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FEATURE



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Conquering and Coping with the 'Big C'

A phenomenological study of exceptional cancer survivorship

Introduction

I was a thirty-six year old nurse teacher when diagnosed with secondary adenocarcinoma. This later proved to be breast cancer and resulted in a sincere pursuit of health, especially through a six year period of recurrence. I realised there was a scarcity of professional literature to suggest that survivors of cancer are ever asked why they thought they had survived (Roud, 1986). It is suggested that people who accomplish remarkable recoveries may possess practical knowledge not yet captured by a purely theoretical account of the disease. It seems that the person in our society, who survives against the odds is undervalued. Little time or money is available to study the pursuit of well-being.

Health workers often have a persistently negative attitude to the likelihood of cancer survival and may therefore have hampered attempts to restore people to their optimal level of functioning. This means that

ABSTRACT

This is a study of the experiential phenomena of the cancer survivor's healing journey. The phenomenology of cancer survivorship included six themes common to overcoming disease – commitment (to finding out facts and therapies), the challenge (the determination to live), control (over mind/body), caring (for self and others), changing and gaining confidence in self, other and God.

cancer patients may get a very different deal than say, cardiac patients. I suggest that a phenomenological study of cancer survivors' stories may be useful to both would-be cancer survivors, and to nurses who might be in the position to 'coach' them.

A combined interpretive approach, grounded in Heideggerian hermeneutic phenomenology was used to study the experience of cancer survivors. This could be

described as focusing on quality of life and illuminating meaning from the person's perspective. This is a useful approach for a topic about which little is known, or when what is known has perceived biases or omissions (Sandelowski, Davis & Harris, 1989: 78).

This methodology is about 'getting to the things themselves', and 'understanding the everyday world'. The aim is to examine particular phenomena, investigate general essences, apprehend essential relationships, then analyse and describe the findings. The methods are inductive and descriptive (Field & Morse, 1985).

This study was undertaken as a nursing doctoral thesis. It aimed to address the question:

'Do exceptional cancer survivors have anything in common?' That is, 'is there such a phenomenon as a cancer survivor?'

The study sought commonalities in the person's view of how he or she overcame cancer, and coped with survivorship. This stance

proposes that the phenomenon can best be described from the perspective of the survivor's subjectivity.

Method

Defining terms

It appeared necessary to define a 'cancer survivor' medically. This was necessary because it is impossible to know the current prognoses of different people with different types of cancer, or to know whether these people even had cancer. For this thesis this read as having survived beyond a medical prognosis of 'less than 20 percent chance' and being cancer symptom free at the time of interview. A 'healing journey', included any body/mind/spirit aspects deemed relevant (by the informant) to survival, since a cancer diagnosis.

Obtaining ethical approval

Before ethical approval was obtained the consent form was redesigned to not only include consent for interview, but also to include consent for a doctor to confirm their story.

Locating informants

The researcher used theoretical rather than random sampling, in which subjects were selected because they could illuminate the phenomenon being studied. Sandelowski *et al.* (1989: 79) suggest that the investigator will not know in advance the kinds of informants that need to be sampled, but will attempt to saturate the categories as they evolve.

Attempts were made to contact people in broad demographic categories and with as many

types of cancer as possible, -- within a 100 kilometre radius of the researcher's home. Interviewing included some significant others. It was realised that 'conjoint interviews might allow mutual collaboration or correction' (Sandelowski *et al.*, 1989: 81).

After writing to oncologists, surgeons and general practitioners for patient referrals that fitted the above definition, the researcher only achieved referrals from general practitioners who were prepared to consider alternatives and also

... the context of the personal narrative will always alter the story itself.
— Stahl, 1989

alternative therapist sources.

Eventually the research included 10 participants. Their ages at time of diagnosis were 35-65 years. Survival times ranged from 3 to 30 years. The researcher did not obtain histology reports on any, as medical confirmation had been problematic enough. Relocating the first informants was always approached rather diffidently as mortality in this research was sometimes literal. The researcher was pleased to find informants who were not just willing and able to talk, but actually enthusiastic about the journey we would undertake together.

Data collection

In depth interviewing was used as the main form of data collection. It asked the question 'What is it like to be a cancer survivor?'

