and feeling hopeless, but it need not be. By actively and productively engaging with their own experience of illness as the somatic treatment progressed, the participants in this study were able turn their uncertainties into possibilities, showing that meaning-making, enhanced agency, and coping are closely linked (Moran & Russo-Netzer, 2016; Kayser & Acquati, 2019; Dauphin et al., 2020).

By telling and being listened to, a human being becomes aware, understands, and builds the world themselves and their relationship with the surrounding world. Possible, more favorable meanings for individual issues or events, or for larger entities, at their broadest for the whole of life and the self, strengthen and increase well-being and mental health (Kerr et al., 2020). This psychological work was enabled through the methodologies proposed in this study at several levels, first at the level of the interviews and then at the level of the dense telling enabled by the Momentary Key Metaphors and Clips. The way the stories began to live and the experience to deepen indicates the benefits of the new methodologies. The unfolding stories of illness and life could be widened and deepened by them.

The only life worth living is a well-examined life, and any story told about anything can be better understood by looking at other possible ways of telling it (Bruner, 2004). By exploring and learning something about “how people put their narratives together when they tell stories from life, considering as well how they might have proceeded” (Bruner, 2004, p. 709), this dissertation may have brought something new to this great ideal.

8.3 Strengths and Limitations

As the interview methodologies developed in this study have not been widely applied, variation related to the interviewer has not yet been evaluated. On the other hand, this study possesses several strengths. By involving men of different ages, the study provided a broad picture of the prostate cancer experience at various stages of life. Including spouses not only widened the perspective, but also allowed couples to work through the experience as dyads, creating shared agency and strengthening mutual support. Multiple consecutive interviews over a longer period of time, together with careful listening and intensive responding, built trust (Murray et al., 2009) and enabled deep personal exploration and

working through the cancer experience within the process. Transcribing the interviews without outsourcing the work to professionals supported immersion in the data, which served both the participants and the research (McLeod & Balamoutsou, 2001). The narration was reflected back to the participants and meanings were explored in a variety of ways at many different levels, not only in relation to the illness experience but also in relation to the wider story of life. The interview context was openly reciprocal, providing the participants with the opportunity to comment on their narration both during and at the end of the interview process. The methodologies allowed the stories to emerge, evolve, and continue (Sparkes & Smith, 2008). The number of participants and interviews was high enough to show the applicability and advantages of the new methodologies. Moreover, there was no difference between the richness of the metaphors and Storyboards created in the individual and couple interviews.

The trustworthiness and authenticity of the study are based on several validity procedures presented for qualitative inquiry in the literature (Creswell & Miller, 2000). These include (a) close collaboration with the participants throughout the research process with the intent to respect and support them; (b) prolonged engagement in the field to build a tight and holistic case; (c) researcher reflexivity—writing research journal entries immediately after each interview and using the entries during the interview process and in the data analysis; (d) member checking—the participants validated and commented on the accuracy of the metaphors and the Clips as raw data, and the Storyboards as accounts, with the comments being incorporated into publications 1 to 3; (e) triangulation from multiple data sources (participants) and through multiple methods (observations, interviews, and documents—with Momentary Key Metaphors, Clips, and Storyboards as textual and/or visual artifacts); and (f) detailed and rich description of the setting, the participants, the development of the new methodologies, the data, and the interview process as a whole.

The role of the researcher in developing the methodologies, in the interviews, and in the construction of the stories has been described and illustrated. To enable the reader to evaluate the results, and the interpretations and conclusions drawn from them, Momentary Key Metaphors, Clips, excerpts and photographs of the Storyboards, as well as interview excerpts are widely presented in the publications.

The permeability (Stiles, 2003) of the research is enhanced by the personal engagement of the researcher, by the iterations in both the research process and the analysis and by making the interpretations explicit and accessible by systematically linking them to observations through substantial amounts of illustrative texts. Contextual interpretation, in turn, enhances its transferability (Stiles, 2003). Contracting a serious illness, prostate cancer, and the illness experience during the treatments—from the perspective of the patient and the spouse—were the frameworks of this study. The study does not, however, aim to provide knowledge generalized to this population; but instead, to the phenomenon of the added value of the use of metaphors and visual artifacts as part of a psychosocial interview intervention in the context of a serious health crisis. This dissertation highlighted the phenomenon. Identifying the preconditions

for the use of the methodologies requires further research. As always in qualitative research, the results are tentative and evolving. Just as the study did not seek to reach a final understanding of the cancer experience and life for the participants themselves, it does not aim to present a final interpretation of the results (Stiles, 2003).

One of the Clips presented in publication 3 included personal data and was made generic. No other challenges to the ethical principles occurred.

8.4 Possible Topics for Further Research

The material collected in this dissertation study is extensive and provides an opportunity to further reflect on many research questions and to raise new ones. Some of these potential research questions relate to the metaphors, others to the Storyboards, and some to the interview data as a whole.

The analysis of the *Momentary Key Metaphors* could be widened to an inspection of the longitudinal development of each participant's metaphors and the relationship between sequential metaphors describing the participant's current experience (in interviews 1 to 5) and metaphors describing the whole (in interviews 5 and 6). Another interesting research angle related to metaphors is which spontaneous metaphors and metaphoric expressions the participants used in the interviews and how these metaphors relate to their Momentary Key Metaphors. In the analysis of the metaphors, narrative, hermeneutic, discursive, or even poetic methods could be used. Furthermore, a new metaphor domain classification could be created. In this new classification, for example, *Journey* metaphors could be divided into sub-categories to reflect the different nuances inside this large cancer metaphor domain.

Storyboards, too, could be analyzed further. As discussed earlier, Storyboards are like poems, and—inspired by the work of Gee (1985, 1986, 1991) on units of speech, Kohler Riessman (1993, 2012) on narrative interview data, and McLeod and Balamoutsou (1996) and Speedy (2005) on therapy interview data—they could be analyzed *directly* as such. Each Clip equals a verse, and sequential Clips may form a stanza. As Kohler Riessman (1993) suggests, the analysis of the poetic structures of such stories supports the identification of meaning units within them and the “hearing” of the structure of the stories. Reading stories aloud reveals their “rhythm and tempo” (Speedy, 2005, p. 290) and may bring to light deep structures earlier unknown to the teller and the listener alike (Ricoeur, 1991, p. 23).

In the analysis of the Storyboards, for example, the following questions could be asked. Is the story clear and coherent? What are the core questions of the story and does the story provide answers to these questions? What kind of turns are there in the story, and what is the overall trend of the plot? Is the story linear, progressive, sequential, or recursive (Bruner, 2004)? What is the theme, discourse, and genre of the story (Bruner, 2004)? How does the participant/couple tell their story using the Clips? What about the untold? What Clips did the participant/couple not use? What do these Clips refer to? Why were they not used?

At any time during the analysis, it is possible to return to the broader interview extract to which the Clip refers for further answers.

As with the metaphors, the development of the sense of agency and empowerment presented by the stories could be analyzed. Even the development of self could be explored. This could be achieved by coding the stanzas and verses according to McAdams's (2013) three-level framework of psychological self (Actor, Agent, Author) and by analyzing the narrator's movement from one level to another as the story progresses.

Furthermore, Storyboards could be classified, for example, based on the typologies created by Frank (1995, 2007). Is the story one of Restitution, Chaos, or Quest (Frank, 1995)? And how does the story present the drama of illness? Is it about genesis, emotion work, fear and loss, meaning, or the self (Frank, 2007)?

Storyboards are visual representations of illness and life; thus, they even offer the possibility of analyzing stories visually. What is the visual appearance and structure of the story? What does the "poetic use of space" (Speedy, 2005, p. 290) in the story communicate? What do these dimensions add to the analysis of the story and how do they relate to the content of the story?

Finally, *the interview material* or certain parts of it could be further analyzed with narrative, hermeneutic, or discursive methods. Potential research questions could relate to the discourse around various topics during the interview series. How does the participant's/couple's discourse about cancer develop? How does the meaning of the cancer experience change? How do issues related to sexuality emerge and change during the interview series? How does the discourse about death evolve? What topics and issues do the participants bring up outside the interviewer's questions?

Research questions could also relate to the interviews and the dynamics between the interlocutors. How does the stage of treatment affect the content of the interview, the atmosphere, and the focus of the discussions? How do the interviews change and evolve during the interview series? How do the dynamics between the interviewer and the participant(s) develop during the interview series? What kind of verbal and nonverbal support do the spouses show to each other during the interview series, and how do these develop?

Finally, research questions could relate to the potential results of the interview series. How do the participants describe the meaning of the interviews in coping with the cancer experience and reconstructing their life story? What kind of mental growth do the participants describe?

8.5 Potential Directions for Future Research

The dissertation introduces several new narrative frameworks and methods providing structure for future narrative research. Potential directions for future research may relate to the rupture experience itself, the context, the participants, the interviewer, the interviews, or the temporal dimension.

Future research may use the new methodologies to explore the handling of autobiographical ruptures caused by, for example, various serious illnesses,

acute accident crises, social changes such as unemployment or divorce, or developmental changes such as the transition to parenthood or retirement. Perhaps the methodologies could also be used to study the processing of a collective rupture experience, or any experience that would bring together people who are previously unknown to each other, such as peers. Potential methods of analysis include visual, narrative, hermeneutic, discursive, and poetic approaches.

Some of the suggested research alternatives would introduce the methodologies to different kinds of social contexts and various kinds of participants. Potential research questions in this research direction could include the following: How do the methodologies work in contexts other than health care? How do they work and what kind of results do they produce among participants of different ages and backgrounds? And how do they work between different types of dyads, such as between a parent and an adult child, or between several interlocutors, such as a whole family, or a group of people who do not know each other beforehand?

The next potential research line relates to the interviewer(s). How does variation related to the interviewer affect the results? What interviewer characteristics are key to the success of the interviews and the use of the developed methodologies? How can these characteristics be supported and developed? And, with prostate cancer in particular, what is the impact of the gender of the interviewer on the way the threat to masculinity posed by the disease is approached and dealt with in the interviews and the interactions therein?

There are also several possible research questions related to the interviews. For instance, how would changing the number and frequency of the interviews affect the outcome? What number of interviews is sufficient for positive outcomes? What is the optimum number of interviews? What is the optimal duration and timing of the interview series? Could the interviews be conducted, and the methodologies used, remotely? What further development would it require? How would remote implementation affect the results?

Finally, future research could investigate the impact of the proposed interview series and methodologies on participants' lives in the long term. Do they provide participants with support and tools to work out other autobiographical ruptures they may face later in life, for example if the cancer reoccurs? And what is the long-term impact of the proposed interview process on the psychological well-being of the participants.

9. Clinical Implications

Listening to patients as they rebuild meaning and coherence is pivotal to caring and healing (Frank, 1995; Skott, 2002). This dissertation illuminates the potential of a qualitative research process as an intervention and introduces new methodologies to support the implementation of patient-centered holistic cancer care. Based on the results, experiences, and participant feedback from this dissertation, I propose a similar type of series of interviews as part of the diagnostic and treatment process of (prostate) cancer to support patients' and spouses' mental well-being during and after the cancer treatment.

