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Ensnared by positivity: A constructivist perspective on 'being positive' in cancer care

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A B S T R A C T

Background: The concept of 'positive thinking' emerged in cancer care in the 1990s. The usefulness of this approach in cancer care is under increasing scrutiny with existing research, definitions and approaches debated. Nurses may wish to judiciously examine the debate in context and consider its relevance in relation to their experience and clinical practice.
Purpose: To offer a constructivist perspective on 'being positive' we extract data from a constructivist grounded theory study on humour in healthcare interactions in order to identify implications for practice and future research.
Methods: We offer three areas for consideration. First, we briefly review the emergence of 'positive thinking' within cancer care. Second, we present data from a grounded theory study on humour in healthcare interactions to highlight the prevalence of this discourse in cancer care and its contested domains. We conclude with implications for practice and future research.
Findings: Patients actively seek meaningful and therapeutic interactions with healthcare staff and 'being positive' may be part of that process. Being positive has multiple meanings at different time-points for different people at different stages of their cancer journey. Patients may become ensnared by positivity through its uncritical acceptance and enactment.
Conclusion: Positive thinking does not exist in isolation but as part of a complex, dynamic, multi-faceted patient persona enacted to varying degrees in situated healthcare interactions. Nurses need to be aware of the potential multiplicity of meanings in interactions and be able (and willing) to respond appropriately.

Introduction

Positive psychology – a response to psychology's previous emphasis on the abnormal – emerged to much acclaim at the turn of the century (Seligman and Csikszentmihalyi, 2000). Notably, this turn to 'flexible optimism' took place against the backdrop of the discussion on 'positive thinking' in cancer care in the 1990s (Gray and Doan, 1990; Rittenberg, 1995; de Raeve, 1997). 'Positive thinking', 'being positive' or any combination of a 'positive' attitude, thought/belief or behaviour, including psychological constructs such as optimism and hope, arguably emerged by stealth via a plethora of quantitative, cognitive scale-based studies (e.g. Folkman, 1997; Taylor and Armor, 1996; Greer and Watson, 1987; Taylor, 1983; Greer et al., 1979). The usefulness of much of the research carried out in this area is debatable. Consequently, Wilkinson and Kitzinger (2000) offer a different analysis of 'positive thinking'.

Wilkinson and Kitzinger (2000) claim there is an inappropriate over-reliance on self-report data (e.g. interviews or questionnaires) in previous literature and offer their data of unstructured focus groups and interviews analysing spontaneous utterances of 'positive thinking'. Their discursive approach views talk as action with meaning constructed for its local interactional context. Talk is therefore, not necessarily accepted as an accurate depiction of the speakers' cognitive processes (i.e, what they say is not necessarily what they mean). Accordingly, Wilkinson and Kitzinger's (2000) analysis suggests that 'positive thinking' may operate, in part, as a conversational idiom or, as a normative way of talking about cancer.

The value of 'positive thinking' in cancer care is therefore, under increasing scrutiny irrespective of the relevance of the research approach adopted and its subsequent interpretation (Ehrenreich, 2009; Pistrang and Barker, 1998; McGrath et al., 2006a). Nevertheless, the prevailing view suggests that 'positive thinking' may be at least an 'artificial pressure' (McGrath, 2004:5) if not, oppressive (de Raeve, 1997). We contend that nurses should judiciously examine the debate in context and consider its relevance in relation

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to their experience and clinical practice. Thus, we consider it appropriate and timely to offer a constructivist perspective on 'positive thinking.'

A constructivist perspective

Constructivism is based upon a philosophy of learning and the premise that, by reflecting on our experiences, we construct our own understanding of the world we live in (Vygotsky, 1978). Individuals actively generate their own understanding and 'rules' are then used to make sense of their experiences. Social constructivists therefore, explore how individuals make meaning *within* a social context while social constructionists (e.g. Wilkinson and Kitzinger, 2000; Edwards and Potter, 1992; Gilbert and Mulkay, 1984) review phenomena (like 'positive thinking') *relative* to context.

The constructivist paradigm draws upon the sociological perspective of symbolic interactionism (SI) (Blumer, 1969) and SI is based upon the triumvirate of meaning, thought and language. A constructivist perspective based upon SI focuses on meaning making within a social context and the multiple realities of the participants. Those multiple realities are individual interpretations (not shared realities) that arise out of interaction and introspection. The constructivist perspective also recognizes the proactive and *a priori* role of individual agency: the capacity to make choices and act upon them. Thus, participants actively engage in constructing, adapting and making sense of their interactions and draw upon a host of experiences in order to do so.