The participants were guaranteed anonymity and referred to by an agreed nickname. The researcher tried to retrieve the information in language that was natural to the participants.

The type of questioning asked them to tell their story beginning with 'could you go back to when you were first diagnosed with cancer?', with such prompts as 'what happened?' and 'what did you do?' 'How did you feel?'

The clients' stories were told from initial symptoms to when they perceived they were well. The questions asked included foci such as symptoms or reasons for seeking medical investigation, medical diagnosis and prognosis, environmental and physical factors — body, mind and spirit issues. All of these were compared over time, before, during and after diagnosis and treatments.

Mind/body/spirit questions have been separated only because of convenience to transcription, not because of any belief that they are necessarily separate entities. Confirmation of, and opportunity to alter or add to, the data transcriptions were made with the participants. Interviews varied from one to five hours.

All interviews are a dilemma of attempting to glean the truth as perceived by the participant. This requires trust and enthusiasm on both sides, rather

than disinterest or manipulation. Much of such assessment is made on non-verbal clues, which is a reason for keeping working notes as well as tapes (Jones cited in Long, 1985: 51). Stahl (1989) warns that the context of the personal narrative will always alter the story itself. This record is only one frozen moment of time.

Data analysis

All tapes were transcribed into computer text. Using NUDIST (non-numerical data information storage and transfer), an index of these themes was begun. NUDIST has some advantages over other word-processing as it allows the researcher to code the data still within its context. Thus the context can be seen as a whole and discussed with others. The researcher can 'use the touch of scissors or the touch of a butterfly' in handling their data (Richards & Richards, 1991: 260).

The index of tentative themes was added to as all interview statements were categorised... a slow, uncertain and tortuous intellectual journey... of taking fragments and trying to fashion them into a mosaic (Ammon-Gaberson & Piantanida, 1988: 160). These themes are rebuilt into a defined phenomenon.

It is this thematic conclusion which is most open to interpretation, as it takes the study from statements, according to the subjects, through to the construction of meaning. What is important from an hermeneutic view is not the patterns but the meanings and interpretation that they reflect

(Allen cited in Chinn, 1986: 30).

The rigour of phenomenology is found in its multiplicity of strategies used to collect and interpret data; and in the art of the researcher using commitment, integrity, personal insight and judgement in the processes of data collection and analysis. This is aided by open and repeated dialogue between all parties (Burgess, 1984).

I came to the research having had a lived experience of cancer but was able to travel only retrospectively through the

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experiences of the subjects, rather than go through a current experience with them. Like an experiential social scientist the researcher tried to see things as they are and remain open to the experience.

Data presentation

This text was mostly worked thematically. The challenge is to live the experience by being-in-the-world of the participants and achieve a fusing of horizons with the participants. Then in the analysis the challenge is to try and define each phenomenon by getting to the heart of the aspect

but still placing it in context. In the final analysis it is not a matter of whether you got it right, but rather whether you negotiated a position *via* open dialogue. The information is distilled to its most essential terms, while still providing enough information to allow the reader to see the plausibility. A synthesis of structures of the lived experience is written.

Completion and writing

Essentially hermeneutic phenomenology becomes a writing activity. Research and writing are aspects of one process as one reflects on essential themes and writes and rewrites. It is a hesitant attempt to say something meaningful that is not reduced to academic chatter. As with poetry there is no punch line. Meaning questions cannot be solved and then shelved, but the researcher must maintain a strongly oriented focus to the original question. The research context is balanced by reconsidering the parts and the whole (Van Manen, 1990). Each theme was supported by participants' quotes, literature review and personal comment.

I imagined that the informants expected to learn what was done with the research findings and so this meant recontacting them at twice yearly intervals. This was a sensitive issue as several were unwell. I felt the need to produce a document that is available to them and hope to write several useful booklets for potential cancer survivors.

Overcoming Themes

The themes common to all stories were defined as 'six little

c's to overcome the big C'.

These were commitment, challenge, control, caring, changing and confidence. Sub-themes are included below with a paradigm quote:

1. Commitment

Finding out about therapy and facts

Nan ... and I said 'my prognosis?' and he said 'three months if you're lucky' and I said, 'the ovary operation how long does it take to recover from it?' He said 'at least six weeks'. I said I couldn't believe him I said I felt reasonably well again though still stuck up and I said 'why would you want to do that'. I was sort of amazed and I thought well ... what happens? what survival rates? like then the shock came ... they had no bank of information nothing whatsoever. they were trotting around in their own little world ... they would have liked to have given me chemotherapy...