The proposed methodologies provide beneficial tools to produce and address the required content in guidance and counseling in cancer treatment contexts. The interviews provided participants with a completely new experience of being heard on issues that are difficult to share and may cause loneliness. The new methodologies helped the participants deconstruct and work through the health crisis and the threat of death they experienced when facing cancer. The study highlighted the need for sufficiently long psychosocial support even in those treatments where the outcome is positive. It is not yet known how many interviews will be required for positive results, but the number and frequency of interviews used in this study produced promising results.

9.1 A Patient-Centered Guidance and Counseling Intervention for Cancer Care

Figure 3 presents a proposal for a series of guidance and counseling meetings for a prostate cancer patient undergoing radiotherapy for two months. The intervention is easily adaptable to patients suffering from other cancers, such as breast cancer. The series begins with a narrative thematic interview focusing on the diagnosis and the emotions it has evoked. For the second session, I propose a life story interview and, for the third, the Dual Lighting method, using polyphonic metaphors the patient has potentially created in the first and/or second interviews. The fourth meeting will again be a narrative thematic interview, expanding on the themes discussed earlier and highlighting topics that have not emerged before.

The choices of narrative interview method made in the example are indicative. The timing of the meeting in relation to the time of diagnosis and stage of cancer treatment and, above all, the specific circumstances and needs of the patient, will guide the choice of interview method and topics to focus on in each meeting.

Guidance and Counseling in Cancer Care: 6 narrative interviews

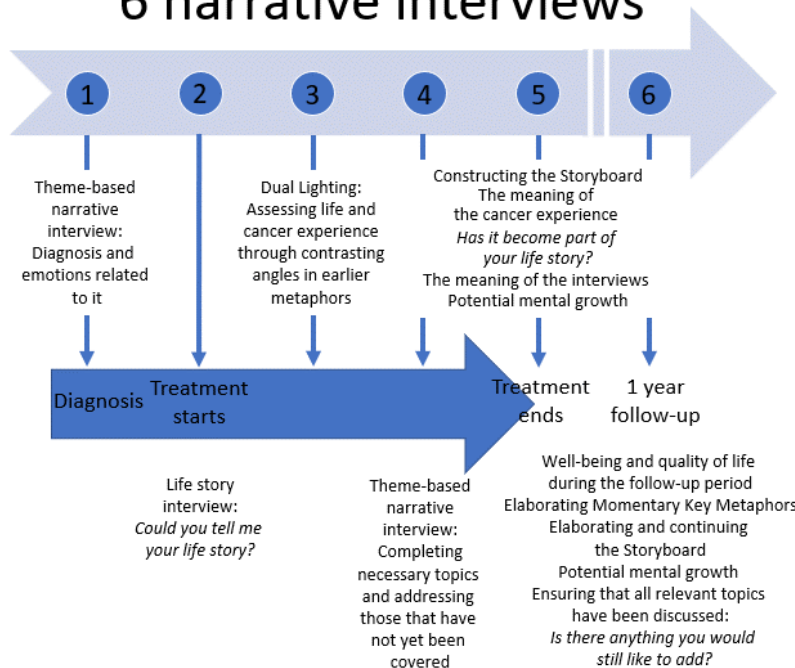


Figure 3. A patient-centered guidance and counseling intervention for cancer care

The fifth session allows the patient to construct his life story through interview quotes and to reflect on the meaning of the cancer experience and whether it has become part of his life story. The role of the meetings in working through the cancer experience, as well as any mental growth that the experience and addressing it may have generated, is also discussed.

In each session, the patient is asked to describe the cancer experience at that particular time in his life using a metaphor and to reflect on the personal meaning of the metaphor. In the fifth interview, this also occurs from a retrospective perspective.

The follow-up meeting begins by discussing the patient's well-being and quality of life during the follow-up period. Then the patient is given his previous metaphors and can re-consider them one by one and as a whole. After that, he is given the opportunity to return to the life story he has constructed in the fifth interview and can reflect on it, change it if necessary, and continue it. The role of the meetings in processing the cancer experience and life, as well as any mental growth that the experience and addressing it may have generated, is also discussed. Before the end of the meeting, it is important to check that all the necessary topics have been covered and determine whether there is anything else the patient would still like to share.

9.2 About Time and Timelessness

The meetings should be unhurried. If possible, no time limit should be set in advance, or if a time limit is to be set, at least 1.5 hours should be reserved for each appointment, allowing the patient to take the time he needs. It is recommendable to schedule the first appointment as soon as possible after the diagnosis. In this phase, anxiety is at its highest (Watts et al., 2014), and the level of uncertainty is also high. Active procedures to control cancer have not yet begun, and since there are no care personnel involved yet, the patient is potentially quite alone with his questions and fears. If the patient needs to wait for the cancer treatment to begin, it is potentially beneficial to organize a second guidance and counseling meeting before the cancer treatment begins, as well.

Meetings 2 to 5 may take place during the cancer treatment period. If the treatment includes a phase that is different from the main treatment, such as brachytherapy, it may offer a useful time to meet. During the cancer treatment period, appointments can be easily scheduled in conjunction with the treatment sessions, and the end of the primary treatment provides a natural time for the fifth meeting. Alternatively, if the patient wishes, the appointments can be spread over a longer period, for example half a year, as was the case for some of the participants in this study. For some patients, the end of cancer treatment is a source of anxiety and fear, as treatment schedules no longer punctuate their daily lives and frequent contact with care personnel comes to an end. Then the knowledge that the guidance and counseling appointments will continue beyond the cancer treatment provides continuity and support to the patient. Overall, it is important to listen to the patient's wishes when scheduling the meetings.

A follow-up meeting, for example, a year after the first meeting, is important for several reasons. First, knowing that there will be another meeting in the future will help the patient at the end of the intensive work together when the main interview series comes to an end. Second, the follow-up meeting provides an opportunity to look at the illness experience as a whole from a distance. Third, the ideas generated during the guidance and counseling series can be reflected upon afterwards, which helps to broaden and deepen them and to see their trajectory.

The model can be modified to support different kinds of treatment options, such as a combination of surgery and radiotherapy, where the second appointment would take place before or after surgery and meetings 3 to 5 during radiotherapy.

9.3 About Listening and Listening Back

Genuine interest and unconditional respect for what the person shares, as well as empathetic, responsive listening, are important elements in creating and maintaining a dialogical context. In dialogically responsive listening, the listener adopts an "active, responsive attitude" (Bakhtin, 1986, p. 68) and moment by moment reflects to the narrator, in one way or another, what the narrator's speech uniquely means to the listener at that specific moment (Shotter, 2009,

p. 39). Responsive listening and questioning help the narrator connect their utterances as “an interconnected unity” that they can explore in detail and invite the narrator to “hear” themselves and put into words their own experiences and the connections between them so that they can better understand them as an interconnected whole (Shotter, 2009, p. 36).

Listening back is an important part of responsive listening. It can be implemented in various ways at different levels of the interview series—within an interview, between interviews, or within the interview series as a whole. First, it can be achieved by reflecting back salient quotes and thoughts during one interview and summarizing the content of the interview at the end. Second, it may occur by beginning an interview with a summary of the previous one and bringing back important excerpts from a previous interview to a later one. Third, it can be performed at the level of the interview series as a whole with the help of Momentary Key Metaphors and Clips which represent the account in its totality. For the narrator, getting back what he has said before is a confirmation of being heard (Martin, 1998), and while it validates what has been told, it is also an opportunity for re-evaluation and the construction of something new (Seikkula, 2008). Listening back shows respect and appreciation for what has been said—and for the teller as a person and as a narrator.

Careful, empathic listening is required both when selecting quotes to be mirrored back to the person vocally in the interviews and when selecting excerpts for the Clips towards the end of the interview series. In describing the co-writing of poetic documents, Speedy (2005) writes about “multiple forms of listening, listening with ‘another ear’,” “a poetic kind of listening” (pp. 289, 292), which leads to listening for unexpected details and nuances:

Capturing words and phrases that are unforeseen, evocative and resonant, that link lives and that attend to ‘particularities’ rather than generalities. Attending especially carefully to ‘talk’ that seems hard come by, or that emerges out of moments of silence or reverie. Including ‘talk’ from all sorts of places of struggle, and difficulty and humour, as well as sparkling and joyful or more hopeful moments, but above all evoking ‘talk that sings’: talk that surprises people, comes unexpectedly to their lips, shifts and/or exoticises their experiences of life’s possibilities. (p. 295)

I fully agree with the ideas Speedy (2005) expresses above. It is important to listen to the narrator’s personal voice, not only what they tell, but also how they tell what they tell: their personal ways of expressing life and its events, self and others, values, goals, and wishes, perceptions and evaluations, meanings, and metaphors—certain kinds of opposites and contrasts that draw out life and the self: search and discovery, feelings and thoughts, questions and answers, options and choices, the past and the future—personal, unique, original expressions and phrases that catch the eye, resonate, “rise” from the text and echo in the ears.

According to Speedy (2005), the co-writing of poetic documents draws the therapist’s attention to their listening and note-taking practices, and conversa-

tions that include the possibility of poetic co-writing appear qualitatively different from other types of therapeutic conversations. Questions asked, spaces that open up, and notes taken are all shaped by new possibilities.

Based on the participants' feedback and my own experience in this dissertation, I am convinced that it is important to listen back a person's own words and phrases verbatim. Freeman, Epston, and Lobovits (1997), as well as Speedy (2005), have come to the same conclusion, although in Speedy's opinion it is possible to include the therapist's words in the documents if additions are exactly marked.

9.4 About the Meaning of the Closest One

The study indicated that the involvement of the spouse in the processes and context of cancer care has therapeutic significance. Encouraging a couple to participate together in different phases of the cancer treatment process is valuable for both partners, their relationship, commitment to treatment, and clinical practice. The study also showed that a serious illness is a crisis requiring psychological work from both the patient and the spouse. The proposed longitudinal, dialogical setting of interviews supports the couple's dyadic coping process and the relational qualities that facilitate it—relationship awareness, authenticity, and mutuality (Miller & Stiver, 1998; Kayser, Watson, & Andrade, 2007; Kayser & Revenson, 2016). The new methodologies allow both spouses to describe their own evolving experience of illness (Skerrett, 2003), support the experience of the other, and create a shared understanding that develops in mutual dialogue over time.

It is essential that both spouses wish to work together and can participate in all the interviews. It is also important that the interview period is sufficiently long, begins soon after diagnosis, and continues beyond the primary treatment of the cancer. This provides enough time to develop dyadic mutual support, where both spouses play their own role at different stages of the illness and treatment process. Reciprocal support between mental work and cancer care is also best achieved when the interview series is sufficiently long and extends beyond primary treatment.

The interviewer plays an important role in building, supporting, and maintaining a dialogical space. Furthermore, they should verify that both spouses' voices are equally heard. In some cases, this may require a conscious effort to ensure that both spouses have been invited to speak and to subtly guide the couple to take turns in a natural way.