We offer three areas for consideration. First, we briefly review the emergence of 'positive thinking' within cancer care. Second, we present data from a grounded theory study on humour in healthcare interactions to highlight the prevalence of this discourse in cancer care and its contested domains. We conclude with implications for practice and future research.

'Positive thinking' – what is it?

One of the difficulties in reviewing existing research on 'positive thinking' is the diverse definitions and interpretations of its constitution and meaning(s). Generally, positive thinking is taken to indicate a particular attitude, belief, mental state or behaviour (e.g. articulating positive thinking). However, with regards to the latter, we agree with Wilkinson and Kitzinger (2000) that when someone says 'I am being positive' – what they say is not necessarily what they 'think'. Moreover, we concur with Wilkinson and Kitzinger (2000) that 'positive thinking' is a relatively ambiguous concept. It follows therefore, that 'positive thinking' may hold multiple meanings depending upon the participants, (individual) experiences and context.

A further difficulty emerges when positive thinking diffuses into the considerable research on related issues such as hope (Herth, 1990, 1992), optimism (Scheier and Carver, 1992) and spirituality (Larimore et al., 2002). Inevitably, these issues have their own semantic tensions to resolve and, correspondingly, their preferred research approaches (see Eliot and Olver, 2002). For example, much of the research quoted does not specifically address the topic of positive thinking but, rather includes it, or some aspect thereof, on a trait measurement scale, e.g. optimism. Accordingly, while psychological constructs such as optimism, positive mental attitude or hope are distinguishable from each other, they are often attributed to, or cited as, part of an amorphous tranche of literature on 'positive thinking' depending upon the perspective being presented.

From our constructivist perspective, what is relevant is not our interpretation (or a particular definition), but the co-construction of 'positive thinking' by researchers and participants from data. However, for the purposes of this paper, we believe it is necessary at this juncture to offer a broad *a priori* interpretation of 'positive thinking'. Thus, 'positive thinking' is a generic phrase used to describe any derivative encompassing hope, optimism, positive mental attitude, including 'being positive' It is taken to mean a particular attitude, belief, feeling or behaviour that *may* infer optimism but may not represent the 'realities' of the individual or of their situated context.

Positive thinking – a contested domain

It appears to be broadly accepted that positive thinking is better than negative thinking (Moberly and Watkins, 2008). However, fairly early in the debate, the idea that positive thinking had a *direct causal* link with well-being (or illness) was refuted (Cassileth and Stimnett, 1982) although this is contested (Siegel, 1986). Consequently, there has been a focus on positive thinking as an *indirect or mediating influence.* Notwithstanding, the theoretical, methodological and definitional tensions, the broad body of work in this area reviews positive thinking in terms of coping *per se* (mental adjustment, reframing) and postulates the potential for this to *(indirectly)* impact upon the progression or otherwise of the disease (e.g. Yu et al., 2003). Thus, Shou et al. (2005) suggest that positive thinking is more likely to create a *perception* of a better quality of life rather than a better quality of life *per se*.

However, while positive thinking may be useful it may also impede important conversations at the end of life in an attempt to protect loved ones (McGrath et al., 2006b). Moreover, it exists as a contested domain *among* patients, particularly the notion that positive thinking is a social norm or moral obligation (Coreil et al., 2004; Holland and Lewis, 2000). Although patients are a valuable and arguably under-used resource in healthcare as a means of peer support (Isaksen and Gjengedal, 2000) they can also project 'unwanted pressure' onto their peers via inappropriate 'cheerleading' or as McGrath (2004) terms it – the 'ra ra positives'. Interestingly, nurses and patients have different understandings of positive thinking: nurses view it as an attribute (e.g. courage) while patients reportedly perceive it as a way to attain normality (O'Baugh et al., 2003).

Finally, several authors raise the issue of the potential for 'blame' or the marginalization of individuals for their 'failure' to think positively and perhaps even for the resultant worsening of disease (de Raeve, 1997; Rittenberg, 1995 Coreil et al., 2004). However, there is no evidence whatsoever to support the notion that psychological coping styles impact upon disease progression (Petticrew et al., 2002).

We now present data from a constructivist grounded theory study which explored spontaneous humour in Clinical Nurse Specialist-patient interactions (McCreaddie, 2008).

Method

The data upon which this paper is based was drawn from the main study which took place over an 18-month period (McCreaddie, 2008). The theory (McCreaddie and Wiggins, 2009) and the methodology (McCreaddie and Payne, in press) are presented in full elsewhere. We will first, briefly outline the main study to provide the reader with appropriate background and context.

The main study (methods)

The main study reviewed the phenomenon of *spontaneous* humour in Clinical Nurse Specialist – patient interactions and their respective peer groups using a constructivist grounded theory approach (Charmaz, 2006). Grounded theory is particularly useful