Keeping on against advice, opinions and set backs, both psychological and physical

Whiskers ... 'I would leave at eight o'clock in the morning (for radiotherapy via train trip for 35 days) it became a routine... and you know I wore the same clothes ... to me they weren't important.

... my attitude is you've got to be busy you must fill your hours you just don't sit there and think about it ... filling the mind up with other stuff - like helping other people mainly, I think by doing something for somebody else and I think by filling the gaps in my mind and so as not to think - I couldn't bear to think what happened and I didn't know if I was grieving for my husband my boob or what had happened in my life. I didn't know it was all one'.

Findings

Participants

Pseudonym	Site of Cancer	Year	Other
Brusta	Bowel with spine and liver secondaries	1987	Normal blood test 1988. Died suddenly 1994.
Bonny	Stomach and liver	1987	Familial polyptosis. Well 1997.
Cathie	Breast left Breast right	1961 1966	Cardiac arrest 1976. Multiple myeloma 1996. Well 1997.
George	Rib and lymph - neck Facial	1977 1992	?Rhabdomyosarcoma. Lymphoma. Well 1997.
Maggie	Ovary with bowel and thoracic lymph	1991	Clear scan 1992. Well 1997.
Moggs	Melanoma-familial	1962	Cardiac arrest post-abortion. Well 1997.
Nan	Breast with liver secondaries	1980	Clear scan 1981. Well 1997.
Noel	Pancreas with aortic involvement	1989	Clear scan 1991. Well 1997
Roy	Lung with neck secondaries Prostatic with spinal secondaries	1981 1991	Died 1995.
Whiskers	Breast with lymph involvement	1981	Emergency CAGS 1993. Well 1997.

2. Challenge

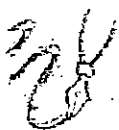
Conscious denial of a death sentence and of pity

George ... 'It was Saturday morning. (My wife) came in and I just said to her 'look I've been doing a lot of thinking' and I said 'I want to make my funeral plans' and that didn't go down too well and she said 'but why', and I said 'well just in case' ... but I said 'I've also decided that I'm not going to die ... you and I will make a pact that we're not going to talk about the negative side of things ever again'. I said 'you ever hear me doing it you can do and say what you like to me' and I

said 'I know I won't hear you talking negative.'

Determination in living and in choosing

Maggie ... 'then whilst I was there I was offered a trip with free accommodation to be the keynote speaker at a conference. I gave the paper 'life sentence'. It was designed to be quite challenging to doctors. While I was there I had a lovely time and I also spent another day vomiting all day long in the Sheraton Hotel thinking what have you done now ... you silly woman and ringing the oncologist to find out (laughter) what could be done ... and the a



pain! I couldn't cope with the headache pain and the suppositories didn't seem to be having any effect and I thought goodness what will I have to do fly back to Australia? He called that the Fiji Fiasco (laughter).'

3. Control

Over disease: Surgery —
Radiotherapy — Chemotherapy
— Hormones

Brusta	Bowel resection and temporary colostomy
Bonny	Bowel resection
Cathie	Mastectomy and radiotherapy
George	Rib and lymph neck Radiotherapy and chemotherapy
Maggie	Surgical clearance, temporary colostomy and chemotherapy
Moggs	Tumour and lymph resection and surgical abortion
Nan	Mastectomy and tamoxifen 3 months
Noel	Pancreas resection and bypass
Roy	Lung lobectomy and radiotherapy Prostatic orchidectomy Hormones and radiotherapy
Whiskers	Mastectomy and radiotherapy

Control over Body: Exercise —
Against Pollutants — Diet

(B) Well the day would start at probably around about six o'clock ... and the first thing I'd do was meditate and then go for a walk and come back and have a good healthy breakfast and then go to work. I would then come home at morning tea time and meditate again and have a juice ... then it would be home for lunchtime and meditation again ... juices-tea-meditation-bed and then you'd

start off the next day again.