With the proposed methodologies, a dialogical coping context can be created for making meaning of the illness experience and building, maintaining, and strengthening the couple's mutual resources in coping with cancer. This is important from both a human and a therapeutic perspective. The psychosocial support, natural problem-solving skills, and social healing that are inherent in close relationships can be easily activated when a space is created for them. Guidance and counseling at the frequency described in this study appear to help

build and maintain the couple's mutual connection and deal with the uncertainty both spouses experience when facing cancer. At the same time, it helps in identifying and managing the risk of loneliness in cancer care and positively influences the couple's engagement and commitment to somatic care as well.

9.5 For Other Contexts

The methodologies were developed among prostate cancer patients and their spouses, but they could be applied in other areas as well. Both methodologies offer encouraging potential for a low-threshold psychosocial support intervention in a variety of application areas. They can be taken into use independently or to support and enrich existing methodologies, such as narrative psychotherapy. They have not yet been tested by practitioners but are likely to offer tools for, for example, counselors, psychotherapists, medical doctors, nurses, and social workers.

The Momentary Key Metaphor methodology can be adopted to support the handling of autobiographical ruptures caused by, for example, different kinds of serious illnesses, acute accident crises, miscarriage, or social changes such as unemployment or divorce. It offers creative ways to apply narrative means of counseling even in shorter encounters in medical settings, a theme that has interested both researchers and practitioners (Williams-Reade, Freitas, & Lawson, 2014). For example, asking for a Momentary Key Metaphor during medical appointments in a longer treatment relationship can be a beneficial way to support the patient's psychological reflection on the illness experience—and to see, understand and encounter patients and their experiences from a new perspective. The methodology allows healthcare professionals to connect with patients' personal images, reach their world, and create a basis for a shared language to build patient-centered care. The Momentary Key Metaphor methodology can potentially be used to support people facing various collective crises as well. It provides useful tools for people seeking support in various crises, both individual and collective, helping them to address different aspects of their experience and re-examine their handling of it (White & Epston, 1990, p. 76).

As such, the Clip Approach methodology suits environments where there is sufficient time for collaborative work, like psychotherapies. If the work intensity of the method can be reduced, for example, by extracting quotes directly from a recording or using speech recognition techniques for the transcription work, the Clip Approach offers encouraging development potential for a low-threshold psychosocial support intervention in various application areas. Potential target groups could include patients with a severe long-term illness in somatic treatment, clients in challenging life change situations in social work, and elderly people in need of support for their life stories in care. The methodology suits different kinds of people, both clients, and providers, if only they have sufficient time, willingness, and ability to deeply interact in a series of respectful discussions. In the creation and recreation of a human, paraphrasing Martin (1998), to speak is one thing, to hear is another, to confirm that one has heard is yet another still.

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10. Epilogue

The empirical phase of the dissertation convinced me that in one way or another I wanted to work with people in crisis situations in the future. Listening to my innermost being is to listen to another person, to make their voice heard. What, then of my own voice?

Whose voice is echoing in my text, whose handwriting do I write? An author searches for her own voice and style for a longer time. Is it even relevant for a researcher to consider such a question? Is she allowed to use her entire repertoire, or should she leave something out, have the mute on, hold back?

Dissertation. Taking one's own place. I take a position that I defend, that is mine. I build the story of science from one perspective, someone else from another, fragments of science challenging and supporting each other. Tensions arise and release. I use my turn in the scientific debate. I have a voice.

Can I even speak in any other voice than my own? I realize that my way of writing is part of me. It dresses my thoughts, aspirations, and endeavors. My personal goal for postgraduate studies is to learn something new, to develop, to gain substance, and a path to what I deeply value and want to achieve. It is something beautiful, humane, constructive, not hard, calculating, instrumental.

Am I allowed to, can I? Why am I asking as if from outside, from authorities? Do I want, do I dare? Is it more like whether I dare to get closer to myself, to who I am?

At its best, my work can show the reader the functionality and the added value of a different approach—provide the reader with a new, memorable experience, and show that scientific work can be performed, and in some cases is worth performing, in a different way. Perhaps a new kind of implementation can even be one of the contributions of my dissertation. That target I can only reach by being bravely present—listening to my innermost being, speaking in my own voice.

(Talsi, 2013, pp. 34–36, shortened)

In early 2018, a routine occupational health check unexpectedly led me to the situation the participants in this study had experienced three years earlier: a cancer diagnosis. My thyroid cancer was operated on a month later.

I remember thinking that now I personally understand how the interviewees felt and what they experienced. It feels like this to sit in a doctor's office and hear that you have cancer. It is this distressing to wait for the treatment and this scary to step into surgery and settle on the "chopping block". This much do I grieve that something is taken away from me. This much I want to ask, find out, strive to make the right decisions. And this much do I ponder whether my decisions are right.

I had dreams. Three of them have been etched in my mind so precisely that I could write them down here by heart. The rest I could fetch from the pages of my dream book of that time.

The concert begins

Wild beast in a cage

A pawing horse

Black rocking chair

Running girl

A tile on the neck

Now, a large fresco is being painted

My Momentary Key Metaphors.

Everyone's life, including mine, contains difficult experiences that unexpectedly interrupt the story. I have given meaning to these experiences, structuring them, and re-constructing my life story in many different ways, also with the writing of this dissertation—and, as a person deeply engaged in self-exploration, I will continue to do so until the end of my life.

When I see what I say, I do know what I think. My story constructs me as part of my world.

References

- Aita, V., McIlvain, H., Susman, J., and Crabtree, B. (2003). Using Metaphor as a Qualitative Analytic Approach to Understand Complexity in Primary Care Research. *Qualitative Health Research*, 13(10): 1419–1431. [10.1177/1049732303255999](https://doi.org/10.1177/1049732303255999)
- Adler, J. M., Dunlop, W. L., Fivush, R., Lilgendahl, J. P., Lodi-Smith, J., McAdams, D. P., McLean, K. C., Pasupathi, M., and Syed, M. (2017). Research methods for studying narrative identity: A primer. *Social Psychological and Personality Science*, 8(5), 519–527. doi: [10.1177/1948550617698202](https://doi.org/10.1177/1948550617698202)
- American Cancer Society (2022). <https://www.cancer.org/cancer/prostate-cancer/treating.html>. Accessed on 29 December 2022.
- Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27, 371–393.
- Appleton, L., & Flynn, M. (2014). Searching for the new normal: Exploring the role of language and metaphors in becoming a cancer survivor. *European Journal of Oncology Nursing*, 18(4): 378–384. doi: [10.1016/j.ejon.2014.03.012](https://doi.org/10.1016/j.ejon.2014.03.012)
- Badr, H., & Acitelli, K. (2017). Re-thinking dyadic coping in the context of chronic illness. *Current Opinion in Psychology*, 13, 44–48. doi: [10.1016/j.copsyc.2016.03.001](https://doi.org/10.1016/j.copsyc.2016.03.001)
- Bakhtin, M. M. (1981). *The Dialogic Imagination: Four Essays* (ed. Holquist, M., trans. Emerson, C., & Holquist, M.). University of Texas Press.
- Bakhtin, M. (1984). *Problems of Dostojevskij's poetics: Theory and history of literature* (Vol. 8). Manchester University Press.
- Bakhtin, M. M. (1986). *Speech Genres and Other Late Essays* (Eds. Emerson, C., & Holquist, M.). University of Texas Press.
- Bandara, V., Capp, A., Ahmed, G., Arm, J., & Martin, J. (2019). Assessment and predictors of fatigue in men with prostate cancer receiving radiotherapy and androgen deprivation therapy. *Journal of Medical Imaging and Radiation Oncology*, 63(5), 683–690. doi: [10.1111/1754-9485.12922](https://doi.org/10.1111/1754-9485.12922)
- Black, K., & Warhurst, R. (2015). Opening the visual methods toolbox. In Saunders, M. N. K. & Tosey, P. (eds.), *Handbook of research methods on human resource development* (pp. 108–126). Edgar Elgar Publishing. <https://nrl.northumbria.ac.uk/id/eprint/24413/>
- Blomdahl, C., Wijk, H., Guregård, S., & Rusner, M. (2018). Meeting oneself in inner dialogue: a manual based Phenomenological Art Therapy as experienced by patients diagnosed with moderate to severe depression. *The Arts in Psychotherapy*, 59, 17–24. doi: [10.1016/j.aip.2017.08.006](https://doi.org/10.1016/j.aip.2017.08.006)

- Bowie, J., Brunckhorst, O., Stewart, R., Dasgupta, P., & Ahmed K. (2022). Body image, self-esteem, and sense of masculinity in patients with prostate cancer: a qualitative meta-synthesis. *Journal of Cancer Survivorship*, 16, 95–110. doi: [10.1007/s11764-021-01007-9](https://doi.org/10.1007/s11764-021-01007-9)
- Briggs, L. G., Sentana-Lledo, D., Lage, D. E., Trinh Q.-D., & Morgans A. K. (2022). Optimal assessment of quality of life for patients with prostate cancer. *Therapeutic Advances in Medical Oncology*. 2022;14. doi: [10.1177/17588359221141306](https://doi.org/10.1177/17588359221141306)
- Brockmeier, J. & Harré, R. (2001) Narrative: Problems and promises of an alternative paradigm. In Brockmeier, J., & Carbaugh, D. (eds.), *Narrative and Identity: Studies in Autobiography, Self and Culture* (pp. 263–283). John Benjamins.
- Bruner, J. (2004). Life as Narrative. *Social research*, 71(3), 691–710.
- Bruun, P., Pedersen, B., Osther, P., & Wagner, L. (2011). The Lonely Female Partner: A Central Aspect of Prostate Cancer. *Urologic Nursing*, 31(5), 294–9.
- Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health and Illness*, 4(2), 167–182. doi: [10.1111/1467-9566.epi11339939](https://doi.org/10.1111/1467-9566.epi11339939)
- Caldwell, R. L. (2005). At the Confluence of Memory and Meaning—Life Review With Older Adults and Families: Using Narrative Therapy and the Expressive Arts to Re-member and Re-author Stories of Resilience. *The Family Journal*, 13(2), 172–175. doi: [10.1177/1066480704273338](https://doi.org/10.1177/1066480704273338)
- Carlick, A., & Biley, F. C. (2004). Thoughts on the therapeutic use of narrative in the promotion of coping in cancer care. *European Journal of Cancer Care*, 13(4), 308–317. doi: [10.1111/j.1365-2354.2004.00466.x](https://doi.org/10.1111/j.1365-2354.2004.00466.x)
- Castonguay, L. G., & Hill, C. E. (eds.) (2007). *Insight in Psychotherapy*. American Psychological Association.
- Cayless, S., Forbat, L., Illingworth, N., Hubbard, G., & Kearney, N. (2009). Men with prostate cancer over the first year of illness: Their experiences as biographical disruption. *Supportive Care in Cancer*, 18 (1), 11–19.
- Chafe, W. (1985). Linguistic differences produced by differences between speaking and writing. In Hildyard, A., Olson, D. R., & Torrance, N. (eds.), *Literacy, language, and learning : the nature and consequences of reading and writing*, (pp. 105–123). Cambridge University Press.
- Coreil, J., Wilke, J., & Pintado, I. (2004). Cultural Models of Illness and Recovery in Breast Cancer Support Groups. *Qualitative Health Research*, 14(7), 905–923. doi: [10.1177/1049732304266656](https://doi.org/10.1177/1049732304266656)
- Chow, E. O. W. (2015). Narrative therapy an evaluated intervention to improve stroke survivors' social and emotional adaptation. *Clinical Rehabilitation*, 29(4), 315–326. doi: [10.1177/0269215514544039](https://doi.org/10.1177/0269215514544039)
- Corbin, J., & Strauss, A. (1988). *Unending Work and Care: Managing Chronic Illness at Home*. Jossey-Bass Publishers.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, 39(3), pp. 124–130. doi: [10.1207/s15430421tip3903_2](https://doi.org/10.1207/s15430421tip3903_2)
- Cronon, W. (1992). A Place for stories: Nature, History and Narratives. *Journal of American History*, 78(4), 1347–1376.
- Dauphin, S., Van Wolputte, S., Jansen, L., De Burghraeve, T., Buntinx, F., & van den Akker, M. (2020). Using liminality and subjunctivity to better understand how patients with cancer experience uncertainty throughout their illness trajectory. *Qualitative Health Research*, 30(3), 356–365. doi: [10.1177/1049732319880542](https://doi.org/10.1177/1049732319880542)
- Dimaggio, G., Salvatore G., Azzara, C., & Catania D. (2003). Rewriting Self-narratives: The Therapeutic Process. *Journal of Constructivist Psychology*, 16, 155–181. doi: [10.1080/10720530390117920](https://doi.org/10.1080/10720530390117920)

- Dimaggio, G. (2006). Disorganized Narratives in Clinical Practice. *Journal of Constructivist Psychology*, 19, 103–108. doi: [10.1080/10720530500508696](https://doi.org/10.1080/10720530500508696)
- Evans, M., Shaw, A., & Sharp, D. (2011). Integrity in patients' stories: 'Meaning-making' through narrative in supportive cancer care. *European Journal of Integrative Medicine*, 4 (1), e11–e18. doi: [10.1016/j.eujim.2011.12.005](https://doi.org/10.1016/j.eujim.2011.12.005)
- Ewenstein, B., & Whyte, J. (2007). Visual representations as 'artifacts of knowing'. *Journal of Building Research and Information*, 35(1), 81–89. doi: [10.1080/09613210600950377](https://doi.org/10.1080/09613210600950377)
- Fergus, K. D., McLeod, D., Carter, W., Warner, E., Gardner, S. L., Granek, L., & Cullen, K. I. (2014). Development and pilot testing of an online intervention to support young couples' coping and adjustment to breast cancer. *European Journal of Cancer Care*, 23, 481–492. doi: [10.1111/ecc.12162](https://doi.org/10.1111/ecc.12162)
- Fergus, K., Ahmad, S., Ianakieva, I., McLeod, D., & Carter, W. (2017). Metaphor and meaning in an online creative expression exercise to promote dyadic coping in young couples affected by breast cancer. *Arts & Health*, 9(2), 139–153. doi: [10.1080/17533015.2016.1208667](https://doi.org/10.1080/17533015.2016.1208667)
- Flick, U. (2002). *An Introduction to Qualitative Research*. Sage Publications.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness and ethics*. University of Chicago Press.
- Frank, A. W. (1998). Just listening: Narrative and deep illness. *Families, Systems & Health*, 16(3), 197–212.
- Frank, A. W. (2007). Five Dramas of Illness. *Perspectives in Biology and Medicine*, 50(3), 379–394. doi: [10.1353/pbm.2007.0027](https://doi.org/10.1353/pbm.2007.0027)
- Fransson, P. (2010). Fatigue in prostate cancer patients treated with external beam radiotherapy: A prospective 5-year long-term patient-reported evaluation. *Journal of Cancer research and Therapeutics*, 6(4), 516–520.
- Freeman, J., Epston, D., & Lobovits, D. (1997). *Playful Approaches to Serious Problems: Narrative therapy with children and their families*. Norton.
- Fox, H. (2003). Using therapeutic documents: a review. *The International Journal of Narrative Therapy and Community Work* 2003(4), 25–35.
- Galbraith, M. E., Hays, L., & Tanner, T. (2011). What men say about surviving prostate cancer: complexities represented in a decade of comments. *Clinical journal of oncology nursing* 16 (1), 65–72.
- Gale, J. (1992). When research interviews are more therapeutic than therapy interviews. *The Qualitative Report*, 1(4), 1–4.
- Gauntlett, D., & Holzwarth, P. (2006). Creative and visual methods for exploring identities. *Visual Studies*, 21(1), 82–91. doi: [10.1080/14725860600613261](https://doi.org/10.1080/14725860600613261)
- Gee, J. P. (1985). The Narrativization of Experience in the Oral Style. *The Journal of Education*, 167(1), 9–35.
- Gee, J. P. (1986). Units in the production of narrative discourse. *Discourse Processes*, 9, 391–422.
- Gee, J. P. (1991). A Linguistic Approach to Narrative. *Journal of Narrative and Life History*, 1(1), 15–39.
- Geertz, C. (1978). *The interpretation of cultures*. Basic Books.
- Gibbons, S. W., Ross, A., Wehrenb, L., Klagholz, S., & Bevans, M. (2019). Enhancing the Cancer Caregiving Experience: Building Resilience Through Role Adjustment and Mutuality. *European Journal of Oncology Nursing*, 43, 1–8. doi: [10.1016/j.ejon.2019.09.004](https://doi.org/10.1016/j.ejon.2019.09.004)
- Gibbs, R. W., & Franks, H. (2002). Embodied Metaphor In Women's Narratives About Their Experiences With Cancer. *Health Communication*, 14(2), 139–165. doi: [10.1207/S15327027HC1402_1](https://doi.org/10.1207/S15327027HC1402_1)

- Global Cancer Observatory (2022). <https://gco.iarc.fr/today/data/factsheets/cancers/27-Prostate-fact-sheet.pdf>. Accessed on December 29, 2022.
- Gonçalves, M. M., Matos, M., & Santos, A (2009). Narrative Therapy and the Nature of “Innovative Moments” in the Construction of change. *Journal of Constructivist Psychology*, 22:1–23. doi: [10.1080/10720530802500748](https://doi.org/10.1080/10720530802500748)
- Gonçalves, M. M., Mendes, I., Cruz, G., Ripeiro, A. P., Sousa, I., Angus, L., & Greenberg, L. S. (2012). Innovative moments and change in client-centered therapy. *Psychotherapy Research*, 22(4), 389–401. doi: [10.1080/10503307.2012.662605](https://doi.org/10.1080/10503307.2012.662605)
- Gustafsson, A. W., Hommerberg, C., & Sandgren, A. (2020). Coping by metaphors: the versatile function of metaphors in blogs about living with advanced cancer. *BMJ Medical Humanities*, 46(3). doi: [10.1136/medhum-2019-011656](https://doi.org/10.1136/medhum-2019-011656)
- Habermas, T. (2011). Autobiographical reasoning: Arguing and narrating from a biographical perspective. *New Directions for Child and Adolescent Development*, 2011(131), 1–17. doi: [10.1002/cd.285](https://doi.org/10.1002/cd.285)
- Habermas, T., & Köber, C. (2015). Autobiographical reasoning in life narratives buffers the effect of biographical disruptions on the sense of self-continuity. *Memory*, 23(5), 664–674. doi: [10.1080/09658211.2014.920885](https://doi.org/10.1080/09658211.2014.920885)
- Harrington, K. J. (2012). The Use of Metaphor in Discourse About Cancer: A Review of the Literature. *Clinical Journal of Oncology Nursing*, 16(4), 408–412. doi: [10.1188/12.CJON.408-412](https://doi.org/10.1188/12.CJON.408-412)
- Hermans, H. J. M. (2003). The construction and reconstruction of a dialogical self. *Journal of Constructivist Psychology*, 16, 89–130. doi: [10.1080/10720530390117902](https://doi.org/10.1080/10720530390117902)
- Holma, J. (1999). The Investigating Acute Psychosis and the Need-Adapted Treatment Model from the Narrative Viewpoint. Dissertation. University of Jyväskylä. Jyväskylä.
- Hommerberg, C., Gustafsson, A. W., & Sandgren, A. (2020). Battle, Journey, Imprisonment and Burden: patterns of metaphor use in blogs about living with advanced cancer. *BMC Palliative Care*, 1–10. doi: [10.1186/s12904-020-00557-6](https://doi.org/10.1186/s12904-020-00557-6)
- Hänninen, V. (2004). A model of narrative circulation. *Narrative Inquiry*, 14(1), 69–85. doi: [10.1075/ni.14.1.04han](https://doi.org/10.1075/ni.14.1.04han)
- Jakobsson, L., & Holmberg, L. (2011). Individual personal relations: effects on service quality. *International Journal of Health Care Quality Assurance*, 24(6), 430–440.
- James, C., Brunckhorst, O., Eymech, O., Stewart, R., Dasgupta, P., & Ahmed, K. (2022). Fear of cancer recurrence and PSA anxiety in patients with prostate cancer: a systematic review. *Support Care Cancer*, 30, 5577–5589. doi: [10.1007/s00520-022-06876-z](https://doi.org/10.1007/s00520-022-06876-z)
- Jordan, J. V. (2017). Relational–Cultural Theory: The Power of Connection to Transform Our Lives. *Journal of Humanistic Counseling*, 56, 228–243.
- Kamen, C., Mustian, K. M., Heckler, C., Janelins, M. C., Peppone, L. J., Mohile, S., McMahon, J. M., Lord, R., Flynn, P. J., Weiss, M., Spiegel, D., & Morrow, G. R. (2015). The association between partner support and psychological distress among prostate cancer survivors in a nationwide study. *Journal of Cancer Survivorship*, 9, 492–499. doi: [10.1007/s11764-015-0425-3](https://doi.org/10.1007/s11764-015-0425-3)
- Kayser, K., Watson, L. E., & Andrade, J. T. (2007). Cancer as a “we-disease”: Examining the process of coping from a relational perspective. *Families, Systems, & Health*, 25(4), 404–418. doi: [10.1037/1091-7527.25.4.404](https://doi.org/10.1037/1091-7527.25.4.404)
- Kayser, K., & Revenson, T. A. (2016). Including the cultural context in dyadic coping: directions for future research and practice. In Falconier, M. K., Randall, A. K., &