Control over Mind:

Visualisations — Relaxation
Affirmations — Distraction/
Work

Bonny ... 'I've got packmen. I've got six packmen that makes it three ones on the top and three ones lower in my body, they will attack and eat cancer cells and then I will get a big vacuum cleaner and it suctions all the bits and pieces away, and if I'm really good I might get under a waterfall and let the water wash away any cells left.'

4. Caring

For self enjoyment, (travel, music, humour, food, hobbies, nature) — Health, alternatives and supplements — Well being and balance — Self worth

Caring for self-enjoyment:

George ... 'I used to love doing the singing and that was what I used to look on as an outlet from the stress from work.'

(C) How much did your music help.

(G) Oh a hell of a lot.

(C) A psychologist said that to survive cancer you have to learn to sing your own song ... you found that easy really from the beginning cause you already had that.

(G) Yeah that's exactly right ... yes I'm glad I did I'd have been lost without it.'

Caring for others: Cancer sufferers and family

Cathie ... '(I said) I'm not going to die because I can't leave (my youngest daughter). Just give me a few more years I used to say to myself about the future give me a few more years until my youngest at least gets to school ... once she's at school then my husband will be able to cope.'

Caring from others: Friends, groups, family, therapists and survivors

Moggs (my husband) was very supportive of course and I mean he had to be ... my mother she was absolutely wonderful ... she had to take, well she didn't have to but she did take the 2 children and she had my husband to live with her the whole time I was in hospital or in and out of hospital and then when I came home I went there as well so she had a big job.

(C) Who helped you person wise ... you've talked about your husband being supportive.

(M) I've never found anybody that didn't give you support ... no one felt sorry for me and I think that helped a lot you don't need sympathy.

(C) What do you need?

(M) Well you just need to know that people care more than anything I think and that they are there if you need them ... I mean it's nice for people to go round and do their own thing but if you need them and they're there then that's what you need at that time'.

Roy claimed meeting another survivor was a turning point. Roy ... 'Yes, a very specific point in time ... when I met her — an elderly woman — two mastectomy operations, lung cancer, I think she was 72 ... my thoughts immediately went to 'if you can beat this so can I ... I had something positive whereas with everything else I'd had negative.'

5. Changing

Letting go: Control, judgement, resentment, fear, hurt, responsibility, striving and worry

(N) 'I had very bad nerves too when it happened. I mean I'm not

Caring for self health

Brusta	attended a naturopath initially and received some vitamins and minerals
Bonny	attends two GPs who practice alternatives and has maintained supplements for years
Cathie	did not take supplements
George	did not take supplements
Maggie	did not take supplements
Moggs	did not take supplements for cancer but does now for other problems
Nan	does an occasional vitamin 'lunge'
Noel	attends both a GP and a Chinese doctor and has maintained supplements
Roy	once received Vitamin C from his oncologist, once received homoeopathy from an alternative therapist, but maintained sarsaparilla for years
Whiskers	continues to take a multivitamin pill

nervous person but inwardly nerves ... stomach rumbling you know all sort of things ... uncontrollable type of rumblings and nerves.

(C) And the meditation helped that?

(N) Yes it did ... it took a while but then I had a while. I needed the six or at least half hours a day and I look back and I definitely needed it ... and you're never clear (of cancer). You've got that the rest of your life.

(C) So how do you deal with that?

(N) I don't worry about it. You just cut it off. You just put it aside.

(C) ... How do you do that?

(N) You decide. It doesn't matter, you put something at the back of your mind, which isn't that difficult to do ... it's all in a sort

of self hypnosis even though you're not in a trance but your mind is. If you condition your mind to it nothing worries you. You don't want it to get too far like they say it's terrible if it worries but you can't have nothing worry you ... It's as though I'm conditioning - it's literally mind conditioning'. Learning: Thankfulness, discipline, simplicity, openness, acceptance, (faith, hope and love, the help of others, hard times, self and feelings) forgiveness and assertiveness Nan ... 'Really after I sort of got everything in order and accepted the fact that I was going to die ... I felt it and I accepted it ... it was over. I'm right ... you know what I mean? I had this and then it was just gradually (that) I realised that

I was getting better'.

Changing - learning

forgiveness:

Maggie ... 'one thing I used in meditation and which I used at one period, over and over and over again, is forgiveness ... The steps are - I forgave the other person for hurting self then asked forgiveness for hurting the other person and forgave myself for all deficiencies ... I went over and over and over with that meditation.