- Bodenmann, G. (eds.), *Couples Coping With Stress: A Cross-Cultural Perspective*, (pp. 285–299). Routledge/Taylor and Francis Group.
- Kaysner, K., & Acquati, C. (2019). The influence of relational mutuality on dyadic coping among couples facing breast cancer. *Journal of Psychosocial Oncology*, 37(2), 194–212. doi: [10.1080/07347332.2019.1566809](https://doi.org/10.1080/07347332.2019.1566809)
- Kerr, D. J. R., Deane, F. P., & Crowe, T. P. (2020). A Complexity Perspective on Narrative Identity Reconstruction in Mental Health Recovery. *Qualitative Health Research*, 30(4), 634–649. doi: [10.1177/1049732319886285](https://doi.org/10.1177/1049732319886285)
- Kohler Riessman, C. (1993). *Narrative Analysis*. Sage Publications.
- Kohler Riessman, C., & Speedy, J. (2007). Narrative inquiry in the psychotherapy professions: A critical review. In Clandinin, J. (ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 426–456). Sage Publications. doi: [10.4135/9781452226552.n17](https://doi.org/10.4135/9781452226552.n17)
- Kohler Riessman, C. (2012). Analysis of Personal Narratives. In Gubrium, J. F., Holstein, J. A., Marvasti, A. B., & McKinney, K., D. (eds.), *The SAGE Handbook of Interview Research: The Complexity of the Craft*, (pp. 367–380). SAGE.
- Konopka, A., Neimeyer, R. A., & Jacobs-Lentz, J. (2018). Composing the self: Toward the dialogical reconstruction of self-identity. *Journal of Constructivist Psychology*, 31(3), 308–320. doi: [10.1080/10720537.2017.1350609](https://doi.org/10.1080/10720537.2017.1350609)
- Kövecses, Z. (2015). *Where metaphors come from: Reconsidering context in metaphor*. Oxford University Press. doi: [10.1093/acprof:oso/9780190224868.001.0001](https://doi.org/10.1093/acprof:oso/9780190224868.001.0001)
- Labov, W. (2006). Narrative preconstruction. *Narrative Inquiry*, 16(1), 37–45.
- Lakoff G., & Johnson, M. (1980). *Metaphors We Live By*. The University of Chicago Press.
- Langston, B., Armes, J., Levy, A., Tidey, E., & Ream, E. (2013). The prevalence and severity of fatigue in men with prostate cancer: a systematic review of the literature. *Support Care Cancer*, 21, 1761–1771. doi: [10.1007/s00520-013-1751-5](https://doi.org/10.1007/s00520-013-1751-5)
- Laranjeira, C. (2013). The role of narrative and metaphor in the cancer life story: A theoretical analysis. *Medicine, Health Care and Philosophy*, 16, 469–481. doi: [10.1007/s11019-012-9435-3](https://doi.org/10.1007/s11019-012-9435-3)
- Legowski, T., & Brownlee, K. (2001). Working with Metaphor in Narrative Therapy. *Journal of Family Psychotherapy*, 12(1), 19–28. doi: [10.1300/J085v12n01_02](https://doi.org/10.1300/J085v12n01_02)
- Lehto, U.-S., Helander, S., Taari, K., & Aromaa, A. (2015). Patient experiences at diagnosis and psychological well-being in prostate cancer: A Finnish national survey. *European Journal of Oncology Nursing*, 19, 220–229.
- Lehto, U.-S., Aromaa, A., & Tammela T. (2017a). Experiences and psychological distress of spouses of prostate cancer patients at time of diagnosis and primary treatment. *European Journal of Cancer Care*, 27(1), 1–11. doi: [10.1111/ecc.12729](https://doi.org/10.1111/ecc.12729)
- Lehto, U.-S., Tenhola, H., Taari, K., & Aromaa, A. (2017b). Patients' perceptions of the negative effects following different prostate cancer treatments and the impact on psychological well-being: a nationwide survey. *British Journal of Cancer*, 116, 864–873. doi: [10.1038/bjc.2017.30](https://doi.org/10.1038/bjc.2017.30)
- Leiman, M. (2012). Dialogical sequence analysis in studying psychotherapeutic discourse. *International Journal for Dialogical Science*, 6(1), 123–147.
- Levitt, H., Korman, Y., & Angus, L. (2000). A metaphor analysis in treatments of depression: metaphor as a mark of change. *Counselling Psychology Quarterly*, 13(1), 23–35.
- Lidbom, P. A., Bøe, T. D., Kristoffersen, K., Ulland, D., & Seikkula, J. (2015). How Participants' Inner Dialogues Contribute to Significant and Meaningful Moments in

- Network Therapy with Adolescents. *Contemporary Family Therapy*, 37(2), 1–8. doi: [10.1007/s10591-015-9331-0](https://doi.org/10.1007/s10591-015-9331-0)
- Lindfors, O. (2019). Psykoterapioiden yhteiset ja erityiset tekijät. <https://www.psykoterapia-lehti.fi/verkkolehti/tilaajat/psykoterapia-12019/olavi-lindfors-psykoterapioiden-yhteiset-ja-erityiset-tekijat/>. Accessed on May 18, 2023.
- Litwin, M. S., & Tan, H. (2017). The Diagnosis and Treatment of Prostate Cancer: A Review. *JAMA* 317(24):2532–2542. doi: [10.1001/jama.2017.7248](https://doi.org/10.1001/jama.2017.7248)
- Martin, F. E. (1998). Tales of transition: Self-narrative and direct scribing in exploring care-leaving. *Child and Family Social Work*, 3(1), 1–12. doi: [10.1046/j.1365-2206.1998.00067.x](https://doi.org/10.1046/j.1365-2206.1998.00067.x)
- Matos, M., Santos, A., Gonçalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research*, 19(1), 68–80. doi: [10.1080/10503300802430657](https://doi.org/10.1080/10503300802430657)
- McAdams, D. P. (2013). The psychological self as actor, agent, and author. *Perspectives on Psychological Science*, 8(3), 272–295. doi: [10.1177/1745691612464657](https://doi.org/10.1177/1745691612464657)
- McAdams, D. P., & McLean, K. C. (2013). Narrative identity. *Current Directions in Psychological Science*, 22(3), 233–238. doi: [10.1177/0963721413475622](https://doi.org/10.1177/0963721413475622)
- McLean, K. C., Pasupathi, M., & Pals, J. L. (2007). Selves creating stories creating selves: A process model of narrative self-development in adolescence and adulthood. *Personality and Social Psychology Review*, 11, 262–278. doi: [10.1177/1088868307301034](https://doi.org/10.1177/1088868307301034)
- McLean, K. C., & Fournier, M. A. (2008). The content and processes of autobiographical reasoning in narrative identity. *Journal of Research in Personality*, 42, 527–545. doi: [10.1016/j.jrp.2007.08.003](https://doi.org/10.1016/j.jrp.2007.08.003)
- McLeod, J. (1996). The emerging narrative approach to counselling and psychotherapy. *British Journal of Guidance & Counselling*, 24(2), 173–184. doi: [10.1080/03069889608260407](https://doi.org/10.1080/03069889608260407)
- McLeod, J. & Balamoutsou, S. (1996). Representing narrative process in therapy: Qualitative analysis of a single case. *Counselling Psychology Quarterly*, 9 (1), 61–76. doi: [10.1080/09515079608256353](https://doi.org/10.1080/09515079608256353)
- McLeod, J., & Lynch, G. (2000). This is our life: Strong evaluation in psychotherapy narrative. *European Journal of Psychotherapy, Counselling and Health*, 3(3), 389–407.
- McLeod, J., & Balamoutsou, S. (2001). A method for qualitative narrative analysis of psychotherapy transcripts. *Psychologische Beiträge*, 43(3), 128–152.
- McLeod, J. (2013). Developing pluralistic practice in counselling and psychotherapy: Using what the client knows. *The European Journal of Counselling Psychology*, 2(1), 51–64. doi: [10.23668/psycharchives.1999](https://doi.org/10.23668/psycharchives.1999)
- Melman, A., & Newnham, R. (2011). After prostate cancer: A what-comes-next guide to a safe and informed recovery. Oxford University Press.
- Miller, J. B. (1986). *Toward a New Psychology of Women*. Beacon Press.
- Miller, J. B., & Stiver, I. P. (1998). *The Healing Connection – How Women Form Relationships in Therapy and in Life*. Beacon Press.
- Mitchell, C., Delange, N., Molestane, R., Stuart, J., & Buthelezi, T. (2005). Giving a face to HIV and AIDS: On the uses of photovoice by teachers and community health care workers working with youth in rural South Africa. *Qualitative Research in Psychology: Special Issue on Visual Methodologies*, 2, 257–270. doi: [10.1191/1478088705qp0420a](https://doi.org/10.1191/1478088705qp0420a)

- Moran, G., & Russo-Netzer, P. (2016). Understanding universal elements in mental health recovery: A cross-examination of peer providers and a non-clinical sample. *Qualitative Health Research*, 26, 273–287. doi: [10.1177/1049732315570124](https://doi.org/10.1177/1049732315570124)
- Morgan, A. (2000). *What is narrative therapy? : An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre Publications. Kindle Edition.
- Moris, L., Cumberbatch, M. G., Van den Broeck, T., Gandaglia, G., Fossati, N., Kelly, B., Pal, R., Briers, E., Cornford, P., De Santis, M., Fanti, S., Gillessen, S., Grummet, J., P., Henry, A. M., Lam, T. B. L., Lardas, M., Liew, M., Mason, M. D., Omar, M. I., Rouvière, O., Schoots, I. G., Tilki, D., van den Bergh, R. C. N., van Der Kwast, T. H., van Der Poel, H. G., Willemse, P.-P. M., Yuan, C. Y., Konety, B., Dorff, T., Jain, S., Mottet, N., & Wiegel, T. (2020). Benefits and Risks of Primary Treatments for High-risk Localized and Locally Advanced Prostate Cancer: An International Multidisciplinary Systematic Review. *European Urology*, 77(5), 614–627. doi: [10.1016/j.eururo.2020.01.033](https://doi.org/10.1016/j.eururo.2020.01.033)
- Mundle, R., Afenya, E., & Agarwal, N. (2021). The effectiveness of psychological intervention for depression, anxiety, and distress in prostate cancer: a systematic review of literature. *Prostate Cancer and Prostatic Diseases*, 24, 674–687. doi: [10.1038/s41391-021-00342-3](https://doi.org/10.1038/s41391-021-00342-3)
- Murray, S. A., Kendall, M., Carduff, E., Worth, A., Harris, F. M., Lloyd, A., Cavers, D., Grant, L., Sheikh, A. (2009). Use of serial qualitative interviews to understand patients' evolving experiences and needs. *The British Medical Journal*, 339, 1–8. doi: [10.1136/bmj.b3702](https://doi.org/10.1136/bmj.b3702)
- Nelson, C. J., Emanu, J. C., & Avildsen, I. (2015). Couples-based interventions following prostate cancer treatment: a narrative review. *Transational Andrology and Urology*, 4(2), 232–242. doi: [10.3978/j.issn.2223-4683.2015.04.04](https://doi.org/10.3978/j.issn.2223-4683.2015.04.04)
- Nnate, D. A., Anyachukwu, C. C., Igwe, S. E., & Abaraogu, U. O. (2021). Mindfulness-based interventions for psychological wellbeing and quality of life in men with prostate cancer: A systematic review and meta-analysis. *Psycho-Oncology*, 30, 1680–1690. doi: [10.1002/pon.5749](https://doi.org/10.1002/pon.5749)
- Parahoo, K., McDonough, S., McCaughan, E., Noyes, J., Semple, C., Halstead, E., J., Neuberger, M. M., & Dahm, P. (2015). Psychosocial interventions for men with prostate cancer: a Cochrane systematic review. *BJU International*, 116(2), 174–183. Doi: [10.1111/bju.12989](https://doi.org/10.1111/bju.12989)
- Paterson, C., Robertson, A., Smith, A., & Nabi, G. (2015). Identifying the unmet supportive care needs of men living with and beyond prostate cancer: A systematic review. *European Journal of Oncology Nursing*, 2015, 19, 4, 405–418. doi: [10.1016/j.ejon.2014.12.007](https://doi.org/10.1016/j.ejon.2014.12.007)
- Penson, R. T, Shapira, L., Daniels, K. J., Chabner, B. S., & Lynch Jr., T. J. (2004). Cancer as Metaphor. *The Oncologist*, 9, 708–716.
- Persson, C., Benzein, E., & Morberg Jämterud, S. (2020). Dignity as an Intersubjective Phenomenon: Experiences of Dyads Living With Serious Illness. *Qualitative Health Research*, 30(13), 1989–2000. doi: [10.1177/1049732320938343](https://doi.org/10.1177/1049732320938343)
- Prashar, J., Schartau, P., & Murray, E. (2022). Supportive care needs of men with prostate cancer: A systematic review update. *European Journal of Cancer Care*, 31, e13541. doi: [10.1111/ecc.13541](https://doi.org/10.1111/ecc.13541)
- Predeger, E. (1996). Womanspirit: A journey into healing through art in breast cancer. *Advances in Nursing Science*, 18(3), 48–58. doi: [10.1097/00012272-199603000-00006](https://doi.org/10.1097/00012272-199603000-00006)
- Prostate Cancer Interview Study, Protocol of the Clinical Study, 2014
- Prostate Cancer Interview Study, Summary of the Study Plan, 2014

- Qan'ir, Y., & Song, L. (2019). Systematic review of technology-based interventions to improve anxiety, depression, and health-related quality of life among patients with prostate cancer. *Psycho-Oncology*, 28(8), 1601–1613. doi: [10.1002/pon.5158](https://doi.org/10.1002/pon.5158)
- Qiu, S., & Linghui, D. (2017). Psychosocial Interventions to Improve the Quality of Life for Men with Prostate Cancer: A Network Meta-analysis of 31 Randomized Controlled Trials. *European Psychiatry*, 41(S1), S252–S253. doi: [10.1016/j.eurpsy.2017.02.043](https://doi.org/10.1016/j.eurpsy.2017.02.043)
- Rajaei, A., Brimhall, A. S., Jensen, J. F., Schwartz, & Torres, E. T. (2020): Striving to Thrive: A Qualitative Study on Fostering a Relational Perspective Through Narrative Therapy in Couples Facing Cancer. *The American Journal of Family Therapy*, 49(4), 392–408. doi: [10.1080/01926187.2020.1820402](https://doi.org/10.1080/01926187.2020.1820402)
- Rajaei, A., & Jensen, J. F. (2020). Empowering Patients in Integrated Behavioral Health-Care Settings: A Narrative Approach to Medical Family Therapy. *The Family Journal: Counselling and Therapy for Couples and Families*, 28(1), 48–55. Doi: [10.1080/01926187.2020.1820402](https://doi.org/10.1080/01926187.2020.1820402)
- Reavey, P., & Johnson, K. (2011). Visual approaches: Using and interpreting images. In Willig, C. & Stainton Rogers, W. (eds.), *The SAGE handbook of qualitative research in psychology*. London: SAGE Publications (pp. 296–373). doi: [10.4135/9781848607927](https://doi.org/10.4135/9781848607927)
- Resendes, L. A., & McCorkle, R. (2006). Spousal Responses to Prostate Cancer: An Integrative Review. *Cancer Investigation*, 24(2), 192–198. doi: [10.1080/07357900500524652](https://doi.org/10.1080/07357900500524652)
- Ricks, L., Kitchens, S., Goodrich, T., & Hancock, E. (2014). My Story: The Use of Narrative Therapy in Individual and Group Counseling. *Journal of Creativity in Mental Health*, 9(1), 99–110, doi: [10.1080/15401383.2013.870947](https://doi.org/10.1080/15401383.2013.870947)
- Ricoeur, P. (1991). Life in quest of narrative. In Wood, D. (ed.), *Paul Ricoeur: narrative and interpretation*, 20–33. Routledge.
- Roberts, C., Toohey, K., & Paterson, C. (2022). The Experiences and Unmet Supportive Care Needs of Partners of Men Diagnosed With Prostate Cancer: A Meta-aggregation Systematic Review. *Cancer Nursing* (0):10.1097/NCC.0000000000001172, December 1, 2022. doi: [10.1097/NCC.0000000000001172](https://doi.org/10.1097/NCC.0000000000001172)
- Sabbadini, A. (1998). Letters, Words and Metaphors: A Psychoanalytic Reading of Michael Radford's *Il Postino*. *International Journal of Psychoanalysis*, 79, 609–611.
- Salvatore, G., Conti, L., Fiore, D., Carcione, A., Dimaggio, G., & Semerari, A. (2006): Disorganized Narratives: Problems In Treatment And Therapist Intervention Hierarchy. *Journal of Constructivist Psychology*, 19:2, 191–207. doi: [10.1080/10720530500508936](https://doi.org/10.1080/10720530500508936)
- Sánchez Sánchez, E., González Baena, A. C., González Cáliz, C., Caballero Paredes, F., Moyano Calvo, J. L., & Castiñeiras Fernández, J. (2020). Prevalence of Anxiety and Depression in Prostate Cancer Patients and Their Spouses: An Unaddressed Reality. *Prostate Cancer* 2020. Article ID 4393175. doi: [10.1155/2020/4393175](https://doi.org/10.1155/2020/4393175)
- Scandurra, C., Muzii, B., La Rocca, R., Di Bello, F., Bottone, M., Califano, G., Longo, N., Maldonato, M. N., & Mangiapi, F. (2022). Social Support Mediates the Relationship between Body Image Distress and Depressive Symptoms in Prostate Cancer Patients. *International Journal of Environmental Research and Public Health*, 19(8), 4825. doi: [10.3390/ijerph19084825](https://doi.org/10.3390/ijerph19084825)
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Sutela, M. (1995). Treating psychosis by means of Open Dialogue. In Friedman, S. (Ed.),

- The reflective team in action: Collaborative practice in family therapy* (pp. 62–80). Guilford Press.
- Seikkula, J., & Trimble, D. (2005). Healing Elements of Therapeutic Conversation: Dialogue as an Embodiment of Love. *Family Process*, 44(4), 461–475. doi: [10.1111/j.1545-5300.2005.00072.x](https://doi.org/10.1111/j.1545-5300.2005.00072.x)
- Seikkula, J. (2008). Inner and outer voices in the present moment of family and network therapy. *Journal of Family Therapy*, 30, 478–491. doi: [10.1111/j.1467-6427.2008.00439.x](https://doi.org/10.1111/j.1467-6427.2008.00439.x)
- Semino, E., Demjén, Z., & Demmen, J. (2018). An integrated approach to metaphor and framing in cognition, discourse, and practice, with an application to metaphors for cancer. *Applied Linguistics*, 39(5), 625–645. doi: [10.1093/applin/amw028](https://doi.org/10.1093/applin/amw028)
- Semino, E., Demjén, Z., Hardie, H., Payne, A., & Rayson, P. (2018). *Metaphor, cancer and the end of life: A corpus-based study*. Routledge.
- Shotter, J. (2009). Listening in a Way that Recognizes/Realizes the World of 'the Other'. *The International Journal of Listening*, 23, 21–43. doi: [10.1080/10904010802591904](https://doi.org/10.1080/10904010802591904)
- Singer, J. A., & Bluck, S. (2001). New perspectives on autobiographical memory: The integration of narrative processing and autobiographical reasoning. *Review of General Psychology*, 5(2), 91–99. doi: [10.1037/1089-2680.5.2.91](https://doi.org/10.1037/1089-2680.5.2.91)
- Skerrett, K. (1998). Couple adjustment to the experience of breast cancer. *Families, Systems & Health*, 16(3), 281–298.
- Skerrett, K. (2003). Couple Dialogues with Illness: Expanding the “We”. *Families, Systems & Health*, 21(1), 69–80.
- Skott, C. (2002). Expressive Metaphors in Cancer Narratives. *Cancer Nursing*, 25(3), 230–235.
- Sparkes, A. C., & Smith, B. (2008). Narrative constructionist inquiry. In Holstein, J. A. & Gubrium, J. F. (eds.), *Handbook of constructionist research* (pp. 295–314). Guilford Press.
- Speedy, J. (2005). Using poetic documents: An exploration of poststructuralist ideas and poetic practices in narrative therapy. *British Journal of Guidance & Counselling*, 33(3), 283–298. doi: [10.1080/03069880500179343](https://doi.org/10.1080/03069880500179343)
- Stein, M. (2007). Nonverbal techniques in personal construct psychotherapy. *Journal of Constructivist Psychology*, 20(2), 103–124. doi: [10.1080/10720530601074689](https://doi.org/10.1080/10720530601074689)
- Stiles, W. B. (2003). Qualitative Research: Evaluating the Process and the Product. In Llewelyn, S., & Kennedy, P. (eds.), *Handbook of Clinical Health Psychology*, (477–499). John Wiley & Sons Ltd.
- Syöpäjärjestöt (2022a). <https://syoparekisteri.fi>. Accessed on April 2, 2022.
- Syöpäjärjestöt (2022b). <https://kaikkisyovasta.fi/tietoa-syovasta/syopataudit/eturauhassypa/>. Accessed on December 29, 2022.
- Syöpäsäätiö (2022). <https://syopasaatio.fi/syopasaatio-on-nyt-miesten-asialla/>. Accessed on December 29, 2022 .
- Talsi, R. (2013). Saako tutkija kuunnella sisintään, puhua omalla äänellään? In Räsänen, K. (ed.), *Tutkija kasvaa ja kehittyy*. Aalto-yliopiston julkaisusarja KAUPPA + TALOUS 4/2013. <https://urn.fi/URN:ISBN:978-952-60-5284-7>
- Tanner, T., Galbraith, M., & Hays, L. (2011). From a Woman's Perspective: Life as a Partner of a Prostate Cancer Survivor. *Journal of Midwifery & Women's Health*, 56(2), 154–60. doi: [10.1111/j.1542-2011.2010.00017.x](https://doi.org/10.1111/j.1542-2011.2010.00017.x)
- Teucher, U. (2003). The therapeutic psychopoetics of cancer metaphors: Challenges in interdisciplinarity. *History of Intellectual Culture*, 3(1), 1–15.