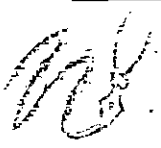
(C) When you've had so much hurt that would probably be difficult.

(M) I know that when I first started doing that meditation - it brings it back now - I would have tears running down my face the whole way through. I feel forgiveness was a major component and really found that that was more valuable than any of the other meditations that I did at that time ... so with all that coming to me all at once it's quite a lot to cope with (laughter)'.
'

6. Confidences

God, the hereafter, future, improvement, therapists, therapies and self

Maggie ... 'I was having visions of the back of Christ in front of me and of him turned half towards me with his hand reached out back towards me and he was smiling and of my hand reaching out towards his hand as if he was saying 'come walk with me and let me hold your hand' and I had this vision over and over again and I think it was this that eventually brought me to the step in which I let go of fear in the moment. I let go of control and said Lord (to God) I will be safe no matter what happens I am safe in you ... and I think now, though I can't relate



exactly which day I said that, but I think now that that was the moment at which I started getting better.

(C) So that was a step of just total trust regardless of the consequences?

(M) Yes irrespective of the fact that I might die and loss of fear of dying.'

Hardiness

Perhaps *hardiness* is a good term for these persons. It is defined by Dossey, Keegan, Guzzetta and Gooding Kolkmeier. (1988: 128-133), as 'individual characteristics of stress-resistant individuals who possess certain attitudes, beliefs, and a sense of control over all aspects of their lives'. These attitudes include being open to change and challenge, involvement, commitment and a sense of control. I added confidence and caring as I continued to analyse the statements.

Banks and Gannon found that *hardiness* did act as a stress buffer and a resistor to the development of illness. These individuals also optimistically appraised the world and therefore had a tendency to minimise the severity of illness or traumatic events (1988: 35).

Research on *hardiness* has alienation from work and alienation from self as the two sub components of commitment. Security scales of the Californian Life Goals measure challenge, powerlessness and external locus of control as the measured sub components for control.

Wagnild and Young (1991) and Funk (1992), argue that the *hardiness* literature is

inconsistent in what it is measuring. It is unclear whether *hardiness* is a unitary construct or three separate dimensions. They compare Pollock's finding, that using only emotionally focused coping suggests the absence of *hardiness* (and therefore something to be discouraged), with Lazarus and Folkman's definition that this is wresting positive value from negative events and therefore desirable.

Funk (1992) asks whether it

'These individuals also optimistically appraised the world and therefore had a tendency to minimise the severity of illness or traumatic events.'

— Banks & Gannon, 1988

wouldn't be better to measure the dimensions of commitment, control and challenge separately. *Hardiness* psychology researchers have typically adopted a total score approach in analysing their data. Hull, Lehn and Tedlie (1991) argue that either this approach, which totals sub components; or treating them as independent predictors, such as regression, have disadvantages. They suggest a multifaceted approach using structural modelling.

Obstacles Themes

There were also three other issues raised as obstacles by the participants which I have also begun with 'C'. These were Causes, Costs and Controversies about cancer. These three themes had sub themes as follows. Once again a paradigm quote is given for each theme.

1. Causes

Internal: Genetic —

Psychological — Immunity

Maggie ... 'When I get depressed I feel that I'm killing myself.'

(C) Can you expand that more — in what way?

(M) Well that means that one doesn't have a reason for living ... and it just seems to me that when I get down I'm going to go backwards and I feel that it's really taking a choice not to live ... I think undoubtedly losing hope is what kills one and that's what I was saying about when I get depressed that I'm killing myself.'

External: Stress — Pollution — Diet

Brusta ... 'I still cannot really pinpoint anything to say that is the reason ... but I realise that everyone creates their own cancer and I think basically eating habits over many many years ... and I'm not putting any blame on my mother at all but obviously when you look ... we didn't eat right as children there was always salted stuff and all this.'

(C) You ate right according ...

(B) According to the times I think that's probably the best way of putting it and I think that sort of ... disrespect for my body I suppose did the rest.'

spirit. They have to be 'high

2. Costs

Physical: Dollars — side effects — set-backs

Noel ... 'I was glad when (the mistletoe) stopped because it was pretty expensive a couple of hundred dollars a time.

(C) Yes that takes us to the money issue. So it wasn't a problem to keep up all these things money wise?

(N) No it wasn't ... but ... these vitamin things ... they're not cheap and see I got some yesterday and that was \$100 worth. You could be perhaps using it for something else. But, no, we were lucky like that we were able to'.

Psychological: Reduced energy, fear, set-backs and uncertainty

Noel ... 'Well you know (I was) pretty crook. I must admit I had a few quiet weeps in the hospital ... You sort of go to sleep wondering if you're going to wake up in the morning ... I suppose I kept thinking of my family ... my own children my grandchildren ... I won't see them when they're 21 sort of thing ... I must admit I suppose there wasn't a day went by that you didn't wonder what was going to happen and when it was going to happen, you know. The surgeon was a bit discouraging because not so long after the operation he asked me if we intended taking a trip of any sort. I said 'yes we were thinking of going to Hawaii' and he said 'oh well then do it sooner rather than later'. So it was hardly ... an encouraging statement to make ...

One time when I was with the specialist and he was giving me the ultra scan he just happened to say 'oh I'm having difficulty locating the tumour' and I said 'oh well does that mean it's getting

smaller?' He said 'oh no you couldn't expect that'.

3. Controversies

Blame

(D) 'Brusta's efforts did make a difference. He got six years with the kids that he wouldn't have had. It actually changed him so that he spent time with us that he wouldn't have otherwise spent. It makes you look at yourself and others.

Being positive made a bonus. It was easier for us to contribute and

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help because he was trying too. Even when I've had to tell people that he died they have thought that what he did was worthwhile. The other cancer sufferers haven't said 'well he failed, so I'll give up'.

Therapies: Conventional and unconventional

Noel ... 'we'd go and see the Professor ... one thing I always have to be careful about is this ... if I was going to him to make sure that I wasn't going to the specialist the next couple of days. They put these suction caps sort of things on you to increase ... your circulation and they sometimes leave a nasty bruise ... One time I did forget ... another one of the GP's treatments

was Thiscadore mistletoe extract ... and the wife was having to give me that just under the skin each day and ... well it would sometimes leave an ugly red mark ... She'd done that one morning and I went to the specialist. 'What's that?' he said and I said 'it's just an injection my wife has to give me'. 'Oh it looks infected to me' and that was all he said. He didn't ask what it was or anything so that was why I didn't sort of volunteer any further information about what I was doing. I mean there was a golden opportunity'.

Truths: Progress/Prognosis and Health Counselling

Bonny ... 'I don't think they can honestly give (an absolute prognosis). I mean how can they tell? I mean most times they have got a rough idea, but really people are too different.'

George ... 'No, no, I asked doctors about that ... People say to me 'oh you shouldn't eat all this red meat. You shouldn't do this but the doctor said 'eat what you like' and I've never ever not right from the outset ever had to worry about diet.

(C) So you just eat anything?

(G) Just eat anything I like'.

It appears there are a variety of obstacles to cancer recovery. These might be lack of early detection, aggression of tumour, and overwhelming carcinogen load. Other obstacles might have to do with gender and class. Hardy and Hargreaves (1991: 574) have shown that American Blacks tend to have poorer outcomes even if (which was unlikely) they were diagnosed at the same stage.

Socioeconomic class and status have been shown to be significant predictors of poor



outcome, but some studies also showed significant race effects independent of income. These same authors go on to suggest that to reduce disparity would require increased opportunity for upward mobility, research into causes and risk factors. Education programs about the latter, and access to early treatment and rehabilitation are also vital.

Implications for Nursing Practice

Nurses are in a unique position to coach patients, but they will lose that role if they don't embrace it. The rush through the 'conveyor belt' of the disease treatment system barely caters to physical needs, so staff are unlikely to find time to cater to health counselling needs. It does take time and encouragement for people to change. Much of what this study pleads for is an attitude so that at all encounters 'health professionals' could barrack for their patients with such statements as...

'Regardless of whether your disease is acute or chronic, life threatening or just a nuisance ... you can make a difference to your chances. Your body and mind are well equipped to heal. Your healing is within you. You can't remove every burden you are carrying, but make sure you remove as many as possible to give yourself the best chance to be able to get up again and go on. Nobody else can choose to do it for you but many can help you once you decide to try.'