- Timulak, L. (2010). Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, Research and Practice*, 83, 421–447.
- Tomm, K. (1987a). Interventive interviewing: Part I. Strategizing as a fourth guideline for the therapist. *Family Process*, 26, 3–13. doi: [10.1111/j.1545-5300.1987.00003.x](https://doi.org/10.1111/j.1545-5300.1987.00003.x)
- Tomm, K. (1987b). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. *Family Process*, 26, 167–183. doi: [10.1111/j.1545-5300.1987.00167.x](https://doi.org/10.1111/j.1545-5300.1987.00167.x)
- Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions? *Family Process*, 27, 1–15. doi: [10.1111/j.1545-5300.1988.00001.x](https://doi.org/10.1111/j.1545-5300.1988.00001.x)
- Tsang, V. W. L., Skead, C., Wassersug, R. J., & Palmer-Hague, J. L. (2019). Impact of prostate cancer treatments on men's understanding of their masculinity. *Psychology of Men & Masculinities*, 20(2), 214–225. doi: [10.1037/men0000184](https://doi.org/10.1037/men0000184)
- Turner, B. S., & Hepworth, M. (1982). *Confessions: Studies in deviance in religion*. Routledge.
- Viou, M., & Georgaca, E. (2021). “Enriching Our Inner Dialogue”: An Activity to Explore Compassionate Voices. *Journal of Constructivist Psychology*, 34(2), 207–217. doi: [10.1080/10720537.2020.1717150](https://doi.org/10.1080/10720537.2020.1717150)
- Walther, S., & Fox, H. (2012). Narrative therapy and outsider witness practice: Teachers as a community of acknowledgement. *Educational & Child Psychology*, 29(2), 8–17.
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14, 270–277. doi: [10.1002/wps.20238](https://doi.org/10.1002/wps.20238)
- Wang, L., Lu B., He, M., Wang, Y., Wang, Z., Du. L. (2022). Prostate Cancer Incidence and Mortality: Global Status and Temporal Trends in 89 Countries From 2000 to 2019. *Frontiers in Public Health*, 16. doi: [10.3389/fpubh.2022.811044](https://doi.org/10.3389/fpubh.2022.811044)
- Watts, S., Leydon, G., Birch, B., Prescott, P., Lai, L., Eardley, S., & Lewith, G. (2014). Depression and anxiety in prostate cancer: a systematic review and meta-analysis of prevalence rates. *BMJ Open*, 4(3), 1–9. doi: [10.1136/bmjopen-2013-003901](https://doi.org/10.1136/bmjopen-2013-003901)
- Wennerberg, C, Schildmeijer, K., Hellström, A., & Ekstedt, M. (2021). Patient experiences of self-care management after radical prostatectomy. *European Journal of Oncology Nursing*, 50, 1–10. doi: [10.1016/j.ejon.2020.101894](https://doi.org/10.1016/j.ejon.2020.101894)
- White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. W. W. Norton & Company.
- Wibowo, E., Wassersug, R. J., Robinson, J. W., Matthew, A., McLeod, D., & Walker, L. M. (2019). How Are Patients With Prostate Cancer Managing Androgen Deprivation Therapy Side Effects? *Clinical Genitourinary Cancer*, 17(3), 408–419. doi: [10.1016/j.clgc.2018.12.006](https://doi.org/10.1016/j.clgc.2018.12.006)
- Williams-Read, J., Freitas, C., & Lawson, L. (2014). Narrative-informed medical family therapy: Using narrative therapy practices in brief medical encounters. *Families, Systems, & Health*, 32(4), 416–425. doi: [10.1037/fsh0000082](https://doi.org/10.1037/fsh0000082)
- Wittmann, D. (2015). Coping with Losses, Grief, and Mourning in Prostate Cancer. In Balon R. and Wise T. N. (eds.), *Clinical Challenges in the Biopsychosocial Interface, Update on Psychosomatics for the 21st Century*. (pp. 109–122). Karger AG. doi: [10.1159/000369089](https://doi.org/10.1159/000369089)
- Wooten, A. C., Abbott, J. M., Farrell, A., Austin, D. W., & Klein, B. (2014). Psychosocial interventions to support partners of men with prostate cancer: a systematic

- and critical review of the literature. *Journal of Cancer Survivorship*, 8, 472–484. doi: [10.1007/s11764-014-0361-7](https://doi.org/10.1007/s11764-014-0361-7)
- World Cancer Research Fund International (2022). <https://www.wcrf.org/cancer-trends/prostate-cancer-statistics/h>. Accessed on December 29, 2022.
- Wright, P., Wilding, S., Watson, E., Downing, A., Selby, P., Hounsome, L., Wagland, R., Brewster, D. H., Huws, D., Butcher, H., Mottram, R., Kearney, T., Allen, M., Gavin, A., & Glaser, A. (2019). Key factors associated with social distress after prostate cancer: Results from the United Kingdom Life after Prostate Cancer diagnosis study. *Cancer Epidemiology*, 60, 201–207. doi: [10.1016/j.canep.2019.04.006](https://doi.org/10.1016/j.canep.2019.04.006)
- Yiannopoulou, K. G., Anastasiou A. I., Kontoangelos K., Papageorgiou C., & Anastasiou I. P. (2020). Cognitive and Psychological Impacts of Different Treatment Options for Prostate Cancer: A Critical Analysis. *Current Urology*, 14, 169–177. doi: [10.1159/000499242](https://doi.org/10.1159/000499242)
- Yin, R. K. (2018). *Case study research and applications: Design and methods*. 6th ed. SAGE.

Appendix 1. Interview Themes

Cancer treatment

- Phase
- Treatments
- Needs in different phases
- Knowledge
- Care personnel

Physical well-being

- Physical effects of cancer and treatments and needs arising from them
- Pain
- Fatigue
- Sleep
- Appetite
- Nausea
- Urination
- Defecation
- Sexual effects

Mental well-being

- Mental effects of cancer and treatments and needs arising from them
- Emotions
- Tension
- Fear
- Worry
- Grief
- Death
- Acceptance
- Adaptation
- Hope
- Manhood
- Identity
- Attitude
- Thinking

Social well-being

- Social effects of cancer and treatments and needs arising from them
- Need for social support
- Meaning of social support
- Human relationships
- Friends
- Help and support

Patient and spouse

- The effects of cancer and treatments on the relationship between the patient and the spouse and needs arising from them
- Relationship between patient and spouse
- Encountering difficult emotions related to the illness
- Effects of cancer on sexuality and intimate life
- Learning to live with changes in the relationship

- Closeness, openness, compassion and neediness
- New normal
- Interaction
- Meanings and shared meanings
- Supporting the spouse
- Well-being of both spouses
- Ability to encounter cancer together
- Commitment
- Common story

Family

- The effects of cancer and treatments on family members and needs arising from them
- Support needed by family members
- Help and support given by family members

Work and leisure

- The effects of cancer and treatments on work and leisure and needs arising from them
- Work
- Leisure
- Action

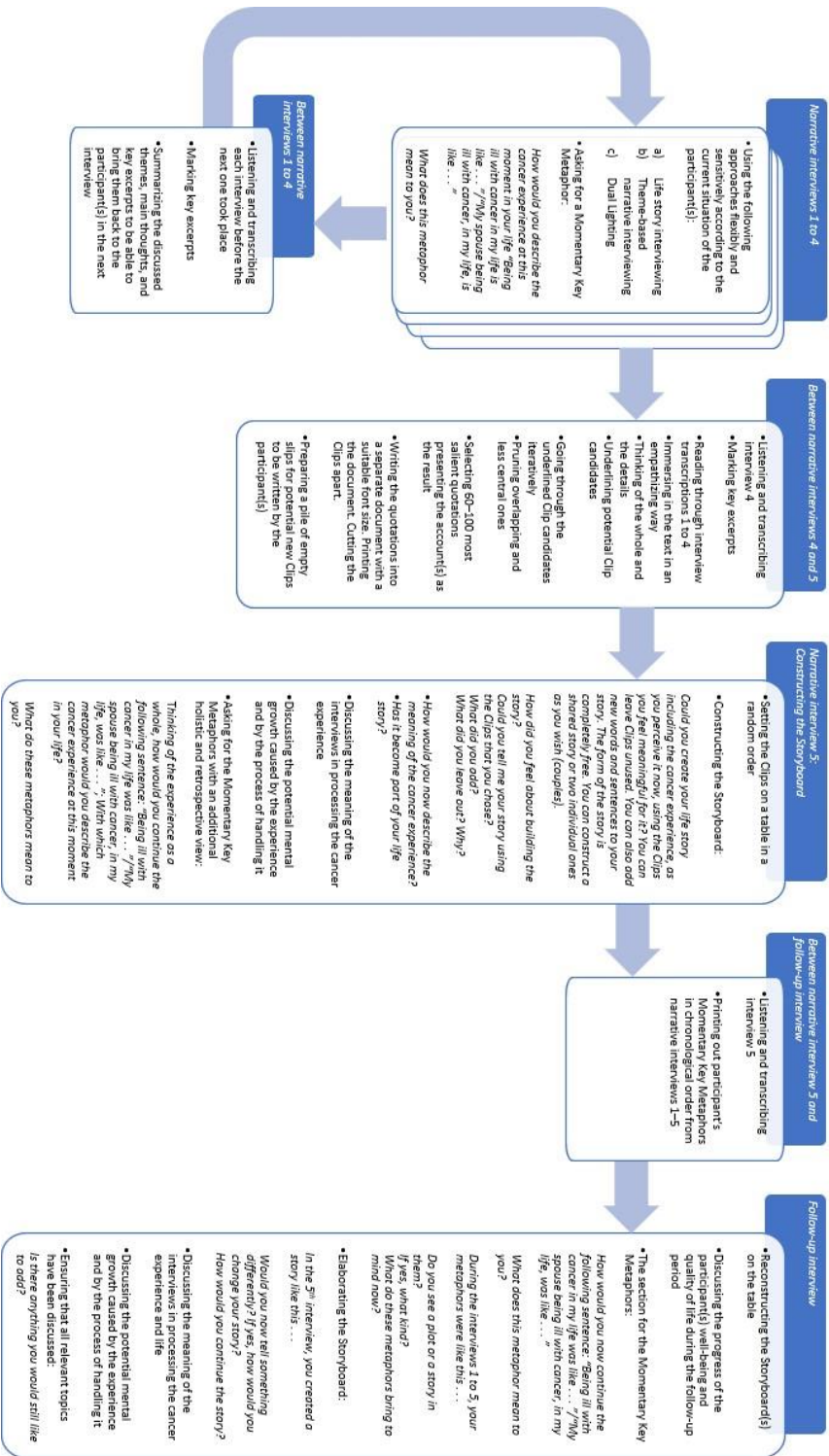
Future

- New perspectives
- New direction
- Possibilities
- In spite of the illness
- Experiencing one's health
- Rehabilitation
- Healing
- Well-being
- Quality of life

Cancer experience and life story

- The whole
- Wonder
- Openness to change
- The element of surprise
- Humor
- Mystery
- Trust
- Own voice
- Meaningfulness
- Reasonableness
- Coping
- Achievements
- Strengths
- Priorities
- Values
- Gratitude
- Mental growth

Appendix 2. The Interview Process



Appendix 3. The Interview Methodologies in a Manual Style

To encourage researchers and practitioners to use the methodologies developed in this dissertation, I describe them in this appendix in manual style.