The capacity to help people through their illnesses requires an appreciation of the uniqueness of people, their

situation and the stage they are at. It seems nurses are in a better position than most other health professionals to be able to get to know the individual patient. They are also in a more holistic position to give health counselling than other health professionals. If the 'Living with Cancer' group or the support group is run by a social worker, then the emphasis will be psychosocial. If it is run by a physiotherapist then the emphasis will be physical.

Nurses have a last chance to grasp such roles, rather than the other allied professions. To not do so is to narrow the role of

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the nurse and the focus of the counselling. Nurses are more likely than the medical profession to allow, and maybe even encourage, cancer sufferers to think they can live through the experience. They are less oriented to only conventional therapies and have even included therapies such as reflexology in their own areas of practice. This means they are in the unique position to be a bridge of understanding and communication between alternatives and conventional therapies and therapists. In this way they may coach the cancer sufferer to make choices for

themselves, and reduce the polarisation that is so detrimental to healing.

Nurses are also in the unique position of being able to meet the significant others in the cancer sufferer's life. They may therefore be able to help the support person to cope and guide them in their counselling of the person with cancer.

They can explain that the times of diagnosis, treatment, and follow up and later uncertainty are all times of unique stresses and require different understanding. The nurse can highlight how vulnerable and sensitive the person can be in each phase. The nurse might be able to see when and if either persons need extra counselling.

Cancer sufferers are found in homes, in medical clinics, in acute hospitals, in palliative care units, and in community health settings. Fortunately nurses are also found across all settings. The concern is that too few nurses realise how often their jobs are being divided up between 'less expensive part-care' givers. The plea is that registered nurses increase their voice and emphasise their unique capacity to be multiskilled across all health care settings.

Implications for Nursing Education

Nurses need to be educated with the above roles in mind. Nurses have to be able to be 'high tech' when administering such therapies as chemotherapy and plasmaphoresis. They have to be 'holistic' when encouraging cancer patients to nourish their

touch' when massaging feet. Educational preparation of nurses has an enormous challenge to manage to create such a multi skilled nurse for a changing world. If educators emphasise the psychosocial over the technical they risk 'reality shock' leading to disillusionment. If they emphasise the technical over the psychosocial they might as well have trained a technician.

The balance is a fine one that is made even more difficult when the educational system is also being driven by cost-effectiveness and mass production philosophies. The best solution might be to maintain close links between practice and theory, and to be honest with students about the challenges of the new world.

Implications for Nursing Research

Roud (1986), suggests that further research could be done that compared cancer sufferers who received support and those who didn't. The sort of support he suggested was being given information with hope, meeting with or reading about survivors, encouragement to experience the preciousness of life and time to develop more meaningful relationships with the clinic staff (1986: 121).

It would also be useful to have nursing research look singularly at the effects of laughter, crying, massage, prayer and pain relief on survival and relief of symptoms. Unfortunately nurses have been inclined to look to other disciplines to conduct such research, rather than owning such areas for

themselves.

Other research might compare the effects of healthy living compliance on survival. Exercise and nutritional aspects are the obvious ones which come to mind. However the challenge is no longer so much what people should do, such as quitting smoking, but rather why they don't change.

The isolation and understanding of the barriers to change and how to remove them is a relatively untapped area of research. It is probably no

The capacity to help people through their illness requires an appreciation of the uniqueness of the situation and the stage they are at.

longer lack of knowledge that handicaps most people, yet the 'health promotion' machinery continues to repeat the same awareness messages over and over. Perhaps research would show a far more cost effective way to empower the sufferer to decide and be able to change.

Summary

This thesis studied the experiential journey of exceptional cancer survivors. The phenomenology of cancer survivorship included six themes common to overcoming disease. These were commitment to

finding out facts and therapies, whilst keeping on against advice and setbacks. The challenge included conscious denial of death sentence and pity while determining to choose and to live.

Control was exercised over disease, over mind and over body in a variety of ways. Caring incorporated caring for self and others as well as accepting caring from others. Changing involved learning to accept some things and let go of others. Confidence was gained in self, others and God.

The thesis also uncovered some obstacles to recovery. These included external and internal causes, as well as physical and psychological costs. The controversies of conventional versus unconventional therapies, blame and truth telling were also raised.

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