The guide is written using cancer experience as an example of an autobiographical rupture experience. However, the methodologies can also be used to address other autobiographical rupture experiences, in which case the necessary wordings will be adapted to the experience in question.

In the manual, different interview sections are separated with two hyphens.

Preparing the Physical Setting

Arrange a quiet place for the interviews, preferably the same room for the entire interview period. The room should contain a large enough table with 2–4 chairs around it for constructing and re-exploring the stories (hereafter, “Storyboard”) and a soft, comfortable seating area, such as a sofa and armchair, for the dialogues.

Creating and Nurturing a Dialogical Space

As important as it is to create a suitable physical space, it is also essential to create and nurture the dialogical space. Show the interviewees that you are interested in them, in what they have experienced, and in their lives as a whole. Listen to them in a careful, empathic, and responsive way. Show respect to them and what they say.

One essential means that supports you in accomplishing the above, and the interviewee in building a broader picture, is that you, throughout the process, reflect back what the interviewee has told you before. You can do this within an individual interview, for example, by summarizing the contents of the interview, and between the interviews by bringing material from the previous interviews to the next ones. Use the interviewee’s own words, expressions, and phrases when reflecting back their narration. You may even quote whole sentences or small excerpts of the dialogue when bringing something salient back to the dialogue.

When you are interviewing couples, encourage both interviewees to take part in the dialogue. Respect the natural flow of the interaction.

Instructions Concerning the First Interview

Tell the interviewees that they are the focus of the session and that you will interview them using different narrative interviewing methods, but in general you

hope that they will freely reflect on their lives and the cancer experience, its impact, and the needs that arise from it, with an emphasis on what they find meaningful.

Emphasize that the interviews are confidential, but the interviewee does not need to tell you anything that they do not want to share. Let the interviewee(s) know that there is no hurry in the interviews; there is as much time as is needed for each interview.

At the end of the first interview, agree on the length of the interview period and a tentative interview schedule within it. These may be influenced by the length of the treatment period, certain specific events during it (personal or treatment-specific) or the interviewee's/couple's wish to process the illness experience over a longer period. Agree on the date and time of the next interview.

Narrative Interviews 1 to 4

Use the following narrative interview approaches flexibly and sensitively depending on the current situation of the interviewee(s):

- Life story interviewing: “Could you tell me your life story?”
- Theme-based narrative interviewing with the following main themes:
 - cancer treatment
 - physical, mental, and social well-being
 - patient and spouse, family
 - work and leisure
 - the future
 - cancer experience and life story from different viewpointsFor further details, see Appendix 1
- Dual Lighting
 - can be used when the interviewee has created a Momentary Key Metaphor that presents two or more different (often contrasting) angles on the cancer experience

Start one of the interviews with a simple life story prompt: “Could you tell me your life story?”

Raise other themes according to the interviewees' current concerns at the time of each interview. Make sure that all the main themes will be addressed during interviews 1 to 4. When necessary, continue by asking clarifying questions or present subthemes (Appendix 1) as narrative topics.

Use Dual Lighting to help the interviewee explore their cancer experience and life through the contrasting perspectives presented in the metaphor they have created earlier (e.g., being in the midst of a nightmare vs. being awake). You may ask, for example:

- In which areas of your life and this experience do you still feel like being in the midst of a nightmare and in which do you already feel like being awake?

and then go through the interview themes.

--

Towards the end of the interview, ask the interviewee(s) with which metaphor they would describe the cancer experience at that moment in their life. Encourage the interviewee(s) to form the metaphor by continuing the following sentence:

- “Being ill with cancer in my life is like . . .” (patient)
- “My spouse being ill with cancer, in my life, is like . . .” (spouse)

When sharing a metaphor opens up a dialogue, let the conversation continue under its own guidance. You may also ask the interviewee to reflect on the metaphor’s personal meaning to help open the metaphor further:

- What does this metaphor mean to you?

If you are interviewing a couple, encourage the couple to share their metaphors in varying order during the interview series.

--

Agree on the date and time of the next interview.

Between Narrative Interviews 1 to 4

Listen and transcribe each interview before the next one. Mark key excerpts. Summarize the themes discussed, main thoughts, and key excerpts, so that you can return them to the interviewee(s) in the next interview(s).

Between Narrative Interviews 4 and 5

Listen and transcribe the 4th interview. Mark key excerpts.

Read through interview transcriptions 1 to 4. Immerse yourself in the text in an empathizing way. Think of the whole and the details.

Underline potential Clip candidates. Focus on the interviewee’s personal ways of expressing:

- life and its events
- self and others
- the past and the future
- feelings and thoughts
- options and choices
- evaluations and perceptions
- questions and answers
- values, goals, and wishes
- meanings and metaphors

The length of the Clip candidates may vary from a single word to a long sentence. Probably many of the key excerpts that you have previously marked are potential Clip candidates.

Go through the underlined Clip candidates iteratively and prune any that overlap or are less central, with the aim of identifying 60–100 most salient quotations representing the account(s) as a result. Write the quotes in a separate document in an appropriate font size. Print the document. Cut the Clips apart. Prepare a pile of empty slips for potential new Clips to be written by the interviewee(s) in the 5th interview.

Narrative Interview 5

Set the Clips on the table in random order before the interviewee(s) arrive(s).

When the interview starts, let the interviewee(s) face the Clips and emotions they evoke in peace. You can tell them how the Clips were born.

Instruct the interviewee(s) as follows:

- Could you create your life story including the cancer experience, as you perceive it now, using the Clips you feel meaningful for your story?
- You do not need to use all the Clips, just the ones you feel are relevant to your story.
- You can also add new words and sentences to your story. Here is a pen and slips of paper in case you need them.
- The form of the story is completely free.
- You can construct a shared story or two individual ones as you wish (couples).
- First have a look at all the Clips in peace. Then, take your time in constructing the story.
- The story will not be grammatically complete, but it may evolve in many ways: chronologically, thematically, developmentally, etc.
- I will do something else nearby so as not to disturb you, but you can ask me any questions you have in mind now or while constructing your story.

Move aside to the sofa or armchair, for example, to read some papers that you have with you. Be present in case the interviewee(s) need anything.

When the interviewee(s) indicate(s) that they are ready, go to the Storyboard and give the interviewee(s) appreciative feedback on the outcome. Ask the interviewee(s) for feedback as well:

- How did you feel building the story?

Then you can ask the interviewee(s) to tell their story with the Clips:

- Could you tell me your story using the Clips that you chose?

Let the interviewee(s) expand their account:

- What did you add? What did you leave out and why?

--

Invite the interviewee(s) to the sofa and armchair to continue the dialogue:

- How would you now describe the meaning of the cancer experience?
- Has it become part of your life story?
- How would you describe the meaning of the interviews in processing the cancer experience?
- Have you noticed any mental growth caused by the cancer experience and by the process of handling it?

--

Towards the end of the interview, ask the interviewee(s) for a Momentary Key Metaphor in two ways. First thinking of the cancer experience retrospectively, as a whole, by continuing the following sentence:

- “Being ill with cancer in my life *was* like . . .” (patient)
- “My spouse being ill with cancer, in my life, *was* like . . .” (spouse)

and thereafter, describing the cancer experience at that specific moment as in the preceding interviews.

When sharing a metaphor opens up a dialogue, let the conversation continue under its own momentum. You may also ask the interviewee to reflect on the personal meaning of the metaphor to help open the metaphor further:

- What do these metaphors mean to you?

--

Agree on the date and time of the follow-up interview (approximately one year after the first interview).

When the interview has finished, take a photograph/photographs of the Storyboard and number the Clips on the back.

Between Narrative Interview 5 and the Follow-up Interview

Listen to and transcribe the 5th interview.

Print out the interviewee’s Momentary Key Metaphors from narrative interviews 1 to 5 in chronological order.

The Follow-up Interview

Before the interview, reconstruct the Storyboard(s) on a table according to the photograph(s) taken after the 5th interview.

Start the interview by asking about the progress of the interviewee's/couple's well-being and quality of life during the follow-up period:

- Could you describe your well-being and quality of life, and how they have evolved since the 5th interview when we met last time?

--

Then ask the interviewee(s) for a Momentary Key Metaphor, thinking of the cancer experience as a whole from a longer-term perspective by continuing the following sentence:

- “Being ill with cancer in my life was like . . .” (patient)
- “My spouse being ill with cancer, in my life, was like . . .” (spouse)

When sharing a metaphor opens up a dialogue, let the conversation continue under its own guidance. You may also ask the interviewee to reflect on the personal meaning of the metaphor to help open the metaphor further:

- What does this metaphor mean to you?

Then hand the interviewee(s) the sheet of paper with their personal Momentary Key Metaphors in chronological order and ask the interviewee(s) to share their thoughts on the metaphors:

- During interviews 1–5, you created these metaphors, in this order, to describe the cancer experience in your life. Take your time to look at them.
- Do you see a plot or a story in them? If yes, what kind?
- What do these metaphors bring to mind when you look at them now from a longer-term perspective?

--

Then go together to the Storyboard and give the interviewee(s) the following instructions:

- In the 5th interview, you created a story like this. . . . Take a look at it in peace. Then I will ask you to ponder:
- Would you now tell something differently? If yes, how would you change your story?
- How would you continue your story?
- You may add new Clips, move Clips, take Clips away—change and continue the story in just the way that you wish and feel right at the moment, from the current perspective.
- Here is a pen and slips of paper for your possible needs.

Move aside to the sofa and armchair, as in the 5th interview.

When the interviewee(s) indicate(s) that they are ready, go to the Storyboard:

- Did you change something? If yes, what kind of changes did you make and why?
- How did you continue your story?

--

Invite the interviewee(s) to the sofa and armchair to continue the dialogue:

- How would you describe the meaning of the interviews in processing the cancer experience and your life?
- Have you noticed any mental growth caused by the cancer experience and by the process of handling it?

Finally, ensure that all relevant topics have been discussed during the interview series:

- Is there anything you would still like to add?

Thank the interviewee(s) for sharing their experience and life story.

"Here, the whole of life intertwines with the stories now on these clips, so this in a way sheds light on how you have lived and where you are now, and how to get forward . . . I am now much more mature and able to face the life ahead again; I won't worry about this cancer anymore." (patient)

This dissertation developed two key interview methodologies to work through an autobiographical rupture experience and to support the (re)construction of life narratives with 10 prostate cancer patients, five with their spouses, in a series of interviews conducted over a timespan of several months. In the Momentary Key Metaphor methodology, the interviewee is asked to describe the illness experience using metaphors and to reflect on their personal meaning; the metaphors are then returned to the interviewee for retrospective review in the last interview. In the Clip Approach methodology, the interviewee's narration is reflected back through visual artifacts, "the Clips," that allow the interviewee to re-enter their cancer experience and life and to re-construct their narratives concerning them. The dissertation proposes a series of interviews as a patient-centered guidance and counseling intervention for cancer care and outlines several different options for the use of the methodologies in practical client/patient work and research. The methodologies offer encouraging potential for low-threshold psychosocial support interventions in a range of application areas and may also provide new tools for existing contexts, such as psychotherapies, and medical appointments in a longer treatment relationship.



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